

A History of the Disability Listings

by

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Other Information:

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Summary:

In order to facilitate the processing of applications for disability benefits, the Social Security Administration has created a list of diseases and conditions which are felt to be incompatible with substantial gainful activity (gainful employment). Persons who are not engaged in substantial gainful activity, and whose conditions meet the requirements of one or more of the listed conditions, are considered disabled. Called the *listings*, the criteria have proved so useful that they have been retained, revised periodically, and kept in continuous for almost fifty years.

The first brief disability listings were part of the Civilian War Benefits Program, under which the Social Security Board adjudicated about 1,000 disability claims between March 1943 and May 1945. In the years leading up to the passage of the first disability legislation in 1954, methods for processing disability applications, including the use of listings, were discussed extensively. After the passage of the first disability legislation in 1954, a Medical Advisory Committee of fifteen persons, appointed by the Commissioner of Social Security, created an extensive list of diseases and conditions which were felt to be incompatible with gainful employment. Although these were initially considered only *guides* to the evaluation of disability, their adoption and use as almost the sole criteria for granting disability benefits, gave them the status today's disability listings have after final publication in the *Federal Register*. They soon came to be called the *listings*. By 1967, the listings had been revised extensively, making them less dependent on diagnosis and more dependent on function.

During the years leading up to the passage of the *Freedom of Information Act*, the Social Security Administration resisted calls for the publication of the listings. In 1968, after passage of the *Act*, the listings were first published in the *Federal Register*. Since then, primarily in response to changing disease patterns and changing technology, additional revisions have been published periodically, making hundreds of minor changes and generally making the listings less dependent on diagnoses and more dependent on function. Despite these improvements, the listings have always been less-than-perfect determinants of disability. Further research remains to be done, particularly to demonstrate that the listings are accurate criteria for the determination of disability as defined by the Social Security Act.

Abbreviations:

CFR	Code of Federal Regulations
FEV ₁	one-second forced expiratory volume
MVV	maximum voluntary ventilation

INTRODUCTION

With the passage of the Social Security Amendments of 1954 (Public Law 83-761, signed on September 1, 1954), the Social Security Administration was faced with the task of efficiently processing a large number of applications for disability benefits. In order to facilitate the process, the Social Security Administration created a list of diseases and conditions which were felt to be incompatible with substantial gainful activity (gainful employment). Persons who were not engaged in substantial gainful activity, and whose conditions met the requirements of one or more of the listed conditions, were considered disabled. Called the *listings*, the criteria proved so useful that they were retained and revised periodically, and have been kept in continuous use ever since. They are now part of the *Code of Federal Regulations* as 20 *CFR* Part 404, Subpart P, Appendix 1.

Since 1955, the listings have been a factor in millions of disability decisions. By studying their origins and development, we can better understand how disability decisions have been made since 1955, how the listings affect today's decisions, and why much work still needs to be done on the listings.

HISTORY PRIOR TO 1954

Federal programs for the provision of benefits to disabled persons were discussed for at least 20 years before the first legislation was passed in 1954. During the debate on the Social Security Act, a disability benefit was proposed but defeated (Solomon 1986, p. 7). Soon after the Social Security Act was passed in 1935 (Public Law 74-271, signed on August 14, 1935), the Roosevelt Administration's Committee on Economic Security recommended that the issue be studied (Committee On Economic Security 1935) and this was done (Falk 1938; Murray 1938). In 1938, the Advisory Council on Social Security recognized the desirability of providing benefits to persons who become totally and permanently disabled (Advisory Council on Social Security 1938) and between 1939 and 1941 at least four articles concerning disability benefits were published in the Social Security Bulletin by Elizabeth Otey (1939), I.S. Falk and Barkev S. Sanders (1941) Arthur J. Altmeyer (1941) and Ruth Stocking (1941). The Social Security Board¹ also expressed an interest in a program offering protection for the disabled worker (Stocking 1941).

