Disability Determination in Social Security and Veterans Affairs:
A Comparative Analysis of Convergence

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THESIS
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This thesis does not represent the views of and is not endorsed by the Social Security Administration, Department of Veterans Affairs, or the Department of Defense. The material presented in this thesis is independent analysis of publically available information, and the author is not writing in any official capacity. The purpose of this thesis is to contribute to the academic inquiry of social policy.
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SUMMARY

The Social Security Administration has experienced a substantial growth of disability beneficiaries, whereas the Department of Veterans Affairs faces a substantial backlog of disability compensation claims. Though both programs essentially replace lost income due to physical and/or mental disabilities, the literature tends to refer to the two largest federal disability programs separately. Likewise, the public conceptions of these programs and beneficiaries tend to differ significantly. While these agencies have taken steps for improvement in the disability determination process, scholars indicate the need for greater research on the interaction of disability with social policy and programs such as Social Security Disability Insurance and veterans compensation. Is there a significant relationship between the two principal federal disability cash benefit programs, and how do their policies, processes, and outcomes inform each other? In the current environment of government deficits, fiscal austerity, and cost savings initiatives, this thesis explores policy processes and program integrity, examines how benefits are being provided in accordance with the statutory definitions of disability, and analyzes the convergence of both disability programs, with implications of potential streamlined and cooperative disability determination systems.
I. INTRODUCTION

For their service and sacrifice, warm words of thanks from a grateful nation are more than warranted, but they aren't nearly enough. We also owe our veterans the care they were promised and the benefits that they have earned. We have a sacred trust with those who wear the uniform of the United States of America. It's a commitment that begins at enlistment, and it must never end. But we know that for too long, we've fallen short of meeting that commitment. Too many wounded warriors go without the care that they need. Too many veterans don't receive the support that they've earned. Too many who once wore our nation's uniform now sleep in our nation's streets. (President Obama, 2009)

A. Background

We all likely will face disability, eventually and inevitably. Sooner than later, we may confront injury, illness, or environments than no longer allow us to function to our potential. For America’s veterans, homelessness, poor health, and trauma, altogether embody a reality that policies cannot fully ameliorate.

The government maintains a leading role in developing policies and legislation that aim to protect the rights of citizens with disabilities and further provide for their financial stability. However, measuring the effectiveness, outcomes, and success of federal disability programs is not a simple task, and should be thoroughly examined. A central rationale for welfare includes promoting social stability in which policies have developed disability cash benefits and health insurance, which provide general means to survive and afford access to medical care (Goodin, Headley, Muffles, & Dirven, 1999). For those who acquire disabilities and become unable to work, disability policies exist to provide income replacement and prevent destitution. Just as policies of workers compensation and employer pensions provide income support for those when unable to work, government’s role of promoting social stability additionally is intended to afford people with disabilities dignity and independence through cash benefits.

Scholars indicate the need for greater research on the interaction of disability with social policy and programs such as Social Security Disability Insurance (SSDI) and veterans’
compensation benefits (Scotch & Berkowitz, 1990). In recent years, the Social Security Administration (SSA) has seen a massive growth in disability benefit applications and awards, partly fueled by economic recession and the early retirement of the baby boomer generation. Similarly, the Government Accountability Office (GAO) (2002) anticipates the Department of Veterans Affairs (VA) disability program will be strained by a substantial increase of returning veterans with disabilities from military service in extended engagements in the Global War on Terror. There is an abundance of recently wounded veterans with disabilities due to extended military engagements and broadening of eligibility for previous conflicts, and consequently, there is also a similar surge of disability claims at the VA. Central to the purpose of VA benefits is to facilitate veteran rehabilitation and reintegration into civilian life (Veterans’ Disability Benefits Commission, 2007).

The question regularly persists, what exactly determines the deserving and undeserving for disability benefits? There is a general misconception and public debate surrounding who actually deserves disability benefits and what it means to be disabled by SSA standards. With inconsistencies in the process and outcomes, there are doubts that the complex administrative, evaluation and determination methods are fair or intrinsically legitimate. The disability claimant ultimately maintains the burden of proof, cooperation and is subjected to the assistance of medical professionals and various third parties to provide evidence to substantiate functional limitations as a result of a medical impairment (Brandt, Houtenville, Huynh, Chan, & Rasch, 2011). The key question is how generous should the public benefit be, and who is entitled to special provisions? An element of the public misconception of disability, the media perpetuates the stigma of disability benefits and entitlement through various exposés, which elicit sensational stories of people, portrayed as not deserving benefits.
One of SSA’s main priorities has been to “implement improvements to the disability program” by goals to facilitate payment of disability benefits to service members and to streamline the disability process (Policy Research Inc., 2014, para. 2). SSA further questions if recent research offers guidance on the disability determination process for the special population of wounded warriors (Policy Research Inc., 2014). A study by the GAO (2009a) indicated that additional outreach and interagency sharing of medical records would improve wounded warriors’ access to benefits.

At the most fundamental level, both disability programs are essentially a work disability benefit, that is a cash benefit intended to replace income lost as a result of the disabling condition. In the context of federal disability programs, both SSA and VA have distinct, yet similar definitions of disability. The two disability benefits programs are quite different from each other, yet research has inadequately addressed what can be learned from both programs to develop more efficient policies and processes. There is insufficient quantitative and qualitative research that analyzes the correlation of a VA disability determination and the SSA disability determination outcomes.

SSA defines disability as the “inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months” (SSA, 2014b). VA’s disability definition, known as a service-connected disability compensation, is defined as “resulting from an injury or disease incurred or aggravated in active service, and in line of duty presumed by law to be related to military service, or resulting from other limited circumstances, such as disability that is the result of Department of Veterans Affairs hospitalization or medical treatment” (VA, 2014b, para. 1).
also defines another disability benefit, the nonservice-connected pension, as a permanent and total, non-service connected disability as determined by VA, or as determined by the Social Security Administration, to claimants in a nursing home for long-term care as a presumption of disability, or has reached the age of 65 years. This is similar to SSA’s Retirement and Survivors Insurance.

Despite a push and pull of SSD benefit generosity over the years, SSA disability determinations involve a stricter evaluation process resulting in an allowance or denial. VA disability determinations utilize a unique system where a range of eligibility exists in the Veterans Disability Compensation program, known as the ratings system of disabilities. The VA Schedule for the Ratings of Disability (VASRD) “range from 0 to 100 percent and are based on the presumed drop in income caused by the disability. Employment is not a factor--veterans can be employed and still receive benefits” (2014, para. 1).

The disability evaluation process is required to obtain certain services, cash benefits, and healthcare. SSA utilizes a legal and administrative definition of disability, which essentially operationalizes disability (Brandt et al., 2011). Within the evaluation, SSA relies on medical consultants whom are contracted to rate impairment severity and access credibility of claimant statements against medical evidence (Bloch, 1992). The process is intended to be objective, however, it becomes a very subjective process. The VA administers a similar disability evaluation system, yet tends to favor the veteran claimant. Scholars suggest that the answer to this problem may be to “universalize” disability, which may offer insight into the improvement of SSA and VA disability determination systems (Scotch, 2000).
B. **Methodology**

A hybrid constant comparative policy analysis methodology is employed in this thesis in order to appropriately address the research questions. The intent of this thesis is to conduct a structured side-by-side comparison of the two largest United States federal disability benefits programs. Through a broad policy analysis framework, this thesis threads the intersection of SSA and VA disability benefit policy themes throughout the analysis. The research details the similarities and differences in order to investigate what can be learned from each, with the hopes to improve both programs. While these agencies have taken steps to improve the programs, this research questions program integrity and investigates to what extent the benefits are getting to the intended beneficiaries in accordance with the agencies’ established definitions of disability. Furthermore, in the current environment of government deficits, fiscal austerity and cost savings initiatives, this thesis looks into the effectiveness of disability benefits and what can be done to cut costs through a streamlined disability evaluation system that involves coordination of disability determination through both agencies, such as in the SSA and Railroad Retirement Board coordination of disability determinations.

The thesis also raises further questions to promote future research. For example, this analysis suggests positive implications of streamlined disability determination through cooperative federal programs and processes. This thesis is a starting point for dissertation research through an expanded mixed methods approach with both statistical and qualitative analysis. This research explores disability policies, processes, and outcomes for veterans with disabilities navigating both the SSA and VA programs from disability studies and public policy viewpoints.
Additionally, this thesis is intended to lay a foundation for future research that addresses the gaps in literature and ultimately the flaws in both disability programs. Would a VA disability rating significantly predict an SSA disability determination? In other words, would the VA determination be an effective predictive modeling or screening tool to make a quick SSA disability determination? Initial ideas for future research may address such questions, such as, does a VA favorable disability determination result in a SSA favorable disability determination? And could these results be used to somehow streamline the SSA side of disability determination, such as the quick disability determination, where the agency would not need to review all evidence, and essentially adopt the VA determination, despite the disability evaluation criteria being different?

1. **Aims of research**

   The following research questions will be addressed:

   (i) First and foremost, is there a significant relationship between the policies, processes and outcomes of SSA and VA disability benefits determinations?

   (ii) What can be learned from both programs, how and why are they different, and what are their strengths and weaknesses? With what is learned from the differences of the two programs, how are benefits being provided in accordance with the statutory definitions of disability?

   (iii) How do the programs converge, and what are the implications of the dually eligible SSA and VA disability beneficiary? What is the significance of the convergence in SSA and VA disability?
2. **Research process**

The research process entails three phases: preparation, consolidation, and integration. These three phases were intended to be a distinct step-by-step process, however, overlapped significantly. First, the preparation phase involved identifying the central research problem, main themes and categories relevant to the research topic, and formulating the research questions. Research questions were formed to address the aims of this topic exploration and guided what data was required. The research questions are correlative and descriptive in order to analyze the relationships of the converging themes and to lay out the complex policy topics (Mertens, 2010).

Secondly, the consolidation phase involved executing the search for data utilizing the identified themes, and categorizing the data to be analyzed and incorporated into the three broad chapters. The data was organized around three broad themes, which became the main chapters of the thesis: policy, process, and outcomes. The data was further apportioned into subthemes, which became the subchapters of the thesis.

Finally, the integration phase involved conducting the constant analysis of the data, and further organizing the data into subthemes. The analysis, chapter and subchapter themes characterize a symmetrical arc, which accentuates the converging similarities of the research subjects. Within the analysis, the diverging themes are clearly articulated. Some data were analyzed in only one chapter or subchapter, while others were analyzed in more than one chapter. To articulate the arc of the thesis, the introduction begins with “For their service and sacrifice, warm words of thanks from a grateful nation ... We also owe our veterans the care they were promised and the benefits that they have earned...” (Obama, 2009, para. 1) and the conclusion ends with “It is a lasting promise ... that workers who become disabled can support
themselves” (Obama, 2010, para. 2). This approach characterizes the shape and symmetry of the thesis content: the big picture situation at the beginning, specific critical analysis throughout the body, and a return to the big picture at the end.

The thesis research entails descriptive, critical, and independent analysis of secondary data. The comparative method was the functional tool for the analysis (Collier, 1993). Additionally, the constant comparison method was utilized, which in effect created a hybrid model of analysis (Dye, Schatz, Rosenberg, & Coleman, 2000). For this thesis, the examination of multiple contexts in similar situations proved valuable to the illustrative and interpretive analysis in the comparative method (Collier, 1993). The descriptive analysis in Chapter II established the relationship between SSA and VA, which addressed the first research question. Furthermore, the critical analysis included disability rights framework in order to accentuate the broader research problem and to lay the foundation for the remaining chapters. Likewise, Chapter III was critically analyzed and highlighted the broader gatekeeping process of public benefits, while also examining the related processes at a granular level. Finally, Chapter IV was analyzed through a case study approach in which two events in the media were compared and contrasted. Mertens (2010) details the benefits of the case study approach as illuminating theory and understanding of the research area. In the context of the research questions, analysis was conducted with intent to clarify the research problem, and answer the questions systematically.

3. **Data collection**

Data collection of the literature is an involved aspect of the research process (Mertens, 2010). Initial searches through the literature were executed utilizing journals, books, reports, and articles were combed by the following keywords: Social Security Administration, Veterans Benefits Administration, Veterans Affairs, disability, determination, compensation,
disabled veteran, process, and evaluation. The Internet was the primary tool for data collection, as online libraries, journals, and electronic search engines were utilized.

The preliminary results were limited to United States disability areas. Searches regarding veteran disability returned fewer results and included mostly United States Government Accountability Office (GAO) reports. There was significantly more literature related to Social Security disability than Veterans Affairs. Interestingly, many commercial sources included texts on how to win a Social Security and Veterans Disability claim. As the analysis of the data progressed, additional sources were identified in the literature. The data collection was ongoing, and more sources were discovered that provided greater insight on the research. All sources were carefully studied, summarized, and relevant themes and subthemes were organized for analysis in the body of the thesis.

The collected data related to the time period of the late 1800s around the Civil War, and spanned through the present. Approximately 100 sources were studied, highlighted, and summarized, and 83 sources were referenced in this thesis. The nature of most of the collected data addressed history, policies, process, and outcomes. However, some sources focused on one area relevant to a certain chapter theme. The case study approach found in Chapter IV required collection of data that includes the historical background, related cases, key players, and economic, political, and legal features (Mertens, 2010). Berkowitz’s (1987) report on Federal Disability Programs provided a great foundation and comparison of intergovernmental policies, history, and processes. Additionally, the Institute of Medicine’s (IOM) (2007a, 2007b) program evaluation reports on SSA and VA provided granular detail and comprehensive information on policies, processes, and systematic areas for improvement.
C. Chapter outline

Chapter II will explore the background on the history, origins, theories, and evolving policies that have contributed to the modern day broad SSA and VA disability determination systems. The chapter will examine the disabled veteran’s place in history, and how they have emerged as a special privileged group that became entitled to greater and more generous benefits and programs, as compared to the civilian population. The research will explain how SSA developed and was implemented gradually. Other areas covered will include how disability benefits are dependent on a perception of deservedness and benefit generosity, related to diminished or no ability to engage in work. Likewise, this analysis will explore the VA disability benefit that primarily emphasizes deservedness based on military service and the Grateful Nation principle. The thesis will present disability benefits policies in relation to rights-based approaches, which center on ameliorating the inability to achieve full citizenship as a result of not participating in the labor force. The analysis will question exactly how cash benefits guarantee full rights to people with disabilities through providing income replacement as a result of disability and further explore if benefits ameliorate other aspects of a disabling condition.

Chapter III will examine the SSA and VA disability evaluation and determination processes that involve a reliance on medical professionals and medical evidence in the award decision. The analysis will explore the gatekeeping process that is expressed through statutory definitions of disability, to exclude those not deserving of benefits. The thesis will illustrate a key distinction, that is Social Security Disability (SSD) beneficiaries are essentially removed from the workforce in order to be eligible for benefits, whereas actual work activity is not a consideration for a VA disability determination. Fundamental to the SSA definition of disability
is the inability to engage in work, and the VA definition accentuates military service, and its relationship to disability. The analysis will show how both programs operationalize disability through similar evaluative processes with key steps in successive levels to make a determination outcome. This chapter will introduce the crossover of programs, in which a veteran may qualify for benefits in both SSA and VA.

