Rehabilitation Needs and Organized Labor

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THIS FIRST National Labor Conference on Rehabilitation is a significant development. Never before have the rehabilitation needs of the family of labor assumed this importance. None can deny that these needs have long been with us, but only recently has the impact of disability and dependency been fully appreciated. Traditionally organized labor has devoted its energies to wages, hours, and working conditions. Long before the first U.S. collective bargaining agreement in 1891 these three issues were of primary concern to every worker and remain so. Relief from the distress of work-inflicted disability seemed possible with the passage of workmen's compensation legislation. However, half a century later, this is a promise still unfulfilled. The passage of vocational rehabilitation legislation in 1920 was initially regarded as an important measure for reducing the long list of handicapped. In the absence of any medical care provisions this legislation was relatively ineffectual until 1943, when funds for physical restoration and rehabilitation of the mentally handicapped were made available. Two decades later this legislation is another unfulfilled promise.

Today, in contrast with earlier periods of labor history, action to relieve disability and dependency is possible. Organized labor no longer limits its concern to the triad of wages, hours, and working conditions. Almost by accident, both labor and management were catapulted into the health field by a 1945 U.S. Treasury Department ruling and a 1949 Supreme Court decision. Rapidly "fringe benefits" grew into a $6 billion industry, and organized labor is now endeavoring to resolve the problems of providing its membership with prepaid, high-quality, comprehensive medical care. Initially this was not so. Who was to judge quality, quantity, or costs? In addition, the purchase of services was of necessity limited to those available in the medical market place. Both services and patients were fragmented and rehabilitation was undefined. Today rehabilitation has assumed its rightful place with prevention, diagnosis, and treatment. Furthermore, labor's contact with rehabilitation is no longer limited to that 5 percent of the nation's disabled who are victims of industrialization. Good health and the ability to work are the two primary capital assets of all those who work for wages or salaries. Illness, accidents, and disabilities reduce their earning power, threaten their economic security, and limit opportunities for advancement. The worker suffers the direct effects of illness or disability, and his family suffers the consequences. The AFL–CIO Executive Council, in authorizing the 1963 rehabilitation conference, has recognized the rehabilitation needs of the membership and closed the circle of comprehensive health services.

The National Institutes on Rehabilitation and Health Services, co-sponsor of the 1963 conference, was conceived 5 years ago at the highly successful National Conference on Labor Health Services. That conference, among other things, called attention to the urgent need for all medical care programs to provide preventive, diagnostic, therapeutic, and rehabilitative services.

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It was noted that while many programs were classified as comprehensive, in reality they were usually limited to the provision of diagnosis and therapy, with prevention and rehabilitation rarely receiving even lip service. Following completion of that conference a committee, including representation from some union health programs and the National Rehabilitation Association, was established to explore the availability of rehabilitation resources and services and methods for including rehabilitation services in union health programs.

In the ensuing discussions it soon became apparent that a third and more important problem was the appalling lack of communication and understanding between organized labor, consumer-sponsored medical care programs, and rehabilitation agencies. It was agreed that a national meeting of leaders in these fields would assist in solving these three problems. The Federal Vocational Rehabilitation Administration made a grant to conduct a national institute on rehabilitation and labor health services.

The Atlantic City Conference

The institute brought together planning groups, technical committees, local pilot meetings, and at the Atlantic City conference held November 30–December 2, 1959, more than 200 leaders broadly representative of consumer-sponsored health programs, organized labor, and the rehabilitation movement. The report, "Rehabilitation and Labor Health Services—Guidelines for Action," contained 77 recommendations for positive action to achieve the institute objectives. More than 10,000 copies of the report have been distributed to medical care programs, labor unions, community organizations, and governmental agencies with the result that many of the recommendations have now been implemented.

Rehabilitation services throughout the institute proceedings as well as in the report were considered as part of the spectrum of comprehensive medical care which, it was agreed, is best provided in prepaid consumer-sponsored group practice. The major emphasis was on union health programs inasmuch as they purchase or provide medical services for the largest single organized group of consumers in the nation, a family of nearly 50 million individuals. Obviously, any improvement or expansion in the scope of medical care benefits to include rehabilitation for their members will have a salutary effect on all other consumer-sponsored programs. This is especially true of rehabilitation resources and services, which are almost entirely tax supported and, as such, available to the entire community.