From March 1943 to May 1945, the Social Security Board adjudicated about 1,000 disability claims for the Civilian War Benefits Program (DeWitt 1997). This program, established by President Roosevelt's executive order, provided disability, survivor's and medical-care benefits to civilian casualties of World War II and their survivors. Under the program, an applicant was assumed to be permanently disabled if he or she had any of the following:

1. the loss of both feet, or the permanent loss of the use of both feet,

¹ From 1935 until 1946, the Social Security Administration was known as the Social Security Board (DeWitt 1977. p. 75).

2. the loss of both hands, or the permanent loss of the use of both hands,
3. the loss of one hand and one foot, or the permanent loss of the use of one hand and one foot,
4. the permanent loss of vision, or
5. any disability which required the individual to be permanently bedridden.

Psychoses were considered to be totally disabling during and for three months after hospitalization. These were, perhaps, the first disability listings used by the Social Security Administration. Lesser injuries were evaluated using a partial disability rating schedule.

In its Ninth Annual Report (1944), the Social Security Board argued strongly for the creation of a disability program (Social Security Board, 1945). Similar recommendations by the Board and other groups followed (CWM 1974).

During the late 40's, the Bureau of Old-Age and Survivors Insurance appointed a *Disability Work Team* which began to look for ways of processing the large number of disability applications which would be received in the event that disability legislation was finally passed (SSA 1962, p. 8). A "preliminary" analysis, produced in February 1949, described methods which the authors believed could be used (SSA 1949). They proposed a 15-step process, including the collection of information by field offices, the making of decisions by an "area, regional or district medical unit," and final action primarily by field offices.

The authors envisioned classifying applicants into eight groups according to the severity of their disabilities. Most severely affected were persons in Group I. These were persons who were completely limited in activity, were confined to a home, hospital or other institution, and were "in need of attendance." Persons in Groups II to VII were progressively less severely affected, with the notable exception of Group VI. These were "persons whose activities are unimpaired or only partly reduced but who, because of disfiguring and repulsive scars or deformities, absence of a body function, presence of some naturally or artificially acquired body abnormality, have very little or no earning opportunity." Least severely affected were persons in Group VIII, who were persons with no medically demonstrable evidence of limitation in usual work activity. The determination of disability was to be made on the basis of the group into which the applicant was classified.

Although cases illustrative of each group were included (e.g. for Group I, the case of a 45-year old man left bed and wheelchair-bound by a stroke), the authors did not suggest how classifications were to be made. A memo from Commissioner Altmeyer to Surgeon General L. A. Scheele, dated June 13, 1949, indicated that disease-specific recommendations were being drafted by a Dr. Carl E. Rice (Altmeyer 1949). However, these were incomplete and bore little resemblance to later versions of the listings.

With the passage of a disability insurance program (H.R. 6000) by the House of Representatives in October 1949, the prospect of having to process disability applications became more immediate, even though the proposed program later was deleted from the bill by the House-Senate Conference Committee (Solomon 1986, p. 25-30).

By 1951 the eight functional groups had been revised to some extent and their number reduced to six (Bureau of Public Assistance 1951). From four to 17 very brief disease-specific examples were provided for each group. For Group I (persons completely or markedly limited in activity by a permanent impairment), the following examples were given:

1. Advanced pulmonary tuberculosis, showing toxemia, with continuing activity for one year or more.
2. Congestive heart failure, with history of heart disease and poor response to therapy.
3. Aneurysm of aorta or branches with disabling symptoms.
4. Myocardial infarction with distress on slight exertion continuing after acute episode; walking on level surface brings on distress.
5. Bronchiectasis with dyspnea at rest or very slight exertion and toxemia.
6. Colitis, ulcerative, severe.
7. Nephritis, chronic, severe, with prostration.
8. Tuberculosis, kidneys, bilateral with toxemia.
9. Any cardiac lesion classified under Class IV (American Heart Association Grouping) where findings support such a classification.
10. Leukemia, progressive, no remissions or short remissions.
11. Cerebral accident, with severe residuals.
12. Multiple sclerosis, late stage.
13. Pellagra, with mental changes, exhaustion, invalidity.
14. Inoperable malignancies in late stage.
15. Osteomyelitis of pelvis or vertebra of chronic and intractable nature, and marked systemic involvement.
16. Tuberculosis of hip, spine or larynx, long continued activity, with toxemia.