Chapter IV will address the shortcomings, challenges and policy outcomes involving disability determination under SSA and VA, and will survey the current state of affairs situated within the disability determination processes. This chapter will explore the status quo and the outcomes in these broad disability programs, what they have become, steps taken to improve processes, and the extent of agency inclination for change. Central to this thesis, the analysis will show that media influences the public perceptions about disability recipients, however treats the SSA disability recipient quite differently than the disabled veteran receiving benefits. The thesis will examine the concept of deserving benefits as on one hand, media portrays SSA as not doing enough to conserve the program benefit, and conversely depicts the VA as not awarding benefits timely enough. The thesis will compare both agencies’ effectiveness and willingness to improve their disability programs. The analysis will demonstrate that the SSA and VA program convergence suggests that greater agency collaboration would benefit the dual citizen veteran population. Finally, the thesis will illustrate similarities in both SSA and VA determination outcomes that provide implications of coordinated and cooperative systems that could better serve the veteran population.

D. **Significance**

This thesis presents a welcome introduction to this topic by way of a broad overview and comparative analysis of the history, theories, policies, processes, and outcomes of SSA and VA
disability determinations. This analysis is very relevant to the current sociopolitical environment of recent returning disabled veterans, the rise of SSA disability rolls, and government fiscal austerity in light of the recession. This work is timely, innovative, and significant to the fields of disability studies, sociology, public administration, public health, and law.

This thesis will challenge underlying assumptions about people with disabilities, and will confront media-influenced perceptions about both SSA and VA disability beneficiaries. The analysis will show the unique and overlapping historical developments in the processes to determine eligibility in both SSA and VA systems, and will create a foundation to analyze disability across federal programs as a way to address the policy related issues arising from the aging population, increased claims, and in the shadow of continued military engagements and their toll on the people who fight in war.

Finally, this thesis will provide a substantial contribution to the inquiry of social welfare policy, as well as the public administration of federal benefits. This thesis will confront contradictions in public policy decisions that treat dissimilar populations differently. Furthermore, this analysis will challenge certain aspects in the government that behold a deep resistance to organizational change and lack of accountability.
II. HISTORY, THEORY, AND POLICIES OF SSA AND VA DISABILITY DETERMINATION

A. Introduction

For those who acquire disabilities and become unable to work, disability policies exist to provide income replacement and prevent destitution, which aim to uphold human dignity. Just as policies of workers compensation and employer pensions provide income support for those when unable to work, the government’s role of promoting social stability is intended to afford people with disabilities dignity and independence through cash benefits. SSA and VA disability benefits provide valuable support to many people with disabilities in the form of income maintenance, healthcare, and vocational rehabilitation. However, there exists an important distinction between the disabled military veteran and the civilian with disability, as well as the extent and quality of benefits they receive, the variance of their individual experiences, and society’s perception and valuation of those deserving public benefits (Gerber, 2012). However, income replacement by itself does not improve the condition of people with disabilities, nor does it fully support full rights and benefits of total citizenship.

The largest federal cash disability benefits in the United States, Social Security Disability (SSD) and veterans disability compensation (VDC), require further academic inquiry into these agencies’ contemporary understandings of disability, how policies uphold dignity of citizenship through human, civil, and disability rights, and the evaluation of operational program effectiveness. SSA questions how research informs the disability determination process for wounded warriors, and meanwhile, the VA’s understanding of disability has not reflected the progressive medical and technological advances of recent history (IOM, 2007b). Currently, some SSD recipients are increasingly perceived as not deserving their benefits, as media
perpetuates allegations of fraud, waste, and abuse in the social welfare benefit system (Joffe-Walt, 2013). Meanwhile, the VA faces enormous backlogs of VDC claims, and leaders within the agency have faced calls to be fired, as outrage grew with veterans’ organizations, politicians, the media, and the public (Maddow, 2013b). Both agencies have been criticized for their lack of coordination with each other and their slowness to revise evaluation criteria in order to keep up with changes in the labor market and advances in medical science and technology (Moulta-Ali, 2011).

The scope of this chapter presents a broad overview and background of the historical developments of disability, highlighting military veterans’ position, and the evolution of theories and policies that shaped SSA and VA disability programs. The theoretical framework of this analysis centers on disability rights, what this means to the benefit programs, and how the rights-based approach appears in the policies.

Chapter II provides the foundation of the history, laws, emerging theories and policies of SSA and VA. The objectives of this chapter are to: (i) provide an overview of the concept of disability and explore the disabled veteran’s position in the history; (ii) survey how the laws, policies, and theories relevant to VDC and SSD benefits shaped; (iii) explore how the concept of work disability and the notion of deserving benefits evolve through time; (iv) analyze policies through a disability rights theoretical framework; and (v) evaluate how these theories and policies of SSA and VA evolved to overlap, converge, and inform each other.

B. **Background and Developing Concepts of Disability and the Disabled Veteran.**

**Origins of Modern Veterans Disability Benefits**

To introduce an overview of the concept of disability and the disabled veteran’s position in the history, first, mention of the earliest form of war disability is necessary. It was a brutal
time in ancient Greece and Rome, in which widespread injury, disease, malnutrition, and impairment due to war, hard labor, poverty, and poor medical care produced one of the earliest disability phenomena. During this period, people born with congenital impairments and deformities were often killed, whereas the ancient society supported and included citizen workers and soldiers who acquired disabilities and became unable to work, particularly war veterans. War veterans who became disabled and poor were awarded war pension benefits. Early Greek society recognized public support for those unable to work through an early form of disability entitlement benefits process, which required citizens with disabilities to demonstrate both poverty and physical limitation by an inspection of a court council (Braddock & Parish, 2001).

Scotch (2001b) indicates people with disabilities in most cultures have customarily been taken care of by their families and communities, but in the West were eventually placed in institutions for care as traditional support systems deteriorated. Early institutions that segregated people with disabilities were operated by charities, religious groups, and private citizens, including one of the first asylums for blind soldiers in 1260 in Paris (Scotch, 2001b). Other institutions for aged, poor, and disabled veterans, such as France’s Hôtel des Invalides in 1633 and Britain’s Chelsea Hospital in 1685, formed to prevent the inevitability of begging on the streets and committing crimes (Gerber, 2012). Domicile institutions provided direct support to disabled veterans and protected them from destitution, in the form of housing, shelter, medical care, and compartmentalization from the public.

During war with the Pequot Indians in 1636, the Pilgrims enacted a law providing for disabled soldiers (VA, 2014a). The beginnings of the desire for a formalized veteran disability compensation for service began upon soldiers’ injuries, loss of limbs, and functional and
economic loss during the American Revolutionary War. Likewise, Major General of the Continental Army in the American Revolutionary War, Nathanael Green expressed to John Adams that enlistments for the military would increase and enthuse courage if the Congress provided assistance for disabled or killed soldiers (IOM, 2007b). The American Revolutionary War saw the first disabled veterans pension law, which passed in 1776 by the Continental Congress and expressed the spirit of the nation’s obligation of charity for the veteran’s sacrifices in the cause of freedom (Braddock & Parish, 2001). Once the United States Constitution was ratified in 1789, the new country’s first pension law was enacted and maintained the Continental Congress (VA, 2014a).

The Bureau of Pensions, later the modern Department of Veterans Affairs, administered all veterans programs in 1808 under the Secretary of War. The first federal domiciliary and medical facility was established in 1811. The veterans’ bureaucracy evolved as Congress established the new Bureau of Pensions in 1833 under the Department of War, the only federal office dedicated exclusively to veterans affairs. Between 1840 and 1849, the administration operated as the Office of Pensions under the Navy Secretary, and after 1849 operated again as the Bureau of Pensions under the Department of the Interior (VA, 2014a).

While charitable and religious groups supported people with disabilities for several centuries, the European Red Cross was created in 1859 to avert disability and help save lives in war (Braddock & Parish, 2001). Goler and Rhode (2012) argue that the public’s responsibility to war veterans was increased by the establishment of a government system to administer the compilation of medical records, amputated limbs, organs, body tissues, and photographs of violent and brutal Civil War injuries. Civil War veterans were entitled to a disability pension of up to eight dollars and prosthetic devices based on the medical evidence compiled by this
centralized system administered by the Surgeon General’s Office, Army field surgeons, Army Medical Museum, and the Pension and Records Department. The result of this compilation of records, including postoperative records later in veterans’ lives, physical specimens, and longitudinal medical evidence, were groundbreaking material for medicine, science, and research, but also for federal pension benefits applications to the Pension Bureau, later the Office of Veterans Affairs. With the passage of the Arrears Act in 1879, the government expanded disabled pension benefits to include lump sum payments. However, as war veterans became elderly, the pension system shifted from injury compensation to old-age benefits for all service members with the passage of the 1890 Dependent Pension Act (Goler & Rhode, 2012).

The early version of the modern VA is rooted in wars, and the federal government traditionally took the lead in providing benefits for disabled veterans, unlike state workers compensation and private pensions. Upon World War I in 1917, Congress enacted authority to the Veterans Bureau, the Bureau of Pensions of the Interior Department, and the National Home for Disabled Volunteer Soldiers to administer a more contemporary organization of veterans benefits which included the VDC, insurance, and vocational rehabilitation (VA, 2014a). The Department of Veterans Affairs’ Schedule for Rating Disabilities (VASRD) is the disability rating guide accentuating the anatomical loss as disability, written into law in the War Risk Insurance Act of 1917 (IOM, 2007a). By 1930, these three federal agencies were consolidated into bureaus within the newly formed Veterans Affairs (VA, 2014a). As previous veterans disability benefits were related to certain conflicts, this Rating Schedule standardized disability evaluation.

The veterans’ history shows extensive efforts of the national, state, and local governments through laws, benefits, and domicile institutions that were designed to care for the
disabled veterans. Berkowitz (1987) insists that veterans benefit programs have typically been more substantial, generous, and well established than that of programs for the civilian population. The disabled veteran remains a special privileged group that has maintained greater benefits than the civilians (Berkowitz, 1987). Beyond a grateful nation that owes gratitude to disabled veterans, the sentiment also includes an element of pity. As disability often evokes feelings of pity on the individual, the need to ameliorate injuries to civilian workers and maintain social security emerged soon after.

C. Origins of Modern Social Security Disability Benefits

As veteran disability benefits programs developed, similarities in SSA theories and policies evolved to overlap, converge, and however, not necessarily inform each other. The need for a federal social insurance program was impeded by a prosperous economy in the 1920s, in which private industry provided pensions and states administered workers’ compensation for work injuries (Kingson & Berkowitz, 1993). However, in light of a devastating economic depression and high unemployment, the United States Congress approved the Social Security Act of 1935 on August 14, 1935, resulting in sweeping social welfare implementation. Prior to this passage, states led localized social welfare policy implementation, but in 1933, President Roosevelt presented this opportunity first as an emergency economic relief to protect old age and the unemployed (Kingson & Berkowitz, 1993). The Social Security Act successfully passed partly due to the strong old age voting block that was most vulnerable to unemployment and would be first to be laid off. This population proved to be influential on politicians that were apprehensive about losing support.

Even though the designers of Social Security envisioned disability benefits insurance beyond the retirement program, there was no immediate need for a federal disability insurance
program, since almost all states in the country had administered workers’ compensation programs (Kingson & Berkowitz, 1993). At this time, workers’ compensation was a big industry for the representing attorneys. In keeping with the tradition of states administering social welfare, the Social Security Act provided federal funding and grants directly to states to manage the public assistance programs for the elderly, blind, and dependent children (Kingson & Berkowitz, 1993). This is demonstrated as cooperative federalism, in which there was a compromise in the form of substantial grants directly the states (Meek & Thurmaier, 2012). The Preamble of the Social Security Act reveals its central purpose as “establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes” (Social Security Act, 1935, para.1). In 1939, Congress made substantial amendments to the Act which included survivors and dependents benefits (Kingson & Berkowitz, 1993).

Comprised of ten titles, Title I of the Act laid the foundation to establish grants to states for old age assistance, and Title II implemented the social safety net for retirement benefits and detailed old age benefits administration through a reserve account system. Title III formed grants to states for unemployment compensation administration, as Title IV crafted grants to states for aid to needy dependent children who lack parental support due to death, absence or physical or mental capacity of their parents. Title V of the Act provided grants to states for maternal and child welfare and health promotion, and included in Part 2 “Services for Crippled Children,” however inadequately addressed the needs of children with more severe disabilities (Braddock & Parish, 2001, p. 42). Title V further created child welfare services and vocational
rehabilitation through state cooperation. Title VI initiated public health work appropriation to support states public health services and training of healthcare professionals. Title VII established the Social Security Board, now known as the Social Security Administration. Title VIII specified the new taxation for the programs of the Act, as Title IX stipulated taxation on employers for unemployment compensation. In such grave poverty and unemployment of the Great Depression, the Act included Title X Grants to States for Aid to the Blind, providing economic relief, specifically for the blind, a special disability population (Braddock & Parish, 2001). Title XI stipulated the general provisions, and spelled out that only the Congress may alter the provisions of the Act. The Act in its current form includes additional titles, such as Title XVI establishing the Supplemental Security Income (SSI), disability benefits for the needy aged, blind or disabled; Title XVIII, which established Medicare health insurance; and Title XIX launching Medicaid in 1971 (Braddock & Parish, 2001).

Implemented by Executive Order in 1943 by President Roosevelt, the Civilian War Benefit Program (CWB) was the first real disability program administered by the Social Security Board, the precursor to SSA (SSA, 1997). The CWB provided cash and medical benefits for civilians injured during the war (IOM, 2007a). The Social Security Board and the Public Health Administration adjudicated disability claims from March 1943 and May 1945. The CWB program was focused on civilians injured in the war effort, and developed policies and procedures that foreshadowed the modern SSDI program. Benefits were calculated based on claimant’s past earnings, and also provided temporary, partial, and full disability benefits. The CWB is characterized as the wartime disability benefit for civilians, that also reflected a grateful nation for their service in the war effort (SSA, 1997).
Since at the time, a worker could not collect Social Security until age 65, legislation enacted the Disability Freeze program in 1954, in which a worker’s old age benefit calculation was not penalized for dropping out of the work force due to disability (Kingson & Berkowitz, 1993). The disability freeze was a big step towards a cash benefit program. Formally passed in 1956, Social Security Disability Insurance (SSDI) benefits encompass a small part of SSA benefits as a whole, yet SSDI remains the most significant area of disability benefits policy, as it is the nation’s solution to disability as a social problem (Kingson & Berkowitz, 1993).

Acknowledging that SSA disability benefits are distinct compared to VA, SSA developed an expedited process for military veterans that become disabled in service on or after October 1, 2001 (SSA, 2014f). Unlike the VA, SSA does not provide partial disability, and military active duty pay does not definitively preclude eligibility for SSA disability benefits. Brandt et al. (2011) expound that SSA operationalizes disability, is too focused on impairment rather than functional consequences, and has significant variability in determinations and conceptual gaps in contemporary understandings of disability in the evaluation. These issues relate to prevailing conceptions of disability and society’s expectations in participation in the labor force.

D. Disablement Models and the Medicalization of Disability, Work Disability

Contemporary disability studies show there are a variety of ways to understand, approach and define disability, impairment, and illness. Sociological, political, cultural, economic, and moral perspectives offer respective interpretations, motivations, and definitions of disability. Two general disability model theories exist, medical, also referred to as individual, and social model. The medical model stresses the limitations of the person and lack or inability to adapt to his or her environment. Conversely, the social model reveals that societal environment essentially disables a person by not fully integrating or facilitating one’s inclusion into society.
The civil rights movements of minority, race, and gender have propelled disability activists to labor for equal ground for people without disabilities. Social activist movements have progressed legal rights, accessibility, language and terminology usage, self-empowerment, and understanding of people with disabilities.