The impact of the Atlantic City conference was immediately apparent. In fact, before the institute was held, plans were well underway for two similarly patterned State meetings, and before the institute report could be published, requests were received for assistance in planning other meetings. To meet these and subsequent requests the National Institutes on Rehabilitation and Health Services was incorporated as a nonprofit, tax-exempt organization sponsored by the National Rehabilitation Association and the Group Health Association of America.

State and regional meetings and conferences on specific problems such as rehabilitation and workmen's compensation have followed in rapid succession. Projects designed to provide rehabilitation services for workers and their dependents have become realities. Another service program was initiated in the spring of 1963 under the aegis of the New York City Central Labor Council, and each month the council reports an increasing number of workers achieving economic self-sufficiency. The Vocational Rehabilitation Administration grant supporting this program is the first such grant ever made to organized labor.

Demand for Service

In our democratic society a catalyst such as the National Institutes and a governmental agency cannot operate in a vacuum. They must know the wishes of the people. A vociferous demand for service cannot be long denied. From its experience, the National Institutes on Rehabilitation and Health Services has singled out three major areas needing concerted action. First is the small number of union referrals to rehabilitation agencies and the fact that only a few union health centers make such referrals. The key to this situation, it seems to me, is the proper identification of those needing referral.

Too often only the severely disabled, such as those with amputations or broken backs, are considered as rehabilitation candidates. But millions with heart and lung diseases, visual and speech defects, and mental disabilities are unable to function adequately on the job, in the home, or at school. They too need to reach the highest possible level of usefulness. The devastating impact of disability on working men and women can be eliminated or most certainly minimized if rehabilitation is started as soon as medically possible after the onset of illness or injury. In fact, it has been said that rehabilitation should start in the ambulance on the way to the hospital.

Identification and referral are not enough; followup with the agencies providing the services is essential. The rehabilitation needs of a disabled person are unique, and each patient needs a complete evaluation of his physical, emotional, social, and vocational status and a program geared to meet his needs. It may take more than one agency to provide all the services essential for successful rehabilitation. At times it may be difficult to know which agency should see the individual initially. Without followup, there is no assurance that services will be provided or that the individual is not lost in the maze. Denial of service, particularly by tax-supported agencies, should not discourage further referrals or limit the referrals to those with carefully selected disabilities. Additional services cannot be provided unless the unmet demand for them can be documented.

Expanding Medical Care Plans

The second problem is the need to increase the emphasis on rehabilitation in union health and welfare programs. The majority of these programs purchase dollar protection for the illnesses of union members and their dependents from commercial insurance companies and nonprofit plans such as Blue Cross and Blue Shield. These plans rarely cover more than the medical care needed during the acute phases of illness. Even the few exceptions provide only limited coverage for rehabilitation services. Despite the shortage of rehabilitation facilities and personnel which may be cited as reasons for lack of insurance coverage, organized labor does have a twofold responsibility.

1. To call attention to the omissions of insurance plans by citing persons whose disabilities could have been prevented or minimized by adequate medical and rehabilitation services.

2. To make it clear to physicians and hospitals providing services under health insurance plans that consumers of medical and hospital services are inadequately cared for if rehabilitation principles are not incorporated in everyday practice.

In addition to those covered by insurance, an increasing segment of workers and their dependents are receiving medical care in group practice health centers sponsored by unions, cooperatives, community nonprofit organizations, and private physicians. Although some centers have physical therapy and medical rehabilitation services available, none provide for comprehensive rehabilitation that includes such services as occupational therapy, gait training, speech and auditory training, and psychological testing. Unfortunately too many centers are not aware of these limitations and the importance of referrals for appropriate specialized rehabilitation services. Moreover, many health center patients recognize they have conditions which impair their ability to function adequately, but they are unaware of the availability of specialized rehabilitation services which could help them. This lack of awareness, coupled with the fact that many physicians do not recognize potential rehabilitation cases, has resulted in far less consumer demand for rehabilitation services than the number of disabled would justify. Accordingly, the membership needs a greater understanding of rehabilitation and what it can do for them.