17. Asthma, bronchial – long continued, severe, attacks frequent, dyspnea on slight exertion, marked cachexia.

The list was “not exhaustive.” Since Group I was the only group for which total disability was considered automatic, these were the only examples that are directly comparable to today’s listings. Some diseases were included in the list that are now uncommon, or now more easily treated, including advanced tuberculosis, bronchiectasis, advanced pellagra and chronic osteomyelitis. A few conditions that now are considered automatically disabling (in the absence of substantial gainful activity) were not mentioned in Group I. These include the loss of both hands, complete paraplegia, complete loss of vision, total deafness, Down syndrome and severe epilepsy not responsive to treatment (SSA 2003). Many terms were undefined, such as “advanced,” “chronic,” “severe,” “late stage,” and “inoperable.”

In 1952 a disability benefit program was passed by Congress (Public Law 82-590, signed July 18, 1952) with the provision that, without special congressional action, the program would expire on June 30, 1953, one day before the first application for benefits could be accepted (Solomon 1986, p. 33).² Although the legislation was ineffective by design, Congress could have put the program into effect very quickly, making the need for methods of efficiently processing disability applications, including the need for listings, even more important.

THE CREATION OF THE 1955 LISTINGS

The Social Security Amendments of 1954 were signed into law on September 1, 1954, creating what was called a “disability freeze” benefit (Public Law 83-761).³ The freeze prevented a person’s retirement benefits from being reduced by a period of disability. Applications for disability freeze benefits were to be processed by the Bureau of Old-Age and Survivors Insurance, a part of the Social Security Administration.

By February 1955 Social Security Commissioner Charles Schottland had appointed a Medical Advisory Committee of 15 persons for the purposes of advising the Social Security Administration on medical matters related to the evaluation of applications for disability benefits and helping to interface between the Social Security Administration and various medical and professional groups with regard to policy and operations (SSA 1962). The Bureau of Old-Age and Survivors Insurance specifically requested that the Medical Advisory Committee help in “the development of acceptable guides for the use of State agencies to assure equality in adjudication” of disability applications and to “permit relatively quick decisions in 85 to 90 percent of all cases.”⁴ (Hess 1955) The Committee consisted of twelve physicians, a professor of psychology, a consultant in social work and a representative of an

2 This was, to some extent, a gesture in honor of Robert L. “Mulie” Doughton, the retiring Chairman of the House Committee on Ways and Means (Berkowitz 1987).

3 Cash benefits for disabled persons would not become a part of the law until 1956.

4 At times the early listings were referred to as *guides*, indicating that they initially were not intended to be absolute rules. Later usage changed this practice.

organization for the blind. They were,

J. Duffy Hancock, M.D., Chairman, professor of surgery, Louisville, KY
Alexander P. Aitken, M.D. professor of orthopedic surgery, Boston, MA
Pearl Bierman, consultant in medical social work, Chicago, IL
Donald Covalt, M.D., professor of Physical Medicine, New York, NY
Charles Farrell, M.D., Pawtucket, RI
J. S. Felton, M.D., professor of Medicine, Oklahoma City, OK
Herman Hilleboe, M.D., public health physician, Albany, NY
Lemuel C. McGee, M.D., occupational physician, Wilmington, DL
Kenneth E. McIntyre, M.D., occupational physician and administrator, Detroit, MI
William A. Pettit, M.D., ophthalmologist, Los Angeles, CA
Leo Price, M.D., occupational physician, New York, NY
William H. Scoins, M.D., life insurance physician, Fort Wayne, IN
Carroll Shartle, Ph.D. professor of psychology, Columbus, OH
Byron Smith, executive secretary, Society for the Blind, Minneapolis, MN
David Wade, M.D., medical consultant in rehabilitation, Austin, TX