The medical model notion of disability emphasizes on functional impairments (Hahn, 1985). Beginning around the 14th century, despite a burst of exploration and advances in science, anatomy, and medicine, primitive beliefs that disability was a result of the unnatural and mystical forces pervaded. Similarly, colonial American settlers explained disability in terms of religion and as a punishment from God, while the colonists were watchful of people that would become public charges and a burden on society. Early America generally adopted British laws, such as the Poor Law of 1601, which indicated the people had responsibility for the poor and disadvantaged (Braddock & Parish, 2001).

The medical paradigm of disability, prevalent in the 19th and early 20th centuries, focused on the inability to perform typical social roles due to medical impairments, aimed on the individual problem that needs corrected by treatment or cure, however, rejected the construction of disability by sociopolitical and cultural elements of one’s environment (Longmore, 2000). It was the 19th century that solidified medical definitions and diagnoses, professional intervention, the classification and labeling of disability, and segregation of people with disabilities via institutions (Braddock & Parish, 2001).

Goodley (2010) depicts the thought of having a disability into a marginalized status and indicates disability is also caused by war. Approximately ten percent of the world population has a disability and 97% of disabling impairments are acquired (Goodley 2010). Oliver (1996)
describes the individual model of disability that focuses on a problem due to physical or mental functional limitation.

Laws and programs such as the establishment of the VA and SSA, show that disability was constructed as a social problem that required amelioration (Albrecht & Bury, 2001). After World War II, expansive rehabilitation and return to work legislation were enacted to attend to disabled veterans and civilians injured in the war effort.

Sociologist Saad Nagi created a conceptual framework referred to as the functional capability model, in 1964, which links the two models by defining disability as an impairment within a social context (IOM, 2002). This conceptual shift of disability, the effects of one’s environment, and advancement in measurement of functioning represented a move to a more inclusive direction that emphasized the impact of an individual’s environment. Oliver (1996) argues that there is no causal relationship between impairment and disability, and the social model is not social theory, but is best served to help us understand, not just explain. Therefore, the social model of disability cannot explain disability completely, and its usefulness is found in how it is applied. However, different environments affect people differently, so how can the disability benefits agencies come to terms with the fairness and inequities? Some people may experience an advantage, while others are disadvantaged due to geographic location, work skills and experience, education, and to what extent their environments are accessible and accommodating. Nevertheless, the same underlying issues remain, and it is a challenge to further incorporate the social model into disability cash benefit programs with all inherent administrative complexity.

In 2008, 50 million live with disabilities, and will increase due to a growing baby boomer population and medical technology advances that extend life (Iezzoni & Freedman, 2008). As
people with disabilities are unable to fulfill typical social and work roles, whether old age, congenital impairments, or traumatic injuries, disability benefits policies have been developed to deal with the problem. However, detecting deception from those who falsely claim disability for individual profit forces the question of how to ascertain who actually deserves or needs assistance (Iezzoni & Freedman, 2008). Scholars describe the disablement process in which people with disabilities are limited by the environment of social and cultural dynamics (Braddock & Parish, 2001). So disability is not as clear-cut as it would appear.

Workers’ compensation and vocational rehabilitation encompassed citizens’ legal rights development to protect workers injured and disabled in the widely labor based industry of the early 20th century (Braddock & Parish, 2001). The first American worker’s compensation law was passed in Maryland in 1902 and led to similar laws in other states. Around the same time created in 1902, Goodwill Industries provided work to the unemployed, and later to people with disabilities via vocational rehabilitation and sheltered work. As early charitable and religious groups supported people with disabilities, the American Red Cross established one of the first vocational rehabilitation programs that later informed similar programs in American military hospitals. Created in 1917, the Institute for Crippled and Disabled Men provided training programs to rehabilitate veterans injured in war.

Workers’ compensation evolved in efforts to return injured employees with disabilities to the work force, yet policy and legal developments seemed to give veterans priority. In 1918, Congress authorized rehabilitation services and vocational training for disabled World War I veterans under the Smith-Sears Veterans’ Rehabilitation Act of 1918 (Braddock & Parish, 2001; Scotch, 2001a). Medical technology development and improvement of prosthetic devices facilitated both disabled veterans and injured industrial workers in returning to work after injury.
The first general vocational rehabilitation law, Public Law 66-236 passed by Congress in 1920, was intended for work injuries, however, the scope of the law included congenital and acquired disabilities separate from work-related injuries (Braddock & Parish, 2001, p. 42). Despite excluding mental disabilities, this was quite a significant development, since traditionally, families, religious, and other charitable groups cared for people with congenital disabilities.

Certain groups of people with disabilities, such as disabled veterans, railroad workers, and merchant seamen, saw the enactment of special benefits due to their contribution and historical significance to the nation’s political economy (Albrecht & Bury, 2001). The focus of these benefits was to provide income replacement, but not to encourage people to work. In general, disabled veterans have maintained privileged access to a variety of benefits, such as vocational rehabilitation, more so than civilian population (Berkowitz, 1987).

E. Disability Rights in the Models of Disability, Civil Rights in Legislation

The theoretical framework of this analysis centers on human, civil, and disability rights, what this means to the benefit programs and how the rights based approach appears in the policies. Approaching these developing disability policies entails an underlying rooting in fundamental human rights, equal citizenship, and full participation in society. Disability benefit policies exist to counter the social problems of injury, illness, and disability. However, income replacement by itself does not improve the condition of people with disabilities, nor does not fully grant full rights and benefits of full citizenship (Berkowitz, 1987).

The medical model of disability, prevalent beginning in the 19th century, focused on the inability to perform typical social roles solely due to medical impairments, aimed on the individual problem that needs corrected by treatment or cure (Longmore, 2000). This era saw
the early stages of solidified medical definitions and diagnoses, professional interventions, the classification and labeling of disability, and segregation of people with disabilities via institutions (Braddock & Parish, 2001). Disability evolved as a public and social problem requiring amelioration, thus SSD was established to provide benefits for people with disabilities to directly engage this problem. Likewise, veterans’ disability benefits were instituted to directly engage the problem of wartime disability and to reintegrate veterans into society. The medical model conceptualization has been engrained and institutionalized in public policies that tend to stigmatize and focus the disability as a problem squarely in the individual person (Longmore, 2000). Recent history has defined disability from this strictly medicalized characterization, in which the emphasis focused on curing, ameliorating, and eradicating disability. There continues to be an emphasis on the causal relationship of a definitive medical impairment resulting in the disability (Hahn, 1985). Consequently, Goodley (2010) indicates that society’s instinct is to see disability as a personal tragedy that requires correction while that problem is positioned firmly within the individual.

Most problematic within the medical model, disability has been used as justification of inequality, discrimination, and oppression throughout history, not only with people with disabilities, but also other minority groups such as African-Americans, women, and immigrants (Baynton, 2001). A focus on the perfect human without deficit, this oppression evolved in American history with the progression of the Eugenics Movement, forced sterilization, institutionalization and segregation, radical shock therapy and lobotomy treatment (Braddock & Parish, 2001). The medical model is explained in these terms, in which SSD and VDC ultimately places people with disabilities into categories of impairments, labels of unemployability, with all the socially constructed stigma, pity, and negative moral implications of
deficits and disability. The minority model of disability centers the disabled person in a discriminated position, receiving different treatment than others, such as racial or gender minorities (Berkowitz, 1987).

The idea of disability in recent history has focused on the medical model of disability, however, this one-dimensional concept has been rejected by proponents of a social model of disability (Longmore, 2000). The social model of disability is defined as an experience influenced by the interaction between people with impairments and their sociocultural and physical environments, and public policies. According to the social model, Longmore (2000) defines disability is an “elastic social category” of identities and social roles that is constantly changing along with public policy and medicine (p. 36). Consequently, this is understood as a disability construction, in which the environment and other factors on an individual’s environment create the limitations, secondary to the physiological limitations of the impairment. As advances in medicine and technology grew, people were living longer and the population of people with disabilities increased, as societal attitudes and physical barriers progressively surpassed the limiting effects of the physical impairments (Scotch, 2001).

After war, injured veterans had difficulty in returning to work, and disability pensions financially allowed men to marry and raise children, an important life goal during the Civil War era (Goler & Rhode, 2012). Additionally, the Vietnam War resulted in a new surge of disabled veterans, which strengthened the need for benefits (Scotch, 2001a). To effectively advance veterans groups’ interests, they had to establish themselves as an influential voting and lobbying assemblage with general public support, as well as developing partnerships with the administration and development of government veterans programs (Gerber, 2012). Furthermore,
politicians responsible for supporting veteran friendly legislation realized they had a liability if they were perceived as not advocating for veterans’ causes.

To secure entitlements to various benefits, disabled veterans utilized political action to fight for their right to social integration. Two categories of disabled veterans groups emerged: single disability interest, and general disabled veterans alliances (Gerber, 2012). Likewise, sizeable civilian disability organizations developed in the 1950s, however largely focused on the prevention of disability, until disability-specific groups emerged, such as the International Federation of the Blind (Braddock & Parish, 2001). Other groups established in the United States, such as the Paralyzed Veterans of America founded in 1946 by World War II veterans, were focused on the advancement of their group, not necessarily the rights of all people with disabilities (Scotch, 2001b).

In order to gain legislative entitlements, the American Legion invoked pity by presenting severely disabled veterans to lobby Congress in the 1920s, and later during World War II to put political pressure to pass the G.I. Bill of Rights, waged a crusade in the media that highlighted the inattention to disabled veterans. However, the Disabled Veterans of America opposed the legislation in order to prevent decreased allocation of assistance to their group (Gerber, 2012). This demonstrates the single disability interest group that already emerged in the civilian disability groups, such as the Association for the Blind.

After developments in civil rights and equality legislation of the 1960s, by the 1970s, the disability rights movement emerged as well as activism that put pressure on lawmakers to pass similar legislation for people with disabilities. One of the most significant legislative breakthroughs was the passage of Section 504 of the Rehabilitation Act of 1973 (Scotch, 2001b).
Disability rights activists focused on equal employment, accommodation, and equal access by removal of barriers, however, eligibility for disability programs was not central to the movement.

The deeper problem is the negative perception of people with disabilities, and even with SSD benefits, moral stigmatization, social, and economic marginalization persist. This is reinforced by disability policies established to ameliorate disability as a social problem (Scotch, 2000). With the existence of varieties of impairments, a hierarchy of disabling impairments naturally exists. The degree of severity, limitations and potential lethality should all be considered and evaluated with perseverance for the very human rights that disability activists have fought for. The fundamental definition of disability is a reflection of the degree of adversities and disruptions an individual encounters in functions of daily living. Clearly, a quantitative and qualitative experience of disabling impairments affects many differently.

Income replacement does not remotely uphold the citizenship rights of people with disabilities. Kingson and Berkowitz (1993) liken SSD to retirement benefits, in which the beneficiary must withdraw from the work force in order to be entitled to disability benefits. In order to qualify for SSD, one must be unable to work; therefore disability receipt likely permanently removes the person with a disability from the working population. This undermines the citizenship rights since SSD receipt discourages employment and participation in the labor force. On the other side, modern VDC benefits do not prevent disabled veterans from employment and do not penalize the beneficiaries from working. Moreover, critics suggest that people with disabilities cannot be equal while being entitled to special privileges, such as cash benefits (Longmore, 2000).
F. **Politics in the Grateful Nation Principle and the Moral and Social Worthiness in Entitlement Legislation and Policies**

Sociopolitical, moral, and patriotic attitudes contributed to how the concept of work disability and the notion of *deserving* benefits evolved through history. To this point, the only existing disability benefits were developed for the Civil War disability pensions, and the earliest federal disability benefits were disability pensions for military veterans (Scotch, 2001a, p. 378). In a significant shift, veterans’ benefits broadened to include the poor with the 1818 Service Pension Law, which established war pensions for veterans based on financial need, not on disability (VA, 2014a).

Scotch (2001a, p. 375) illustrates the 1907 hearing by the Committee on Pensions of the U.S. House of Representatives regarding pensions for the disabled veterans of the Civil and Mexican-American Wars as a disability benefit that is required due to physical limitation, earned through military service, and obligatory by the “moral worth and social worthiness of these men.” Scotch (2001a, p. 375) argues that the perception of “moral worth and social worthiness” have been the decisive factor in determining eligibility to many U.S. disability programs and protections.

In the early 20th century, progressive ideologies of the responsibility to care for veterans injured by war grew. In 1918, the Soldiers Rehabilitation Act was passed by Congress to rehabilitate returning veterans by the Federal Board for Vocational Education, however, only ten percent were successfully rehabilitated. During the World War II era, President Roosevelt pushed for a combined civilian and veteran rehabilitation program, however, due to political pressure for veterans groups, a separate veterans bill passed in 1943, as the distinction in policy between veterans and civilians would remain (Berkowitz, 1987).
Similarly, SSDI benefits were exclusively for those “deserving” Americans that have worked and paid into the system (Scotch, 2001a, p. 376). The passage of the Social Security Act in 1935 provided enhanced old age benefits and established “earned pensions” for the elderly (Kingson & Berkowitz, 1993, p. 33). Detecting deception from those who falsely claimed disability for individual profit forced the question of how to ascertain who actually deserves or needs assistance (Iezzoni, 2008). State workers’ compensation laws were focused on impairment that resulted from work, however were not precise in determining who could or could not return to work (Scotch & Berkowitz, 1990).

There is a general misconception and public debate surrounding who actually deserves disability benefits and what it means to be disabled by SSA standards. Furthermore, what determines how generous a public benefit should be? In 1936, Congress passed the Randolph-Sheppard Act that allowed for work opportunities for the blind to operate vending businesses in federal buildings (Berkowitz, 1987). This represents an early legislation for a special population with disabilities, the blind, who received a public provision.

With inconsistencies in the process and outcomes, there are doubts that the complex administrative, evaluation and determination methods are fair. The disability claimant ultimately maintains the burden of proof, cooperation, and is subjected to the assistance of medical professionals and various third parties to provide evidence to substantiate functional limitations as a result of a medical impairment (Brandt et al., 2011).

It was society’s moral obligation to provide disability pensions for injured military veterans and their survivors for their sacrifice for the Nation. The disability pensions for older American veterans were expanded to include those unable to work due to any disability towards the end of the nineteenth century (Scotch, 2001a). As Social Security created a broad social
welfare system, the VA system provided benefits for a very specific and privileged population of veterans.

G. Conclusion

The concept of disability has significantly evolved throughout history. In the United States, the social and public problem of disability first emerged in the American Revolutionary War, as disability compensation was awarded to Soldiers permanently injured in battle. The American Civil War resulted in a standardized veterans disability compensation mechanism for the thousands injured in the deadliest war in American history. This formalized bureaucracy of veterans’ disability benefits led to the creation of the modern VA.

Social Security was established in a small window of political opportunity during a devastating economic depression. The emergence of Social Security realized sweeping social welfare policies embodied in a broad social safety net. Social Security established a federal social insurance program based on earned contributions as well as created broad assistance to the states to administer public assistance to the elderly, blind and dependent children. SSA laws gradually expanded to provide coverage to a broader population of people with disabilities, even later to include Supplemental Security Income (SSI) for people with no work history and limited means and resources. The first social and public problem was the disabled veteran, later policies addressed disabled civilian workers injured as a result of industrial work, and modern SSD and VDC policies evolved to more generous programs than their early precursors. The criteria for disability benefits became broader and more difficult to pin down and adjudicate.

Within SSD and VDC programs, the rights-based notions relate more to the objective of full citizenship as related to work, specifically the need for income replacement. To a certain extent, these policies do not fully support full citizenship, as well as contradict modern disability
rights. Realization of full and equal rights are not endeavored in these programs, rather the aim remains the amelioration of disability through cash and other benefits, which do not remove barriers to full citizenship, stigma, and oppression. Income replacement by itself does not improve the condition of people with disabilities, nor does not fully grant full rights and benefits of full citizenship. However, veterans have received broad benefits due to their service in war for the nation, that aim to reintegrate them into society.