Responsibility for Leadership

The third problem is the need for organized labor to provide the political leadership essential for meeting the rehabilitation needs of members. This is a vital responsibility, particularly when efforts to secure rehabilitation services through tax-supported agencies and collectively bargained health programs are non-productive. Such efforts in the past have liberalized the Old Age and Survivors Insurance Division disability benefit program, steered beneficiaries to the State vocational

rehabilitation agencies where their rehabilitation potential could be assessed, and made rehabilitation an integral part of cash disability and workmen's compensation programs. Organized labor, as spokesman for the working force and representative of citizens concerned with individual, community, and national well-being, has many opportunities to participate in concerted action in support of rehabilitation services. In this dual role organized labor has a twofold function of taking the initiative as a distinct organization and also of cooperating with others moving toward the same goals. It is essential in this concern for the total membership that special needs of certain groups not be overlooked. While the majority of the nation's hospital beds are devoted to the mentally ill, little attention is focused on their rehabilitation. The unemployed, conservatively estimated at 6 percent of the employable work force, also have rehabilitation needs such as job retraining and placement.

I have briefly outlined three major problems needing the attention of organized labor, but many others need, and in some instances, are receiving attention. For example, what are the criteria for evaluating the quality of medical care and how can they be utilized to upgrade the existing services? Closely related are the difficulties of controlling the costs of medical care to prevent the spiraling drain on the worker's pocketbook. Why do these matters concern labor unions which have traditionally struggled with wages, hours, and working conditions? A labor union is not a social agency and is not so staffed. In a union setting it is unrealistic and could be self-defeating to present rehabilitation as a new and isolated need calling for a high priority. A more realistic approach is to upgrade attention to rehabilitation within continuing programs and activities.

Integrated Rehabilitation Services

In this connection, many techniques and patterns developed by the medical care program of the United Mine Workers of America Welfare and Retirement Fund have been used successfully in whole or in part in some union medical care programs. Many disabled persons other than Fund beneficiaries have already benefited from the Fund's experiences and efforts. It has been authoritatively stated that the Fund has generally advanced the rehabilitation movement further in one decade than would otherwise have occurred in a quarter of a century. Obviously, it is impossible to assess the accuracy of this statement. However, while rehabilitation is important in the Fund program, it is never considered as a separate function. No line is drawn between prevention and rehabilitation, nor are diagnostic and therapeutic services separated from rehabilitation. Separation of these four services fragments a total health program as well as the care of the patient. In the Fund program rehabilitation permeates the spectrum of health services, from beginning to end, wherever they are provided.

A major shortcoming of most voluntary health insurance programs, organized labor finds, is the inability to cope with the complete medical care needs of retired workers. These former workers are protected by some form of national health legislation in several other countries. Also, organized labor is increasingly dissatisfied with insurance plans which fall short of providing services measuring up to the standards of modern concepts, resources, and practices. Medical and hospital bills are being paid from health insurance plans for patients discharged as "cured" but unable to engage in normal activities. Moreover, it is of deep concern to organized labor that relatively few physicians and others in the health professions understand the why and how of rehabilitation and that so few hospitals provide the rehabilitation services needed to preserve or restore functional capacity to the fullest extent possible. The importance of rehabilitation cannot be overemphasized—it offers a tremendous opportunity for conserving the industrial and occupational manpower of the nation.

Summary

Organized labor has added to its traditional concern for wages, hours, and working conditions a growing concern for comprehensive health care for the worker and his family. Union leadership is now seeking to improve and expand the scope of their members' medical benefits to include rehabilitation services. Suc-

cess in this direction will mean better health services for members of all consumer-sponsored medical care groups and for all communities.

The National Institutes on Rehabilitation and Health Services suggest that these efforts of organized labor can best be accomplished by developing programs designed to identify, refer, and follow up persons needing rehabilitation services; increase the emphasis on rehabilitation in union health and welfare programs; and provide the political leadership essential for meeting the rehabilitation needs of labor.

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