The first meeting of the Committee was held on February 9 and 10, 1955. Except for the early replacement of Dr. Aitken by Dr. Philip D. Bonnett, a hospital administrator from Boston, Massachusetts, the Medical Advisory Committee remained unchanged through November 1960 (BOASI 1955, Appendix C; Medical Advisory Committee 1960, III). This group collectively was the author of the first disability listings. In creating the listings, the Committee sought the advice of agencies administering a variety of Federal and State disability programs, the suggestions of specialists in many fields of medicine, and the suggestions of staff physicians of the U.S. Public Health Service (BOASI 1955, §321 (A)).

In December 1954, the Bureau of Old-Age and Survivors Insurance completed a “discussion draft” of a manual that would aid the states in making disability determinations (Division of Disability Operations 1956). After further revision, in May 1955, the Bureau completed and sent to the state agencies the first *Disability Freeze State Manual*, dated May 16, 1955 (BOASI 1955, Transmittal Letter). The Manual set forth “the broad requirements and objectives of the disability freeze program.” It also presented “related standards, policies and procedures, applicable on a nation-wide basis, which are necessary to assure equality of treatment of all individuals who wish to establish a period of disability.” (BOASI 1955, “Explanation of the Manual”) It was divided into seven parts:

1. a general description of the disability freeze, the responsibilities of various federal and state agencies, vocational rehabilitation policies, and policies regarding the disclosure of information,
2. a description of procedures for processing disability freeze cases,
3. the disability evaluation standards, including general policies, definitions, the listing of impairments and representative case decisions,

4. policies regarding fiscal management,
5. a section reserved for additional instructions, called *Freeze Letters*, to be sent later,
6. forms and
7. appendices.

In 1955 the law specified that the impairment(s) of a person who qualified for benefits would be of “long continued and indefinite duration,” or blindness, or would be expected to result in death (Public Law 83-761, Section 216(i)(1)(A)). “Long continued and indefinite duration” meant that the condition had lasted for at least six months and that no approximate future date of improvement or recovery could be determined with reasonable certainty (BOASI 1955, §316 (A)). As stated in the *Disability Freeze State Manual*,

The degree of severity indicated is such that most individuals so impaired will be unable to engage in substantial gainful activity. In the absence of facts to the contrary, an individual so impaired and not engaged in substantial gainful activity will be found to be under a disability (BOASI 1955, §321 (A)).

The State Manual was sent to federal and state disability evaluation staff with the advice that

In deciding whether the applicant’s condition is of listed severity, there will be considerable scope for the exercise of sound professional judgment. ... The listings should not be used mechanically; the State agency should exercise judgment and arrive at decisions only after considering all the facts in the case (BOASI 1955, §321 (C)).

Combinations of less severe impairments could also result in the inability to engage in substantial gainful activity. However,

Minor impairments which have no appreciable effect upon the activities of the individual will not ordinarily be combined. ... In deciding whether a combination of impairments is as severe as any of the listed impairments, there will be considerable scope for the exercise of sound professional judgment (BOASI 1955, §323).

For those whose impairments or combination of impairments did not meet the required severity of a listing, age, education and experience were to be considered.

THE 1955 LISTINGS

The listings were organized according to body system. The major impairment categories were almost identical to those which had been used in the Veterans

Administration's 1945 Schedule for Rating Disabilities (Veterans Administration 1945). They were (1) Musculoskeletal System, (2) Special Sense Organs, (3) Respiratory System, (4) Cardiovascular System, (5) Digestive System, (6) Genito-Urinary System, (7) Hemic and Lymphatic System, (8) Skin, (9) Endocrine System, and (10) Nervous system, including (a) Neurology and (b) Psychiatry.

There were no separate sections for multiple body systems, neoplastic diseases or the immune system, as we have today (SSA 2003). A general introduction was provided at the beginning of each section.