SSD and VDC programs are commonly referred to separately, however, the broad objective of these systems exists for income replacement as a result of disability. The key distinction is the valuation of the notion of deserving benefits: the disabled veteran more deserves the compensation benefit, depending on the type of impairment, due to his or her sacrifice in war service for the country. However, many critics of the broad social welfare program that became Social Security resisted the civilian disabled to be provided benefits. Historically, policies established for the disabled veteran included special benefits, privileges, and programs, specifically unique from and in comparison to the civilian disabled population. The Civilian War Benefit was a link between the two, in which civilians were recognized for their work force injury in the war effort through benefit protections. The SSD program was designed as a solution to work disability, and in effect removes the beneficiary from the labor force. The wide gap between the disabled veteran and the civilian with disability is concerning, since after all, both are people with disabilities. Public policy grounded in upholding civil rights shows inconsistent treatment in the citizenship rights between the two groups.
III. SSA AND VA DISABILITY DETERMINATION PROCESSES

A. Introduction

The development of substantive disability legislation has resulted in a dichotomy characterized by two broad areas: civil rights employment protection and income replacement (Berkowitz, 1987; Bloch, 1992). While most of the government spending is on the latter that essentially removes the individual from the labor force, disability civil rights legislation encourages and facilitates people to enter or reenter the labor force, despite their disabilities (Berkowitz, 1987). The result of this paradoxical contradiction is blurred disability policy and conflicting priorities. Disability determination for public disability benefits is a measure of if, and to what extent a person is disabled, however the definition of disability is not consistent or through different agencies (SSA, 2014a).

In order to understand the complexities of the disability determination process, exploring this operational process mechanism at a granular level first allows for clarity in the overall context of this intersection of disability and social policy implementation. Disability determination involves eligibility, entitlement by way of evaluation, as well as the claims and appeals process. Disability evaluation, only one aspect of the overall decision process, is the most important yet difficult, and imprecise at times, aspect of the determination process (Bloch, 1992). The purpose of this chapter is to detail the foundational and operational disability determination processes of the Social Security Administration (SSA) and Department of Veteran Affairs (VA). By design, the disability determination process is an examination that tests the legitimacy of a benefit claim and substantiates functional limitation by objective medical evidence (Bloch, 1992). The result of the determination process is affected by economic conditions, political factors, internal pressures, and limited government funding (Bloch, 1992).
The big question is how and why do these broad disability programs treat people and impairments differently, and how do cultural, political, and societal perceptions affect the determination process?

The scope of this chapter presents a broad overview and comparative analysis of the SSA and VA disability determination processes utilizing a policy analysis framework. Chapter III examines the SSA and VA disability evaluation and determination processes, and provides the foundation of the processes of SSA and VA disability determination. The objectives of this chapter are to: (i) provide an overview of the mechanisms, operational concepts, and respective statutory definitions of disability; (ii) survey how the criteria of eligibility and entitlement relevant to VA and SSA benefits determination processes interact with sociocultural perceptions of morality; (iii) explore how the SSA and VA processes reflect a gatekeeping process, and how they contribute to more generous or more sparingly determination outcomes; (iv) analyze the medicalized disability determination process that relies on medical personnel; and (v) evaluate how these administrative and legal processes of SSA and VA operationalize disability.


The disability determination process serves as a verification mechanism of proper entitlement to the public benefit. As with any conceivable public policy, there exists an historical concern whether or not, or to what degree, the population receives the benefit or service within the intent, spirit, and letter of the law. However, the subject of disability benefits is much more complex, mainly due to the economic conservatism and modesty built into social policies, and the variable conditions of the broad population of people with disabilities. While disability determination policies employ a medical and clinical examination process,
contemporary understandings of disability show that impairment is only one aspect of a complex disablement process.

Essentially, the disability determination encompasses an inclusion or exclusion test, however, research has not sufficiently addressed how judgments of morality impact the process. Scotch (2000) suggests that disability benefit eligibility may reflect moral stigmatization of certain impairments, and the process involves a labeling, categorization, and inference that further shapes peoples expectations in society. It is reasonable that public programs implement policies to prevent waste and abuse, but it remains unclear how certain populations may be excluded due to specific impairments or identification as cultural or ethnic minorities. Scotch and Berkowitz (1990) describe how the disability process is a reflection of impairment versus work participation, as the situation of being disabled involves complicated personal decisions about work, identity, and disability. Nevertheless, the framers of SSD insisted on a strict medical definition to protect program costs, to prevent awarding unwarranted claims, and institute an accurate evaluation process (Bloch, 1992).

As the veteran’s disability pension was the first national disability benefit program, such policies were eventually and substantially broadened, just as SSD progressively liberalized and expanded to broader populations of citizens. The VA was standardized in light of the prevailing charity model of disability and instituted a pro-claimant posture (Riley, 2010). Scotch (2000, p. 7) illustrates that emerging social insurance policies were intended to serve the “deserving” poor according to morality, earned rights to benefits, and having an unfortunate condition, nevertheless not by one’s fault. For instance, conditions involving mental impairments, obesity, and substance addiction, all share an individual fault element and perceived lack of personal responsibility. Additionally, there is evidence that African-American veterans discriminated
against and were denied VA disability benefits based on prevailing racial and moral inferiority (Hickel, 2001).

Stone (1984) describes how SSA instituted medical professionals as objective clinical gatekeepers in verifying disability, but also as a means to restrict program access by a conversely subjective process. Both SSA and VA resisted the release of their now published disability evaluation criteria, mainly out of apprehension that those undeserving and malingering claimants could potentially manipulate their application for benefits (Hickel, 2001). The moral argument that endures is only those “deserving” should receive the public benefit.

The early SSD program justified a disability test that compelled impairment and hardship, however excused certain people from the labor force, especially the blind (Scotch & Berkowitz, 1990, p. 6). Considerably a “deserving” group, blind individuals historically have been afforded greater and the earliest SSD benefits, an example of a special group without the stigmatization of fault. Likewise, the disabled veterans population represents an elevated and special group within the federal disability programs.

In recent history, the government has invested the majority of spending on income maintenance, which essentially removes the person from the labor force and out of the mainstream through an “all or nothing” policy approach (Berkowitz, 1987; Scotch, 1990). Likewise, Scotch (2000) defines the disability evaluation process as a focus on incapacity, either capable or not. This represents a clear boundary in the gatekeeping of disability benefits, disabled or not.

C. **Statutory Definitions of Disability**

Disability benefits programs such as SSA, VA, Worker’s Compensation, Railroad Retirement Board, encompass a web of plentiful and intricate laws and policies, however, they
are not uniform, in practice, and they serve different populations. The definition of disability is not consistent through different agencies (SSA, 2014a). Government programs that administer disability operate in isolation from one another, and do not use a uniform definition of disability (Berkowitz, 1987). Likewise a finding of disability by one program commonly has little impact on a disability claim with another agency (Bloch, 1992).

Contemporary definitions of disability increasingly reflect the social model of disability that accentuates the barriers, inaccessible work environments, exclusion and stigma imposed by society rather than functional abilities (Brandt & Pope, 1997), whereas SSA’s modern statutory definition of disability is the “inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months” (SSA, 2014e).

This demarcation is a strict operational definition entailing several requirements grounded firmly in a legal and administrative interpretation that reveals conceptual gaps in understanding of contemporary disability (Brandt et al., 2011). This expresses essentially a work disability that replaces income, and provides social welfare for those without employment. In other terms, this represents loosely impairment-induced unemployment insurance, as SSA’s definition is impairment-focused which correlates to the medical model. This is a stringent definition without provision for partial or short-term disability, consistent with the statutory definition.

As legislation gradually expanded the scope and definition of disability, SSA was the last of the federal disability programs to be implemented (Bloch, 1992). In a broad context, SSA’s definition of disability serves as a screening mechanism: if a person satisfies the definition of
disabled, he or she is awarded the disability benefits; if a person fails to satisfy the definition, he or she is denied the disability benefit. Likewise a similar process, the VA may also determine partial disability that reflects the disability’s degree of severity. The founders of SSA insisted on an accurate, meticulous, and medicalized definition of disability to prevent unjustified awards of benefits, thus preserving program costs (Bloch, 1992).

The statutory definition of disability according to SSA encompasses three elements: the inability to work, having a medically determined impairment, and length of time – a durational element to one’s condition (SSA, 2014e). To define disability, staff researchers at SSA borrowed from the War Risk Insurance Act which defined disability as “any impairment of mind of body which continuously renders it impossible for the disabled person to follow any substantial gainful occupation, and which is founded on conditions which render it reasonably certain that the total disability will continue throughout the life of the disabled person” (Berkowitz, 1987, p. 44).

Similarly, the VA’s primary disability benefit, known as a service-connected veteran’s disability compensation (VDC), is currently defined as “resulting from an injury or disease incurred or aggravated in active service, and in line of duty presumed by law to be related to military service, or resulting from other limited circumstances, such as disability that is the result of Department of Veterans Affairs (VA) hospitalization or medical treatment” (VA, 2014c). The statutory definition of disability according to VA encompasses three elements: a medical condition resulting from military service, medical evidence, and diagnosis of the condition, and a link between the two (Weimer, 2008). The two basic disability benefit programs within the VA are the disability compensation and disability pension. Bloch (1992) suggests that the very
unique nature of the VA definition of disability reflects an historic “congressional concern for disabled veterans” (p. 2).

VA also defines another disability benefit, the nonservice-connected pension, as a permanent and total, non-service connected (NSC) disability as determined by VA, or as determined by the SSA, to claimants in a nursing home for long-term care as a presumption of disability, or has reached the age of 65 years (Weimer, 2008). The VA disability determination does not consider whether or not the claimant is working, although the spirit of the benefit is to compensate for functional and vocational loss as a result of the service-connected impairment. In other words, the VA definition operates with the assumption or the expectation that one would be disadvantaged and negatively impacted by his disability. The VA’s intent is to compensate injury irrespective of the veteran’s actual inability to work (GAO, 2008a). On the other hand, SSA emphasizes the inability to work first, and does not further consider applications from people engaging in substantial gainful activity.

Similar in both the SSA and VA, the primary component of the definition is the medical abnormality that potentially impacts one’s economic capacity. This is true in many definitions of disability and benefit programs. Secondly, the key definitional difference involves actual earnings. If one applies for SSA and is working and earning above established thresholds, that person would not be considered disabled, regardless of medical condition. The VA does not consider work activity in the disability determination, except for Individual Unemployability determinations, in which the veteran must prove the inability to work (Moulta-Ali, 2011). Thirdly, the central distinction involves partial disability. SSA determines an all or nothing finding of disability, whereas the VA assigns a percentage reflecting the degree of disability and
estimated functional loss. SSA requires that the medical condition is severe and meets the duration requirement of at least one year, which expresses a total disability (Bloch, 1992).

In summary, the VA definition of disability emphasizes medical impairment interconnected with military service. SSA defines disability as a long-term inability to work as a result of severe medical impairment. Both statutory definitions function to guide the process to determine eligibility and entitlement to the disability benefit.

D. **SSA and VA Disability Claims and Decision Processes**

The SSA and VA administration of disability claims utilize rather different procedures and rules, however share a very similar administrative system of processing claims (Bloch, 1992). SSA relies on a two-person team, disability examiner and a medical consultant, in order to evaluate the disability claim. VA utilizes a three-member rating board, one of which is a medical doctor (Bloch, 1992). However, the VA medical doctor on the rating board does not determine the percentage of disability, rather the nonmedical rater accomplishes this, distinct from SSA (IOM, 2007b).

SSA administers a variety of disability programs according to two distinctive factors: fundamental eligibility and ultimate entitlement by disability evaluation. There is a broad umbrella of SSA disability programs, but the scope of this research highlights Title II Social Security Disability Insurance (SSDI) and Title XVI Supplemental Security Income (SSI) for adults, collectively referred to as Social Security Disability (SSD) since the evaluation process is identical. Similar to SSA retirement benefit criteria, SSDI eligibility requires that the individual worked long enough to attain sufficient Quarters of Coverage and paid adequate taxes into the system to become “disability insured” (Mitchell & Phillips, 2001). SSI is a means tested program for individuals with limited income and resources. Other disability benefits for family
members of the primary disabled beneficiary include Child’s Disability Benefit, Disabled Adult Child, Disabled Widows, and Widowers Benefit (SSA, 2014c).

In both SSA and VA, eligibility is the first administrative and legal consideration, whereas entitlement is the actual evaluation process in determining disability. SSA eligibility involves factors such as work history, age, family relationship, legal status, income levels, etc., and entitlement involves the examination of the individual’s allegations, medical records, treating doctors statements, work history, etc.

An individual claiming disability through SSA is referred to as a “claimant,” and he or she files an application for disability benefits, SSDI, SSI, or both (IOM, 2007a). For application to VA disability benefits, the individual is referred to as a “veteran” (Weimer, 2008). The SSA disability determination is a comprehensive process that encompasses the determination of eligibility and entitlement to benefits through the disability evaluation. The disability evaluation usually encompasses both a medical and vocational assessment, except when it is determined that the claimant’s condition is so severe, no vocational assessment is necessary when disability is matched to a medical Listing (IOM, 2007a).

Initially, SSA disability claims are usually filed in person at one of 1,138 SSA field offices geographically located throughout the United States. Additionally, claimants may file by mail, by telephone to one of 35 teleservice centers, on the Internet, and also at State DDSs (Disability Determination Services) (IOM, 2007a). The field office collects all pertinent information, including the allegations of disabling conditions and the limiting effects of the allegations, medical treatment history and testing, medications, work history, education, and training. At this initial application stage, the field office collects non-disability information such as financial resources and earnings history for eligibility requirements (IOM, 2007a). For
example, the insured status must be met to be eligible for SSDI benefit, just as the means test must be met in order to be eligible for SSI.

Likewise, the VA provides extensive benefits to American military service members, their families, dependents, and survivors. VA eligibility requires records documenting military service and requiring other than a dishonorable discharge, which generally precludes eligibility (Weimer, 2008). The main VA disability program categories are VDC, which compensates a veteran for military induced injury, and disability pension, which compensates a war-time veteran with little income, is unable to work, or is older than age 65 (Weimer, 2008). VA initial disability claims are processed by one of 57 regional VA offices (IOM, 2007b). Additionally, the VA and Department of Defense (DOD) implemented Benefits at Delivery at Discharge, a cooperative program to expedite disability claims for separating service members at 140 military bases in order to “ease the transition from service to veteran status” (IOM, 2007b, p. 146).

Both SSA and VA are obliged to develop the record of pertinent medical evidence and assist the claimant in obtaining the records. At the DDS, a disability examiner requests medical records and additional administrative forms and coordinates the review of the claims file. SSA has been criticized for its overreliance on consultative examinations, a medical examination arranged by the DDS and necessary when additional evidence is required for a determination. However, denial rates increased as SSA ordered more consultative examinations (Bloch, 1992). Once the DDS makes a determination, either an allowance or denial, the case is forwarded back to the originating field office for administrative completion, such as to begin benefit payments or to be held pending a request for appeal.

The disability decision process involves a lengthy appeal process, which statistically favors an award at the Administrative Law Judge level (Brandt et al., 2011). Likewise, the VA
manages a similar and lengthy appeals process. Within SSA, the high Administrative Law Judge allowance rate raises questions of integrity and inconsistent determinations at the initial decision level, while this has created a huge industry of disability lawyers that often collect fees that are significant amounts of a person’s retroactive benefit payments.

Similarly, the VA disability claims process involves obtaining medical records and comparing the evidence to the VASRD to ultimately determine a percentage, or rating of disability. The medical evidence usually is supplemented with an examination by a Veterans Health Administration doctor, or rarely a private medical contractor (IOM, 2007b). In most cases, VA will require a medical examination by a VA doctor for the determination of the claim. In the event of a disability denial or a disagreement of the disability percentage rating, the claimant may submit an appeal of the decision to the Board of Veterans’ Appeals (Moulta-Ali, 2011).

E. **SSA Disability Evaluation through Sequential Evaluation**

Whereas statutory definitions are fairly specific, the disability evaluation process is not so precise, and requires close examination for disability decisions. Disability determination is an inherently imprecise process that seeks to measure one’s employability (Berkowitz, 1987). As disability determination is intrinsically complicated, SSA estimated that up to 25 percent of determinations could be reasonably allowed or denied (Bloch, 1992). To simplify the decision mechanism and improve accuracy, SSA developed sequential evaluation as a more effective and efficient process to guide the determination outcome. The disability evaluation is the examination of medical evidence, claimant allegations, treating doctors’ statements and medical opinions, and results in a determination either awarding or denying disability benefits.
Moreover, central to the evaluative processes of SSA and VA is medical proof, which establishes the medical impairment (Bloch, 1992).

To start, SSA utilizes a five-step disability determination process known as sequential evaluation to consecutively ascertain eligibility and entitlement for benefits. This evaluation process is a decision sequence and matrix to thoroughly evaluate and ultimately adjudicate disability entitlement (Brandt et al., 2011). A finding of not disabled is at step one if a person is engaging in work or substantial gainful activity, which is continuous employment earning exceeding established levels, $1070 per month in 2014 (SSA, 2014g). If one is not working at these levels, the process continues to step two, which requires a diagnosis of a medically determinable impairment by a doctor or psychologist.

If a severe impairment is not established, a finding of not disabled is made, since no work limitations would exist without impairment. At step three, a person’s individual condition is compared to a published compilation of impairments considered severe enough to prevent work functioning, which continues to be updated with advances in medical technology and treatments. A matched condition with exact or equivalent severity results in a finding of disabled. If not, a combined medical and vocational determination is evaluated in the final steps of sequential evaluation (SSA, 2014d).

Whereas SSDI is a social insurance program that is paid into through federal taxes, and SSI is a means tested for people with little or no work history, the disability evaluation remains the same for both benefit programs. At the beginning of the claim at the SSA Field Office, the first step determines if the individual is engaging in work substantial gainful activity (SGA). SGA is defined by set amounts: in 2014 the monthly SGA amount is $1070 and $1840 for blind individuals, as determined by Federal Regulations (SSA, 2014g). So an individual may continue
to work under SGA levels, for example either intermittently or part-time, and SSA may
determine the person is not “working.” If it is determined that the individual is not engaging in
SGA, the claim is then forwarded to the State DDS for adjudication. After this initial step, the
remainder of the disability determination is conducted at the State DDS, where medical evidence
regarding treatment of the medical impairment is developed. Partly as a compromise to address
criticism of a too powerful federal government administering a broad social insurance program,
the framers of SSD gave responsibility of the disability evaluation to state DDSs, however
receiving funding from the central government (Berkowitz & McQuaid, 1980). This
arrangement was a compromise to ensure passage of the disability benefits amendment in
expanding the scope of Social Security.

At the DDS, the second step requires a severe medically determinable physical or mental
impairment, or combination of impairments, that is expected to result in death or to continually
last at least one year, known as the duration requirement. A severe medically determinable
impairment is further described as significantly limiting a person’s ability to do “basic work
activities, such as standing, walking, speaking, understanding, and carrying out simple
instructions; using judgment, responding appropriately to supervision; and dealing with change”
(GAO, 2002, p. 48). If no severe medically determinable impairment is established, the claim
will be denied at step two, and if there is one or a combination of severe impairments, the
decision process continues to step three.

At step three, SSA links the severe medically determinable impairment, or combination
of impairments, to the Listings of Impairments, a collection of conditions that are expected to
prevent SGA, last at least one year, and/or result in death. The Listings of Impairments, also
known as the Medical Listings, is organized medically by major body systems (Brandt et al.,
If the claimant’s impairment or impairments cannot satisfy the requirements of the Listings by meeting or equaling the criteria, the disability evaluation then moves to a medical and vocational evaluation at step four of sequential evaluation, which compares a residual functional capacity (RFC) assessment to the claimant’s past work. At step five, the claimant’s RFC is compared to jobs in the national economy, considering the person’s age, education, and experience. Sometimes this medical and vocational evaluation requires consultation with a vocational expert (Bloch, 1992).

The Listings of Impairments include a categorical collection by major body systems of severe medically determinable impairments that most are expected to result in death and all that are expected to last at least one year. This collection is a standardized reference in which the disability evaluators can quickly make a determination on presumptively disabling conditions according to the statutory definition of disability. The most prevalent physical impairment of SSA disability awards is musculoskeletal disorders (Moulta-Ali, 2011); the requirements for Listing 1.04 require the following (SSA, 2014e):

1.04 Disorders of the spine (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture), resulting in compromise of a nerve root (including the cauda equina) or the spinal cord. With:

A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine); or

B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours; or

C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate effectively, as defined in 1.00B2b. (para. 43)
Within this individual Listing, the general diagnostic criteria plus one of three subcategories must be met. In the C subcategory, the Listing refers to even more specific criteria in the “inability to ambulate effectively” located at the introductory section of the musculoskeletal body system Listings. The most prevalent mental impairment of SSA disability awards is affective disorder, generally known as depression (Mouta-Ali, 2011); the requirements for Listing 12.04 require the following (SSA, 2014e):

12.04 Affective disorders: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation. The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.

A. Medically documented persistence, either continuous or intermittent, of one of the following: 1. Depressive syndrome characterized by at least four of the following: a. Anhedonia or pervasive loss of interest in almost all activities; or b. Appetite disturbance with change in weight; or c. Sleep disturbance; or d. Psychomotor agitation or retardation; or e. Decreased energy; or f. Feelings of guilt or worthlessness; or g. Difficulty concentrating or thinking; or h. Thoughts of suicide; or i. Hallucinations, delusions, or paranoid thinking; or 2. Manic syndrome characterized by at least three of the following: a. Hyperactivity; or b. Pressure of speech; or c. Flight of ideas; or d. Inflated self-esteem; or e. Decreased need for sleep; or f. Easy distractibility; or g. Involvement in activities that have a high probability of painful consequences which are not recognized; or h. Hallucinations, delusions or paranoid thinking; or 3. Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes); AND

B. Resulting in at least two of the following: 1. Marked restriction of activities of daily living; or 2. Marked difficulties in maintaining social functioning; or 3. Marked difficulties in maintaining concentration, persistence, or pace; or 4. Repeated episodes of decompensation, each of extended duration; OR

C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following: 1. Repeated episodes of decompensation, each of extended duration; or 2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or 3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement. (para. 60)
At step four, SSA determines if the claimant is able to still perform his or her past work, considering the medical and vocational limitations as a result of the impairment or impairments. First, the DDS examiner and medical contractor medically assess the claimant’s residual functional capacity (RFC), essentially an evaluation of what the claimant can still do functionally, despite his or her impairment or impairments. A physical RFC is assessed for solely physical impairments and limitations, such as walking, standing, sitting, lifting, carrying, pushing, pulling; and the mental RFC is assessed for mental impairments and limitations, such as following instructions, concentration, persistence, and pace (GAO, 2002).

The DDS examiner compares the RFC assessment to the claimant’s description of past work; if the RFC allows the performance of past work, the disability claim is denied. Often the claimant’s description of past work may vary in regards to how the work is generally performed. At step four, if it is determined that the claimant cannot perform past work as he or she describes it, the DDS examiner compares the job description to the Dictionary of Occupational Terminology, a database of jobs detailing their physical and mental requirements in the national economy (IOM, 2002).

This vocational area of evaluation is problematic, especially since the job descriptions within the DOT are outdated, compared to today’s information and technology labor-based economy. Additionally, the burden of forms and information required by the claimant may result in a denial by technicality. For example, if the claimant describes his or her past work activity as not very physically or mentally demanding, the claim could be reasonably denied. Conversely, if the past work is described very physically and mentally demanding, the jobs may be not as arduous as generally performed in the national economy as indicated in the Dictionary of Occupational Terminology (Brandt et al., 2011). The vocational assessment does not consider
economic recession, availability of jobs, or work accessibility. A finding of not disabled at step four is found if a person’s RFC allows a return to do their past or very similar work.

The final step five looks at the RFC to do other work, considering age, education and work experience according to established occupational rules of disability evaluation which essentially disadvantage young age, education and skilled work history while favoring old age, limited education, illiteracy, non-English speakers, and lack of work history. Functional work capacity is compared to jobs in the outdated Dictionary of Occupational Terminology (IOM, 2007a).

The evaluative process criteria have changed significantly over time, which expressed political and legal fluctuations. Burkhauser and Daly (2002) identify three significant periods that altered the evaluative criteria: mid 1960s through the early 1970s in which the criteria was loosened and expanded, 1981 saw the restriction of criteria and an aggressive continuing disability review, and 1984 saw a relaxing of the previous stringent modifications. These periods affected the number of beneficiaries receiving SSD, however the economic conditions may be interrelated. Nevertheless, sequential evaluation reflects SSA’s initiative to streamline the decision process, however issues such as complexity, sufficiency of evidence and forms, timeliness, and accuracy continue to complicate the process (Brandt et al., 2011).

F. VA Basic Two Step Decision Process

The VA utilizes a basic two-step disability determination process that contrasts eligibility versus entitlement. VA definition of disability is inherently linked to military service and is similar to Worker’s Compensation disability evaluation (Bloch, 1992). At step one, the VA determines eligibility by requiring the claimant to meet the definition of veteran, that is a “person who served in the active military, naval, or air service, and who was discharged or released
therefrom under conditions other than dishonorable” (Weimer, 2008, p. 2). The VA uses military service records to determine this veteran status. If the VA determines the claimant does not meet the definition of veteran, the claim is denied, and if the veteran definition is met, the evaluation proceeds to step two.

At step two, the VA determines entitlement by three key areas: a medical diagnosis of the alleged disability, medical evidence supporting a “worsening of an injury or disease” that occurred during military service, and the “link between” the “worsening of an injury or disease” that occurred during military service and the alleged disability (Weimer, 2008, p. 9). This correlation is similar to the Worker’s Compensation process, which identifies a link between impairment resulting from work and insinuates disability (Berkowitz, 1987).

Once all three of these requirements are met, the VA determines a percentage of disability, 0% to 100% via the Department of Veterans Affairs’ Schedule for Rating Disabilities (VASRD, 2014). The percentage of disability, 0% to 100%, is referred to as a “rating,” which corresponds to the degree of disability (IOM, 2007b). The VASRD is intended to quantify earnings capacity loss and subsequent impacts on quality of life as a result of impairment (IOM, 2007b). This operational process evaluates the severity of conditions as a result of impairments in which the percentage of disability is assigned 0% to 100% incrementally by 10%, thus reflecting an average or estimated functional loss.

The service-connected disability determined to be not severe enough, nonsevere or resulting in slight limitations is rated at 0%, whereas a 100% disability rating is considered a total disability compensation (Moulta-Ali, 2011). The condition or conditions rated 10% or higher result in a monthly disability cash benefit, incrementally paid higher according to the
percentage or rating of disability. For unlisted impairments, the disability examiner utilizes an equivalent condition for evaluation, similar to that of the SSA equaling of Listings.

The VASRD is unique since the disability ratings are written into the Code of Federal Regulations. The VASRD was created as a simple way to accurately determine disability (Hickel, 2001). According to the GAO (2002), the last update to the VASRD was in 1945, raising concern that veterans are being evaluated on old-fashioned medical criteria. The VASRD comprises 14 major body systems and approximately 700 diagnostic codes (IOM, 2007b). The most common disability compensation awards by the VA are auditory conditions (Moulta-Ali, 2011). The VASRD located in 38 CFR 4.85 details the evaluation of disability for hearing impairments, the most prevalent VA disability. Within this individual schedule of ratings of the ear under subheading diseases of the ear, a 10% disability rating corresponds to the following requirements (VASRD, 2014):

6260 Tinnitus, recurrent. NOTE (1): A separate evaluation for tinnitus may be combined with an evaluation under diagnostic codes 6100, 6200, 6204, or other diagnostic code, except when tinnitus supports an evaluation under one of those diagnostic codes. NOTE (2): Assign only a single evaluation for recurrent tinnitus, whether the sound is perceived in one ear, both ears, or in the head. NOTE (3): Do not evaluate objective tinnitus (in which the sound is audible to other people and has a definable cause that may or may not be pathologic) under this diagnostic code, but evaluate it as part of any underlying condition causing it. (para. 13)

The VASRD (2014) located in 38 Code of Federal Regulations 4.126 details the evaluation of disability for mental disorders in which the “frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran’s capacity for adjustment during periods of remission” (para. 1) are considered. Within this individual schedule of ratings of mental disorders under subheading Chronic Adjustment Disorder, a 100% disability rating corresponds to the following requirements (VASRD, 2014):
Chronic adjustment disorder General Rating Formula for Mental Disorders: Total occupational and social impairment, due to such symptoms as: gross impairment in thought processes or communication; persistent delusions or hallucinations; grossly inappropriate behavior; persistent danger of hurting self or others; intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene); disorientation to time or place; memory loss for names of close relatives, own occupation, or own name. (para. 8)

The VASRD broadly utilizes a single rating formula for the evaluation of all mental impairments assessing a variety of psychological based symptoms (IOM, 2007b). The VA evaluates the severity of the condition and determines what percentage of impairment has impacted the claimant’s work capacity (Weimer, 2008).

G. Medicalization, Operationalization, and Hierarchization of Disability

Out of fear of program abuse and faking disability, the creators of SSD enlisted medical professionals to ensure a proper determination of disability (Scotch, 2000). Stone (1984) elaborates on SSA’s reliance of clinical judgment to determine disability. The planners of SSD realized that medical evidence would serve to justify the disability determination and utilized medical professionals to review claims (Bloch, 1992).

Both SSA and the VA have incorporated medical professionals in the final disability determination process. In order to evaluate the disability claim, SSA relies on a two-person team, disability examiner and a medical consultant, however the doctor’s dominance of the decision outcome varies somewhat by office. VA utilizes a three-member rating board, one of which is a medical doctor. However, the VA medical doctor on the rating board does not determine the percentage of disability, rather the nonmedical rater accomplishes this, distinct from SSA (IOM, 2007b).

In both SSA and VA, a variety of medical and legal issues infiltrate the determination process. Bloch (1992) categorizes the problems into three categories: establishing the medical
impairment, the extent and measurement of functional limitations by impairment, and how limitations counteract with labor requirements. Burkhauser and Daly (2002) contend that operationalizing disability is not simple, and considering other factors, SSD does not, in reality, ascertain inability to work.

SSA Listings require the items such as signs, treating physician examination findings that correlate to allegations, the symptoms, and results of laboratory findings, and the objective medical evidence (Bloch, 1992). If the Listings are met, the medical and legal issues are addressed. If they are not met, the evaluative process continues. However, Brandt et al. (2011) indicate that impairment and meeting criteria within the Listings does not necessarily predict the inability to work. The VA Schedule is organized with percentages of disability, therefore the implied degree of functional limitation is built into the rating system.

IOM (2007b) expresses that any comparison of the VA to other disability programs would be lacking because the “standard” is different (p. 22). They further illustrate that the Grateful Nation is the guiding principle in the spirit of repaying military veterans for their service. In reality, the standard is slightly different, but quite similar. In point of fact, both systems have the potential to learn from one another, and share innovation in process and administration of benefits.

The main difference is the “special” population served: VA provides benefits for veterans, SSA provides benefits for civilians, but after all, there is one population – people with disabilities. The veteran’s history shows devotion by governments to care and repay service for the disabled veterans. Berkowitz (1987) contends that veterans benefit programs have typically been more substantial, generous, and well established than that of programs for the civilian
population, and the disabled veteran remains a special privileged group that has maintained greater benefits than the civilians.

GAO (2002) underscores the general belief about the purpose of VA disability benefits as providing income replacement, compensating economic and noneconomic loss, and also as repayment for military service (p. 11). Hickel (2001) reveals despite the intent of the War Risk Insurance Act, VA disability compensation was in effect repayment for military service, not disability or economic loss.

Scotch (2000) describes Zola’s approach to removing the “specialness” of disability by homogenizing disability policy (p. 10). Failed attempts were made by the Hoover Administration to streamline various veteran programs that were categorized by wars, as it was thought that veteran populations would decrease and not be replaced (Scotch & Berkowitz, 1990). This may be an explanation of the substantially more generous provision for the veteran, as well as the lack of political resistance to such programs.

It is important to note that certain situations may preclude eligibility to disability benefits. For instance, “willful misconduct” that resulted in impairment may be precluded from VA eligibility, just as impairment resulting from the commission of a felony may disqualify eligibility to SSD (Weimer, 2008). Also the CFR indicates that drug and alcohol abuse, and venereal disease may not be compensable impairments for VDC if not service-connected. Likewise, SSD prohibits sole impairment of substance abuse, and further has removed obesity from the Listings. Such impairments speak to the morality and social judgments of one’s behavior, in relation to the extent of deserving public benefits.

Another concern, are these broad federal disability programs resistant to change from the status quo, and are they proactive in process improvement? There is no debate that military
veterans deserve recognition and repayment for their service, but disability benefits are established primarily to ameliorate disability, not service. However, there is indication that VA disability benefits were established primarily for repayment for service, not disability (Liachowitz, 1988). In effect, the guiding principle of the grateful nation has created a disability hierarchy, in which a special population is elevated and immune from discourse, comparison, and scrutiny.

GAO (2002) pointed out that beneficiaries’ potential to fulfill their individual potential may be compromised if the determination process miscalculates the limiting effects of some impairments. Not all impairments are treated equally, and some are even more troublesome to diagnose, treat, and evaluate for disability benefits. For example, as a symptom or as a medical impairment, pain is difficult to objectively evaluate (Bloch, 1992). Dizziness, fatigue, and headaches are even more complicated to assess objectively without the existence of substantial medical evidence. Likewise, but historically more controversial, mental impairments are difficult to diagnose and assess functional loss. Bloch (1992) indicates a history of high allowance for VA post-traumatic stress disorder claims, in contrast to a low allowance rate for SSA mental impairment claims.

The VA disability determination process may preclude veterans with bad conduct or dishonorable discharges. However, the VA employs a case-by-case basis of the determination. For example, the VA must determine if the conditions at the time of the offense, as “there does not need to be a direct connection between the insanity and the misconduct” (Weimer, 2008, p. 4).

SSA’s disability standard has evolved through recent history, as the amended Social Security Act of 1967 included disabled widows, however they were held to a stricter standard.
GAO (2002, 2008a) asserts that both SSA and VA are slow to change, and have not kept pace with advances in technology and medicine, and the transforming nature of the US economy and labor force. So the medicalization and operationalization of disability in both programs appear to be functioning on out of date erudition. In summary, federal disability programs understand disability as a fundamentally medical phenomenon, which tends to operationalize the disability determination process.

H. Conclusion

The literature separates the two disability programs in different categories, however the fundamental disability evaluation processes are quite similar. The SSA definition of disability accentuates the inability to work, whereas the VA definition emphasizes the link of a continued or worsening medical condition from military service.

Both SSA and VA disability programs operate with the consistent underlying intent to compensate lost earnings potential due to a physical or mental impairment, however, the VA is distinct in that the claimant may work and earn unlimited income, contrary to the SSA requirement that precludes work (GAO, 2002).

In 2010, the average SSDI benefit was $1066, whereas the maximum VDC benefit was $2673 tax-free (Moulta-Ali, 2011). This shows that the VA administers a much more generous benefit program, especially since SSA continuing eligibility generally precludes work activity, unlike the VA. Furthermore, SSA operates an all or nothing entitlement approach, whereas VA awards a percentage of disability, which also reveals a more attainable benefit (Moulta-Ali, 2011).

SSA’s strict definition of disability assumes no work capacity, therefore inherent in its assessment first is the examination of ability to work. If the claimant is working above
established levels, no further consideration is required and the benefits are denied. In stark contrast, the VA does not consider actual earnings for the disability determination; rather the VA determination process measures an estimation of economic productivity loss due to impairment. The spirit of VA’s disability definition estimates the impact of one’s condition on work capacity limitations. However, VA makes the disability determination independent of actual work capacity and employment activity. In other words, a veteran may work and earn substantial income, regardless of disability compensation.

Both programs utilize a form of sequential disability evaluation, with emphasis on medical record evidence and utilization of medical professionals, which are central to both programs to determine disability, and as such both rely on the medical model of disability. Both federal disability programs rely on a clinical and medical definition of disability, partly to restrict access to those deemed not deserving and unworthy for disability benefits. With reliance on medical impairment, the determination process is operationalized, rather mechanically.

The veteran has been long established as a special population, deserving of public benefits based on the notion of the Grateful Nation principle. However, greater and more generous access to public disability benefits may even further marginalize and stigmatize beneficiaries without identification in the special population. In effect this elevates the disabled veteran to a special status.

The broadest distinction is that SSD beneficiaries are essentially removed from the workforce in order to be eligible for benefits, whereas actual work activity is not a consideration for a VA disability determination. Clearly, veteran status is required to qualify for VA disability benefits, however the veteran may also qualify for SSA disability benefits. This accentuates the
importance to further uncover how these processes overlap, converge, diverge, contradict, and inform each other.
IV. SSA AND VA DISABILITY DETERMINATION OUTCOMES

A. Introduction

SSA and VA administer the largest disability cash benefit programs in the United States, and it remains necessary to examine their effectiveness, shortcomings, as well as similarities and differences for improved benefit delivery to citizens and veterans alike. Regarding SSA, there is some concern about program integrity and solvency. However, regarding the VA, there is concern about the timeliness and accuracy of disability awards. The media plays a central role in portraying these principal issues – very different problems, yet where is the disconnect? Both programs struggle with timeliness of the decision process, yet both agencies are not treated equally. Additionally, research must also consider other factors, such as the budget constraints in the two agencies and must understand the difficulty with precision in the determination process.

Chapter IV addresses the shortcomings, challenges and outcomes involving disability determination under SSA and VA and their current state of affairs. This chapter highlights two distinct media stories in 2013 that demonstrate the prevailing debates surrounding the problems with disability determination in SSA and VA programs. Furthermore, this chapter lays out current debates and consequential issues within the policies, broader socio-cultural and political-economic structures impacting the policies today, and steps being made to improve these programs.

The big question here probes what is the status quo of these broad disability programs, and how is the determination process being improved? And what are the characteristics of dual SSA and VA eligibility for the disability benefit. The scope of this chapter presents a broad overview and comparative analysis of the SSA and VA disability determination outcomes.
utilizing a policy analysis framework. Chapter IV examines the SSA and VA disability determination policy outcomes, and surveys the current state of affairs situated within SSA and VA disability determination process. The objectives of this chapter are to: (i) present a comparative analysis of media influence on the public perceptions of disability recipients; (ii) survey conceptual problems inherent in disability evaluation and determination; (iii) explore how the SSA and VA have taken steps to improve disability determination and ensure program integrity according to their respective definitions of disability; (iv) analyze the current status of disability determination in SSA and VA, and moreover what the programs have become; and (v) evaluate how SSA and VA disability programs continue to converge and what areas need addressed moving forward.

B. Media Reflections and Sociocultural Perceptions of SSA Disability Recipients

Through influence on sociocultural perceptions, the media impacts policy processes and influences systemic change. First, the media can perpetuate stigma, negative images, stereotypes, and societal oppression of the disabled through anecdotal snapshot accounts. Conversely, the media can serve as a source to spread awareness of injustices, inequality and challenges faced by people with disabilities and ultimately lead to significant policies to protect and benefit the disabled.

For 26 days in 1977, disability activists in San Francisco protested the delayed implementation of Section 504 of the Rehabilitation Act of 1973, the first broad civil rights law protecting people with disabilities (Scotch, 2001b). In this case, the media represented the plights of the protesters as unified, persistent, and dedicated, and further portrayed people with disabilities as humans, showing intensity of the new civil rights movement and the unity in a new civil rights era for people with disabilities.
As policies are implemented, transform, and evolve, it seems the intent and spirit are shadowed with continued resistance to social policies, evidenced by anecdotal accounts in the media. An origin of the public misconception of disability, the media perpetuates the stigma of disability benefits and entitlement through various exposés, which elicit sensational stories of people portrayed as not deserving benefits. A recent story featured Republican Senator Tom Coburn questioning the award of disability to an “adult baby” that demonstrated work skills by manufacturing over-sized furniture (Dinan, 2011).

Another investigative exposé highlighted a GAO investigation that found between 2005 and 2009, “fraud and other improper payments” cost the taxpayer $25 billion for payments that beneficiaries “may not deserve” (Attkisson 2011). The GAO report crosschecked disability payments with federal employees, and found 1,500 workers collecting Social Security disability “they probably didn’t deserve” at the Treasury, Post Office and Defense Finance and Accounting Service (Attkisson, 2011). In response, Senator Coburn commented “I’m biased when we have one in 20 people in this county on disability, I don’t believe it…as a practicing physician in a poor area of the country with lots of problems, I don’t buy it” (Attkisson, 2011). A “healthy” worker collecting disability payments makes one question the validity of the disability evaluation process, since after all, how was this person approved for SSA disability if they can work?

Implications in such media stories with highly limited evidence further perpetuate the stigma of receiving disability payments and inflame the discussion as to who actually deserves disability payments. Such stories paint an incomplete picture by ignoring key facts and alternate explanations, and represent a broader misconception of the SSA disability program. These prevalent stories highlight the perception of SSA disability as a failed system that is abused, and incite arguments to further expand such investigations, reduce the social welfare program
recipients and infers the Social Security tax is wasted through government ineffectiveness to combat fraud.

In early 2013, the debate is louder than ever amplifying there is a problem with the SSA disability program. Joffe-Walt (2013) provides the clearest illustration of prevalent misconceptions of SSA disability benefits while emphasizing the increase in disability beneficiaries in the National Public Radio series, *Unfit to Work, the Startling Rise of Disability in America*. Beyond drive-by media accounts accusing SSD beneficiaries of disability fraud, this report took the media spotlight of SSA disability in 2013. The reporter who covers economic topics argues two primary theories: claimants fake disability in lieu of working, and SSD is a logical choice for unskilled, uneducated and impoverished citizens.

This story is important to expand on, since it reveals the conventional broad misconceptions of SSA disability and suggests common shortsighted solutions to reduce federal spending in social welfare and further restrict dependency on the government. This report frames a broad economic argument that the welfare reforms of the 1990s essentially transferred the poor onto the rolls of SSA disability as applications rose with higher rates of unemployment. The reporter points out the enormous cost of the program to taxpayers, and focuses on a rural county in Alabama in which 25 percent of its population receives disability benefits. Joffe-Walt (2013) explains that the conception of disability is not a clear one, and varies greatly between individuals. She notes that the most prevalent impairments are back problems and mental illness, as she learns that most people in the area have less education, unskilled and heavier exertional work histories.

Rupp (2012) indicates demographics, medical impairments, and the local unemployment rate, all influence SSA disability receipt. Likewise, older claimants are more likely to be
awarded disability benefits, and further increases in the unemployment rate result in a decrease in allowances (Rupp, 2012). Such analysis suggests the impact of labor market conditions and old age on disability applications.

In a heartbreaking depiction of a SSA disability recipient, a woman described how she would have dreamed to work at the Social Security office in disability applications, as it was the only sedentary “sit-down” job she was aware of. Joffe-Walt points out the rise of SSA disability is explained by a growing older workforce, but even more so the program has become effectively a welfare program for the unskilled and less educated, since, she argues, the cash benefit coupled with Medicare seems to be a better option than working a job paying minimum wage without health insurance, despite the prospect that disability benefits entail a future of lifelong poverty. Joffe-Walt highlights a child receiving Supplemental Security Income (SSI) based on a learning disability, indicating that even if the child “overcomes some of his disabilities,” the family would be financially impacted without the SSI benefit payment. In this, Joffe-Walt (2013) concludes that the SSA disability programs create a family dependence on the government, and further create disincentive for children to excel in school, for families being able to provide for, encourage, and support their children, and children growing into independent and self-sufficient young adults.

The NPR report precipitated an outrage in the disability community. Davis (2013) gives notice to the confusing message of disability and those that receive disability benefits, and contends that while some people may have the potential to work, others do not. The report resonates the notion that some workers are lazy and make a business decision that is disability benefits, instead of participating in the work force. Presented in a quasi-economic framework, the report highlights unskilled, vulnerable, and poor people with limited education.
In a direct response to Joffe-Walt’s report, eight former Commissioners of SSA expressed the danger of not including all of the facts, mischaracterizing the disability program, and the devastating consequences if the programs were changed. The SSA Commissioners contend that SSD benefits provide a vital lifeline to the country’s most vulnerable population, and despite decreased operating budgets, the agency has improved program and system integrity (Apfel et al., 2013).

While SSA disability payment fraud surely exists, some lawmakers call to reduce government, privatize, deregulate and rely on individual responsibility are amplified. Media stories exposing government waste are evermore prevalent in light of the current poor economic condition of the United States. Previously in the 1970s, financial crises, lack of accountability, government spending, and dependency of the welfare state propelled reforms in social welfare (Dowse, 2009). Scandalous snapshot stories lead to heated discussions to justify the expansion of conservative ideologies and to substantially reduce government spending, especially in social services and SSA disability entitlement programs.

SSA has a history of scrutiny in the media and what the Agency’s disability benefits are all about. To sum it up, portrayed in the media and by lawmakers, the past and continuing problems with SSA disability include the enormous growth of beneficiaries, the insolvency of the SSDI program, and fraud. With the exception of the insolvency issue, the other two problems question the integrity of the disability determination system. Michael Astrue, the former SSA Commissioner, insists that the SSA disability is not a welfare program, as some critics suggest (Resnikoff, 2013). However, the debate in the media and by lawmakers is not questioning the integrity of the VA disability benefits system, rather their debate expresses an outrage of the existing backlog of VA disability compensation claims.
Berkowitz (1987) foretold that disability policies are confounded and muddled with their intricate legal, administrative, and socioeconomic aspects that are required to fully understand disability programs as whole. Without a broad understanding and perspective, it is difficult to improve programs while fulfilling the essential objectives of the benefit systems. Berkowitz (1987) further stated that aspects of disability programs are scrutinized outside of the context of overall disability program intent. Regarding SSA disability, the media often employs sensationalist generalizations that imply rampant and unaccounted abuse. Such anecdotally supported arguments undermine the disability community, propels the stigma of social welfare, question the definition and worthiness of disability and gives fuel to reduce, eliminate, or privatize SSA disability. Media accounts of SSA disability question the deserving disabled, framed in an economic argument, however the VA does not face similar scrutiny. This debate is key to analyze the differences between the two programs, and of why the SSA system is constantly scrutinized and demonized in the public arena, but the VA is not.

C. **Perceptions of Sluggishness in VA Disability Determinations**

Whereas SSA faces scrutiny regarding the validity of the determination process, the prevailing criticisms of VA disability benefits involve the timeliness of disability determinations and the agency’s failure to contend with lengthy backlogs of veteran claims. Reports questioning the legitimacy of VA disability determination are not so prevalent in the media. Nonetheless, the strain of prolonged war on recent veterans and the public’s modern support for service members have brought the backlog concern center stage, and appear to have muddled the need to investigate the validity in determinations.

The claims backlog issue took the media spotlight of VA disability in 2013. Iraq and Afghanistan Veterans of America led a campaign to collect thousands of signatures, put pressure
on Congress, and compel the President of the United States to intervene, all in order to reduce the backlog of VA disability claims (Maddow, 2013b). The Iraq and Afghanistan Veterans of America campaign revealed the inconsistencies in the VA’s disability determination process, such as varying timeframes of waiting for a decision depending on geographic location. Additionally, leaders in the veteran community have targeted top VA officials and demanded that they be removed so the Agency can move forward with a sensible plan to end the backlog (Flatten, 2013b). It appears that the coverage in the media over the backlog was effective in removing old leadership in the VA, since several high-ranking officials in the Agency retired or resigned (Maddow, 2013b).

Contributing to the backlog, in 2009, the VA expanded presumptive disability eligibility to Vietnam Veterans with Agent Orange-related impairments solely based on service in country (Maddow, 2013a). A few months later, similar presumptive disability criteria were announced regarding Gulf War Syndrome for veterans who served in country. The broadening and expansion of VA presumptive disability substantially contributed to the rise in applications for compensation, in tandem with the surge of returning veterans from the Iraq and Afghanistan Wars. Similar as in SSA, impairments such as traumatic brain injury and post-traumatic stress disorder proved to be more complex cases that were more difficult to evaluate. This resulted in hundreds of thousands of additional retroactive claims (Maddow, 2013a). Crowley (2013) points out that one VA office was so weighed down with claims folders that the building was in danger of collapsing. This is one important distinction, whereas SSA processes most disability claims electronically, the VA still processes about half on paper folders (SSA, 2014d). Zavis (2013) describes that the VA has finally made progress in tackling backlogged disability claims with the
help of new electronic case processing system, newly hired staff, additional overtime work, restructuring of workloads, and additional training.

Conversely, in light of an average wait of 265 days for a disability decision, a Congressional hearing highlighted the generous VA benefits provision that allows priority in attaining government contracts to a veteran with a 30% disability rating that suffered an ankle injury playing football in a military prep school. Representative Tammy Duckworth, a disabled veteran and former employee of the VA, publically shamed the veteran and accused him of breaking America’s trust in the VA benefit system that is intended for those that serve and protect the United States (Zimmerman, 2013). This noteworthy example is framed in the context of the extensive VA backlog of disability claims while illustrating the need to reexamine the scope of eligibility.

Breed (2010) asserts that because of Congressional pressure on the VA to resolve the voluminous disability claims, there may be fraud in the system. Furthermore, the VA requirements for post-traumatic stress disorder were loosened and permitted unconfirmed allegations to be used as evidence in awarding the claim. However, VA is required to resolve any reasonable doubt in the veteran’s favor, which is consistent with the Grateful Nation principle (Breed, 2010). A key contrast to SSA, VA operates a pro-claimant system in favor of the veteran (Riley, 2010). This type of story questioning the validity of VA’s disability determination is certainly not in the majority within the media.

Conversely, MacLean (2010) indicates that traumatic combat exposure results in increased rates of disability and unemployment with veterans and gives rise to implications of long-term disadvantage. This discussion is especially relevant considering the vast numbers of combat hardened veterans returning from Iraq and Afghanistan. The VA’s relaxing of medical
criteria and evidence, such as for verification of post-traumatic stress disorder, may be evidence of the Agency’s urgency to quickly resolve claims, in the minimum to reduce the backlog of claims. This coupled with the broadening of eligibility for Vietnam-era Agent Orange and Gulf War Syndrome claims, resulted in a massive backlog of claims. The Agent-Orange claims compared to those backlogged applications for contemporary Iraq and Afghanistan veterans may contribute to the historical intergenerational tension in which the VA has categorized and separated provisions depending on the conflict (Scotch & Berkowitz, 1990).

There are several causes for the extensive VA backlog of claims, however the Agency shares similar issues in the disability determination processes with other programs. In both cases of SSA and VA highlighted in the media in 2013, there is potential for constructive public debate about the policies, processes, and outcomes of the largest federal disability programs.

D. Contemporary Problems in Disability Determination

There is an imbalance in the media that contributes to quite polar opposite perceptions regarding people who pursue and receive SSA versus VA disability benefits. On one hand, some media tends to portray SSA disability beneficiaries as moochers, fakers, takers, defrauders, and on the other hand portrays disabled veterans as waiting more than 600 days for a VA disability determination.

The stark implication is that SSA disability is not an accurate system and continues to burden the country with exorbitant cost. Whereas both disability evaluation systems are similar, why is there not more criticism of the integrity of the VA system? Are there no moochers, fakers, takers, and defrauders under the VA system? Or is it the perception of a Grateful Nation for military service that trumps all, and the VA disability benefit is an entitlement just based on service, without regard to statutory disability evaluation policies and processes. The GAO has
deemed both SSA and VA high-risk programs for waste, fraud, abuse, mismanagement, or in need of broad reform (Moulta-Ali, 2011).

The central problem with administering massive disability programs today is the enormous rise in claimant applications, more than the systems can promptly resolve. And as a result of the surge of applications, the broader issue remains the backlog of claims, long wait times, and a perception of an out-of-touch bureaucracy that is slow to change. SSA and VA serve different respective populations, the civilian and the veteran, however the military veteran may also qualify for the civilian benefit concurrently. Nonetheless, each agency faces different challenges with varying results.

SSA disability claims have increased greatly in the past 30 years, mainly due to many baby boomers entering SSD as they approach retirement age, and masses of women joining the labor market in the 1970s and 1980s (Apfel et al., 2013). SSA’s principal timeliness problem is found in its appeals backlog, similar to the VA. There is also evidence that as the economy stalls and unemployment rises, SSD applications naturally rise (GAO, 2009b). VA disability claims have increased considerably, mainly due to the surge of returning veterans from recent wars in Iraq and Afghanistan, and also the expansion of VDC eligibility for certain impairments, such as Gulf War Syndrome (Maddow, 2013a).

Evolving policies have changed greatly, and it is important to review the current state of affairs in SSA and VA disability programs. Several federal agencies manage programs that support people with disabilities; in 2006, VA administered 32 and SSA operated 10 (SSB, 2006). It is important to explore the number of beneficiaries served by these programs, the benefit amounts, and their operating budgets and administrative expenses. Also, future research should investigate the veteran population versus the SSD population and their implications.
In 2010, SSA paid $8.6 billion per month to 8.1 million SSDI beneficiaries, whereas the VA paid $3.1 billion to 3.2 million disabled veterans (Moulta-Ali, 2011). In 2011, SSA paid an average of $1069.88 per month to 8.4 million SSDI beneficiaries. The VA utilizes a nonmedical professional examiner to rate the veterans disability, whereas SSA utilizes a medical doctor for the final determination (IOM, 2007a). This distinction may result in different outcomes for the claimant, since SSA relies on medical expertise yet VA counts on administrative judgment.

The National Council on Disability (2013) indicates that VA disability claimants were waiting on average more than 125 days for a determination, recommended the importance of sharing medical records with other agencies such as DOD, and calls for updates to the Veterans Claims Assistance Act. Now, it appears that the wait has decreased (Zavis, 2013). Such issues are not uncommon in disability determination throughout other disability programs.

E. Converging Issues in Disability Determination

It is important to analyze the convergence of both SSA and VA programs, since after all, some veterans may be eligible mutually under both disability determination processes. Olsen (2006) notes that one in four veterans receive SSA retirement, survivor, and disability benefits, thus comprising a significant subgroup of SSA programs. GAO (2009a) found that 16,000 veterans have applied for SSA, DOD, or VA disability benefits between 2001 and 2008, however, only 4% were approved for SSA disability. Such a small percentage of approval, this may be the result of SSA’s strict statutory definition or disability, but this intersection needs further investigation. Interestingly, the majority of this 4% have been approved for SSA disability with a primary mental disability. Additionally, GAO (2009a) contends that the higher the VA disability rating, the more likely the veteran will be approved for SSA disability. Taken together, it is not unreasonable that the 100% VA disability represents a severe medical
condition that correlates to the strict SSA definition of disability that emphasizes the inability to work due to a severe medical impairment.

It is precisely this convergence of the military veteran and his interaction with the two largest disability programs that warrant further research in the effectiveness of the determination process. Other areas where SSA and VA intersect suggest that greater collaboration would benefit the dual citizen veteran population. Rosenheck et al. (1999) revealed that a joint SSA and VA initiative and outreach to improve access to disability benefits among homeless veterans with mental impairments resulted in higher disability entitlement. Considering that two separate determination systems may be inefficient, the VA and DOD have tested a joint disability evaluation system to improve efficiency and timeliness (GAO, 2008b). Despite separate determination criteria between SSA and VA, it could be worthwhile to explore the possibility of joint evaluation systems for disability determination.

Moving forward, SSA and VA have substantial areas for improvement and reexamination of the integrity of the disability programs. A GAO report (2002) examining SSA and VA disability program integrity, called attention to the necessity to stay current on advances in medicine, treatments and medical technology, economics and changes in the labor market, in order to prevent under or overestimating the limiting effects of allegations of impairments. The GAO acknowledged the differences in SSA versus VA disability programs, however insists that both agencies are confronted with ensuring program integrity (GAO, 2002). Their analysis shows that the SSA and VA disability evaluation standards have not kept pace with the advances in medicine, treatments and medical technology, and revisions are not accomplished timely. Both agencies share the obligation to ensure program integrity, but to what extent they have not maintained criteria in step with advances in technology, medicine, and labor markets, is not
clear. SSA and VA both utilize outdated labor market data in order to assess disability claims (GAO, 2002).

Despite not directed by law, SSA appears proactive with updating criteria in the disability determination process. Whereas the law directs the VA to periodically modify the evaluation criteria, the agency has been slow to act and has generally made fewer changes than SSA (GAO, 2002). GAO (2002) made two distinctive recommendations to SSA and VA: to implement into the agency annual performance plan a strategy to continually update the published disability criteria (Medical Listings, and Schedule for Rating Disabilities, respectively) and incorporate labor market data into the determination process, and to research incorporation of advances in medical treatment and assistive technology into the determination process and the impact on the programs and report findings to Congress.

SSA concurred with continually updating disability criteria, and cited their own performance plan that encouraged policy change based on beneficiary self-sufficiency as well as medical, technological, and socioeconomic changes (GAO, 2002). On the recommendation to study and report the effect of medical treatment and assistive technologies on the disability determination, SSA indicated they already consider those factors in the evaluation process, however insisted the agency is not unwilling to institute further policy changes. Furthermore, SSA indicated key steps the agency has made already in updating the disability criteria in light of advances in medicine and assistive technology (GAO, 2002).

Consequently, the VA rejected both GAO recommendations. The VA rejected using economic factors for updating the rating schedule, citing a previous study from 1973 sparking objections in Congress, the veteran community, and the Agency. The VA resists validating the Ratings based on economic conditions and asserts that their method is the fairest way to evaluate
disability that has been in place since the early 20th Century (GAO, 2002). Furthermore, the VA contended the basis for disability compensation is medically focused, should not be strictly adhered to according to mechanical process, and is supported by the consensus of Congress, the veteran community, and the Agency (GAO, 2002). While the VA indicates intention to update the Ratings Schedule, they were unwilling to provide a timeline. Secondly, the VA dismissed the recommendation to consider medical treatment and advances in technology, citing a radical change from the disability program and suggested this would demand veterans to undergo treatment and utilize assistive devices in order to qualify for benefits. The VA reiterated that the Congress, the veteran community, and the Agency would not support the recommendation (GAO, 2002).

VA’s resistance to change is illustrated by citing the veteran community and Congressional support, as well as justifying the status quo in the evaluative process since it has worked for so long without much change. However, ten years later, the VA is more amenable to change. In the effort to modernize the VA disability program, GAO (2012a) made three main recommendations: conduct research on the relationship of the Ratings Schedule, impairments, and economic loss, develop an implementation strategy on revisions to the Ratings Schedule, and put into operation a system and polices of regularly updating the Ratings Schedule.

Ten years later, GAO (2012b) notes that VA’s average case turn around time was at 188 days in 2011. GAO determined four elements contributing to the prolonged case processing time and ensuing backlog of VA disability applications: a surge of recent veterans with multiple conditions, some of which are difficult to assess, readjudicating Agent Orange claims based on updated regulations, difficulty in obtain medical records timely, especially from SSA, and VA’s paper folder-based claims processing system.
The VA coordinated with the DOD to share medical records and claims process through a collaborative integrated disability evaluation system (IDES), however its success will be determined by the agencies’ ability to adapt to challenges in the long term (GAO, 2011). There are conceptual differences in the approach and administration of modernized disability determination in both agencies, and extensive independent government researchers provide insight on comprehensive program improvement.

F. **VA Recommendations and Prescriptions for Improvement**

To improve the overall disability decision process, two crucial issues are of great concern for the VA: timeliness and accuracy of disability determinations. Similar in SSA, IOM (2007b) acknowledged that the conception of disability has changed significantly and recognized that VA’s definition of disability is out of step with contemporary understandings of disability, which is expressed as the interaction of impairments with one’s socioeconomic environment.

In order to continually improve the Rating Schedule, the committee made the several recommendations and guidance (IOM, 2007b). Since the single purpose of VDC is to compensate for average economic loss due to impairment, the program should also compensate for noneconomic loss, specifically loss of function in activities of daily living and loss of quality of life. The out of date Rating Schedule should be updated right away and continuous research should be conducted. Acknowledging there is no evidence of the correlation between the Rating Schedule and average loss of earnings, the VA should research this relationship to predict actual loss of earnings, as well as the impact of other factors such as age, education, and work experience, in order to update the Schedule accordingly. The VA should coordinate a comprehensive evaluation system with DOD in addition to research on the most effective model for vocational rehabilitation. VA should support outreach and provide veterans information on
ancillary benefits, such as SSA disability. Regarding employment, the VA should conduct extensive research on trends in employment, earnings history, and implement a gradual reduction in benefits for veterans that have returned to substantial gainful activity. In addition to regularly updating the Ratings Schedule, VA should implement a modern classification of medical impairments such as the International Classification of Diseases and the Diagnostic and Statistical Manual of Mental Disorders, which would support a uniform system of disability evaluation. Considering evaluation, VA should regularly conduct training for examiners and ratings specialists in order to maintain proficiency and knowledge relevant to clinical judgment. Training should be standardized across the entire Agency and implemented uniformly. In order to improve quality and consistency, the VA should incorporate a solid checks and balances system as well as ensuring inter-rater reliability (IOM, 2007b).

In order to reduces VA’s lengthy case processing times and extensive backlog, GAO (2012a) made three main recommendations: collaborate with the military Reserve component to obtain medical records, work together with SSA to collect and share medical records, and establish a comprehensive plan of VA’s initiatives to improve processing timelines with clear goals. The prevalent finding in the GAO report was that the VA continued to use a paper folder-based system, however there were indications of collaboration with DOD to digitalize medical records. The VA generally agreed with all of GAO’s recommendations. In a span of ten years, it appears VA’s tone has changed, and evidently, has been more receptive to suggestions in process modification.

The VA has committed to completing initial disability compensation claims within 125 days by 2015, however, it remains unclear if the Agency will be able to meet this aspirational goal (GAO, 2013). The VA’s Office of Inspector General (2009) reported that the Agency does
not provide a complete assessment of rating accuracy and failed to fully implement plans to ensure consistent disability ratings. Furthermore, former VA officials contend that the Agency have systematically manipulated internal quality reviews of veterans’ claims (Flatten, 2013a). It is understandable that large federal programs have the potential for inefficiency and to not sufficiently serve the public, but such programs require systematic and valuable plans with clear goals. If resources are lacking, especially from the Congress appropriating funds, this should be amplified to the public. However, the VA saw consecutive increases in appropriations.

Moving forward, the VA’s steps to improve appear to be manageable and specific, however the prevailing question asks if the Agency has the capability to manage and continually modernize the program. Compared to the VA, recommended improvements in the SSA disability programs extend deeper into complex aspects of their processes.

G. **SSA Recommendations and Prescriptions for Improvement and Moving Forward**

To improve the overall disability decision process, two crucial issues are of great concern to SSA: timeliness and accuracy of disability determinations (IOM, 2007a). IOM (2007a) acknowledged that the conception of disability has changed significantly and recognized that SSA’s definition of disability is out of step with contemporary understandings of disability, which is expressed as the interaction of impairments with one’s socioeconomic environment. In order to continually improve the Listings, the committee made the several recommendations and guidance (IOM, 2007a). Affirming the Listings of Impairments as a good screening tool, IOM urged SSA to continue to research its effectiveness and areas requiring changes, such as determining if the Listings actually correlate to work disability.

The committee expressed the desire of a general functional screening tool, rather than the medical model-based Listings organized by anatomical impairment. SSA should remain current
on progresses and enhancements in disability assessment methods and systematically research the quick disability determinations with the Listings. SSA should further develop a quality assurance management system that elevates consistency and reliability of determinations, and utilize program data and develop a feedback process for continued introspection on the outcomes of adjudicator determinations. SSA needs to secure resources to keep up with advances in medicine, rehabilitation, labor markets, and technology, and further conduct systematic literature reviews within those fields. SSA should reestablish a multidisciplinary medical advisory committee to include experts in determination criteria and procedures. SSA should implement procedures to stay current on updated regulations. Acknowledging the reality of inequalities of people with limited access to health care and assistive technology, IOM recommended that SSA should not further take this into account as a consideration within the Listings. SSA should greater assess claims functionally and research Listings equivalence determinations and common conditions with comorbidities that should be integrated in the Listings. SSA should conduct research of both medical and functional limitations as they related to the demands of required job functions in order to be incorporated into the Listings. SSA should implement a research program to support the determination process and experiment with revisions to the Listings. Finally, SSA should coordinate with other disability agencies, such as the VA, to conduct recurring research of the prevalence, distribution, and severity of Listings impairments within the population (IOM, 2007a).

Comparatively, SSA’s recommended improvements are more detailed and intricate than those of the VA. This may reflect the varying degree of progress of the two agencies. The main theme that pervades in program examination is the urging of disability agencies to work in partnership with other agencies.
H. **Conclusion**

SSA and VA disability programs have developed significantly through history into the present day extensive benefit delivery systems. Media plays a highly influential role in shaping the public perceptions of the disability beneficiary, whether a civilian receiving SSD or a veteran receiving VDC.

There exist many critics of SSA disability programs, as well as frequent contentions of fraud, waste, abuse, and undeserving disability recipients. The perception of entitlement tends to be confused with welfare benefit, in other words, a government handout. Many overlook that SSD is a social insurance program that is paid into through income tax deductions. What is at question here is the disability determination process. Meanwhile VA faces criticism of extensive backlogs, timeliness of claims, and an element of not taking care of America’s veterans. The timeliness of VA determinations appears to be a result of sluggish policy implementation, weak planning, and deficiency in anticipating changes.

This chapter has examined the current status of disability determination in SSA and VA, and moreover what the programs have become. Comparatively, SSA appears more advanced in modernization and confronting rising disability applications, despite criticism regarding the validity of determinations. The VA has been slow to adapt to modernization, reflects a historic resistance to change, demonstrates disorganization in implementing policies, all of which are likely detrimental to the welfare of returning veterans scarred by war and in need of benefits.

Other areas where SSA and VA intersect suggest that greater collaboration would benefit the dual citizen veteran population. Similarities in both SSA and VA determination outcomes provide implications of coordinated and cooperative systems that could better serve the veteran population. A practical solution to improving broad disability programs entails utilizing
resources and collaborating with other agencies, in order to prevent duplication of efforts and fully modernize programs across federal agencies. Taken together, aggressive action to improve disability programs will hopefully uphold the dignity of future populations of people with disabilities, including the next era of disabled veterans.
V. CONCLUSION

*It is a lasting promise that we can retire with dignity and peace of mind, that workers who become disabled can support themselves, and that families who suffer the loss of a loved one will not live in poverty.* (President Obama, 2010)

A. Recap

This thesis presents a broad overview and comparative analysis of the history, theories, policies, processes, and outcomes of SSA and VA disability determination. Chapter II explores the history, theories, and evolving policies that have contributed to the modern day broad SSA and VA disability determination systems. The disabled veteran emerged as a special privileged group that were entitled to greater and more generous benefits and programs, as compared to the civilian population. Whereas the disabled veteran benefit was one of the earliest federal provisions in United States history, SSA disability appeared much later and was implemented gradually. The award of disability benefits is dependent on a perception of deservedness, and as a result of decreased or lack of ability to engage in work. However, the VA disability benefit primarily emphasizes deservedness based on military service and the grateful Nation principle. Disability benefits policies center around ameliorating the inability to achieve full citizenship as a result of not participating in the labor force. However, cash benefits do not guarantee full rights to people with disabilities, rather provide income replacement as a result of disability and further do not fully ameliorate other aspects of a disabling condition.

Chapter III details the SSA and VA disability determination and evaluation processes that involve a reliance on medical professionals and medical evidence in the award decision. The determination of disability is a gatekeeping process defined through statutory definitions of disability, to prevent unwarranted awards and to separate those not deserving of benefits.
A key difference, the VA determination does not consider if a veteran is actually engaging in work, but rather estimates an average work capacity loss due to disability. On the other hand, SSA first evaluates work activity, which if earning above established limits, could result in a finding of not disabled, regardless of disability. The key distinction is that SSD beneficiaries are essentially removed from the workforce in order to be eligible for benefits, whereas actual work activity is not a consideration for a VA disability determination. Fundamental to the SSA definition of disability is the inability to engage in work, and the VA definition accentuates military service, and its relationship to disability. Both programs operationalize disability through similar evaluative processes with key steps in successive levels to make a determination outcome. This chapter introduces the crossover of programs, in which a veteran may qualify for benefits in both SSA and VA.

Chapter IV examines the SSA and VA disability determination policy outcomes, and surveys the current state of affairs situated within SSA and VA disability determination process. This chapter explores the status quo and the outcomes these broad disability programs, what they have become, steps taken to improve processes, and agency inclination for change. The media influences the public perceptions of disability recipients, however treats the SSA disability recipient quite differently than the disabled veteran receiving benefits, demonstrated by two prominent media reports. Central to these debates is the conception of who does and does not deserve benefits. On one hand, media portrays SSA as not doing enough to conserve the program benefit, where as media depicts the VA as not awarding benefits timely enough. Likewise, the perception of fraud, waste and abuse in SSA disability is common, however not as prevalent in VA determinations. The timeliness of VA determinations appears to be a result of sluggish policy implementation, weak planning, and deficiency in anticipating changes. SSA has
been proactive, quicker to modernize, and more receptive to change, as compared to the VA. The SSA and VA program convergence suggest that greater agency collaboration would benefit the dual citizen veteran population. Similarities in both SSA and VA determination outcomes provide implications of coordinated and cooperative systems that could better serve the veteran population.

B. **Significance**

This thesis presents a comparative analysis on converging themes in disability determination, however highlights the divergent nature of SSA and VA programs. This topic is very appropriate for discussion, since both SSA and VA have experienced substantial growth of disability beneficiaries. First and foremost, this thesis shows there is a significant relationship between SSA and VA disability determinations.

Employment is fundamental to citizenship, influence, and participation in society, and further contributes to one’s self-worth, purpose, and happiness. Both SSA and VA programs were created to ameliorate the problem of disability, with the underlying intent to replace lost income. SSA developed with much resistance, however, was successful in gradually implementing a modest government retirement program, due to citizens’ financial uncertainty as a result of economic recessions and market instability. This eventually led to the current day expanded and comprehensive SSA disability benefit programs. The resistance to broad federal programs has been a recurrent theme in political debates since the conception of the United States. The proponents of state sovereignty and localized control resisted federalism, as demonstrated in the very gradual implementation of SSA disability, from early grants to states and to the current ample disability cash benefit program. This ardent resistance is also found in the modern-day debate and opposition of federalized healthcare. The critics of SSA disability
and the legitimacy of its process intermingle with anti-federalist sentiments and ideology of long ago.

The implementation of a federal benefits system for disabled veterans did not meet much resistance. Rather, a generous disability benefits program was created to repay military service according to the Grateful Nation. Veterans groups lobbied for expanded provisions, and undoubtedly resistance to veterans programs would be political suicide for legislators. Likewise, opponents to broad social welfare spending specifically exclude veteran cash benefits in their legislative slashing of public program funding.

The key comparison in this thesis centers on the populations served: in VA, the disabled veteran, in SSA, the disabled civilian, however, a veteran could potentially be dually eligible. Perhaps it is not well known that the dually eligible veteran can essentially double-dip in both SSA and VA disability programs. Central to the differences in both programs is found with the population served, that is the veteran identity and status that supersede that of the civilian disabled. Another population that retains generous public benefits and special population status is the blind, who like veterans, employed a strong lobby to secure provisions.

The media has played an instrumental role in affecting the public perception of people with disabilities that receive benefits in either program. Though both programs essentially replace lost income due to disabilities, the public conceptions of these programs and beneficiaries differ significantly. The thesis showed examples of prominent media stories that expressed skepticism about the integrity of SSA disability awards, and on the contrary, expressed that veterans were not being awarded benefits timely enough. With contentions of fraud, waste, abuse, and undeserving disability recipients, the perception of SSA disability entitlement tends to be confused with welfare benefit, in other words, a government handout. Conversely, in the
media, the term “veteran” seems synonymous with “disabled veteran”, just as reference to a Social Security disability beneficiary is met with suspicion. In effect, the veteran identity and status supersedes that of the civilian disabled. It is not prudent, helpful, or constructive to doubt one’s eligibility for any disability cash benefit, however, there should be extensive inquiry into ensuring that beneficiaries are properly awarded benefits according to the statutory definitions of disability.

This research shows that the SSA maintains a very strict statutory standard, whereas the VA is more generous. SSA operates under an “all or nothing” statutory definition of disability, while the VA administers more liberal criteria that favor the veteran. SSA is a true income replacement program, however, the VA only estimates potential earnings loss due to impairment, regardless of actual earnings and work activity. Additionally, the VA administers a partial disability that reaches more people and is more inclusive than that of SSA disability. A main theme of this thesis shows a separation of the disabled veteran and the civilian with a disability, where the previous is a member of a special population that is highest in deserving a benefit because of a nation grateful and beholden of their military service. The veteran identity and status supersede that of the civilian disabled, on account of service for the nation.

Considering that public cash benefits require substantial financing, the public, legislators, leaders, and policy makers, with people with disabilities at the table, all need to determine what our priorities are with public benefits for citizens. Does the public desire a modest safety net for people with disabilities, and a generous provision for disabled veterans? Disability policies require a balanced approach in implementation and practice, and as demonstrated in this thesis, so far the balancing act is lop-sided.
For those that call for more stringent criteria in SSA disability determinations should also consider scrutinizing the VA disability determination process. If the priorities of legislators center on reducing government spending, all benefit programs should be examined objectively to find cost savings. This is especially true for programs that have challenges modernizing, adapting to change, and being proactive in program improvement. In the current environment of government deficits, fiscal austerity, and cost savings initiatives, these policy processes reveal the convergence of both SSA and VA disability programs, and suggest the need for revaluation of disability criteria and also streamlined and cooperative disability determination systems.

C. Limitations

The limitations to this thesis show that little has been done in the inquiry of this topic. The literature separates these programs, and inadequate research has been done on the interaction of their policies. The scope of this thesis constrains further inquiry into other important areas of research. Disability benefits policies tend to contradict with disability rights laws. On one hand, broad income maintenance policies may further entrench people with disabilities into poverty and discourage work, while other anti-discrimination policies encourage equal participation in the labor force.

Since this research was about people, the identity and experiences of the person with a disability and the disabled veteran require further exploration. Additionally, the concept of accuracy and validity, and how these relate to program integrity, are not clear in the literature. This thesis raises other important questions, such as, how can SSA and VA create a uniform, consistent, objective and effective disability evaluation system that considers the variety of impairments, unpredictable work environments, unique individual limitations of functioning and the socially imposed adversities of the disability experience? And finally, how can existing
research lead to improvements in SSA and VA programs by streamlining or coordinating the disability determination, in the broader context to ameliorate the quality of life and promote equal rights for beneficiaries?

D. **Future Directions**

The policy intersection presented in this thesis requires further exploration. The starting point for this thesis was SSA’s original inquiry: does research offer guidance on a disability determination process for wounded warriors? This thesis informs the question, however, does not resolve the issue. Likewise, other scholars indicate the need for greater research on the interaction of disability with social policy and programs.

Future research should address the original questions introduced in this thesis. Would a VA disability rating significantly predict a favorable SSA disability determination? In other words, would the VA determination be an effective predictive modeling or screening tool to make a quick SSA disability determination? Does a VA favorable disability determination result in a SSA favorable disability determination? And could these results be used to somehow streamline the SSA side of disability determination, also known as a quick disability determination, where the agency would not need to review all evidence, and essentially adopt the VA determination, despite the disability evaluation criteria being different.

The VA has conducted extensive medical research into war injuries, but further examination of the qualitative experience of the disabled veteran is needed. Additionally, the topic of disability benefits determination requires academic inquiry through a collaborate effort in the fields of disability studies, sociology, public administration, public health, rehabilitation and vocational sciences, economics, and law. Post-traumatic stress disorder in military veterans in the context of disability determination remains a very relevant research topic requiring
exploration. Future research requires innovative longitudinal studies analyzing live data to explore the defects in both programs and to identify required further research. Beyond counting and categorizing disability, public policy research requires investigation of the impacts and outcomes of policy implementation and fine-tuning laws accordingly. The convergence in SSA and VA disability programs and the characteristics of dual eligibility are important areas that need addressed moving forward. And finally, these similar disability benefit systems, policies, and procedures provide implications and a need for streamlined, interagency, and cooperative determination processes.

E. **Conclusion**

As President Obama stated, our nation does owe veterans our gratitude for their service, and we must ensure they are provided the benefits they have earned. Likewise, we owe our citizens with disabilities the social security and self-sufficiency to prevent poverty. Underlying both guarantees to citizens and veterans expresses the need to ensure benefits are provided timely, correctly, and in accordance with law.

The convergence of the two largest disability programs that provide cash benefits to millions of American citizens should be of interest to policymakers for insight on program cost-savings, integrity, and improvement strategies. Innovative action is necessary to enhance SSA and VA disability programs while aiming to uphold the rights and dignity of future populations of people with disabilities, including the next era of disabled veterans.
CITED LITERATURE


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