The listings reflected the prevalent diseases and treatment limitations of 1955, when infectious diseases, particularly tuberculosis, chronic osteomyelitis, syphilis and leprosy were much more common and more difficult to treat. Rheumatic heart disease was much more common and heart failure more difficult to treat. Peptic ulcers sometimes required prolonged hospitalization. At that time, some malignancies, which now can be cured or brought into remission, were considered incurable and generally untreatable.

The 1955 listings (BOASI 1955, Part III) were relatively brief and depended heavily on diagnoses. They were much less concerned with function than are today's listings (SSA 2003). The body system sections were numbered from 380 to 393 and the individual listings were given "code numbers," ranging from 00R, 000, 001, 002 to X33, X34, XR2 and XR3.⁵ There were no listings specifically for children. Examination of the 1955 listings also reveals the following:

Musculoskeletal System: There was no mention of an "inability to ambulate effectively," or the "inability to perform fine and gross movements," as there is in the current listings (SSA 2003). There were listings for "arthritis, neurogenic (e.g. Charcot, Syphilitic) – if involving more than one major joint," gout, active tuberculosis, chronic osteomyelitis involving more than one major joint, osteitis-deformans (Paget's disease), and the loss of use of one hand and one foot or the loss of one hand or foot and one eye. We no longer have these. There was no mention of computerized tomography, magnetic resonance imaging, electrodiagnostic techniques, orthotic devices, prosthetic devices or hand-held assistive devices. All bone malignancies were considered disabling for two years.

Special Sense Organs: Although blindness was defined in Section 216 (i)(1)(B) of the Social Security Act as "central visual acuity of 5/200 or less in the better eye with the use of a correcting lens" or a concentric contraction of the visual field to 5 degrees or less, the 1955 listings considered an acuity in the better eye of 20/200 or less or a bilateral field contraction to 15 degrees or less to be disabling. Frequent attacks of glaucoma "of considerable duration" with progressive loss of vision were considered disabling with an acuity of 20/70 or less or a contraction of fields to 30 degrees or less. We no longer have a listing for glaucoma.

5 The codes were to be used for "punch card recording," designed to permit statistical analysis. The first digit represented the major group, the second digit the number of the listing within the group and the third was R for a major listing or a digit for a sublisting. Because the numbering scheme was inadequate for all the listings, some were given various other combinations of digits and letters. The result was a very peculiar sequence of codes.

Complete loss of hearing was considered disabling if “not improvable by hearing aid.” Pure-tone audiometry was not mentioned, as it is now. Visual efficiency, visual acuity efficiency and speech discrimination were not mentioned, as they are now.

Respiratory System: The 1955 listings stated that “The prescribed treatment of active pulmonary tuberculosis in itself renders the individual unable to work for an indefinite period.” There were specific listings for tuberculous laryngitis and any stage of active pulmonary tuberculosis. Any conditions, such as emphysema, resulting in less than 50% normal vital capacity were considered disabling. There were listings for laryngeal stenosis requiring the continuous use of a tracheostomy tube, severe bronchiectasis, severe pneumoconiosis and “Pleurisy, purulent (empyema) severe.” All respiratory malignancies were considered disabling. There was no mention of cystic fibrosis, cor pulmonale, sleep-related breathing disorders, one-second forced expiratory volumes, or diffusing capacity, as there is now.

Cardiovascular System: The 1955 listings stated that individuals falling in American Heart Association Class IV at any age, and all over the age of 45 falling in Class III would, in general, be found disabled. The “beginning of established congestive heart failure” was considered disabling, as were rheumatic and hypertensive heart disease with definite cardiac enlargement. There were listings for thromboangiitis obliterans (Buerger’s disease), severe Raynaud’s disease, varicose veins (involving veins above and below the knee with the long saphenous vein averaging over 2 cm. in diameter and other evidence of severity) and unilateral phlebitis. Myocardial infarction was to be evaluated “after recovery from the acute attack” on the basis of symptoms and findings. There was no mention of exercise tests, the Doppler measurement of arterial pressures, coronary angiography, congenital heart disease or heart transplantation, as there is now.

Digestive System: The 1955 listings considered the loss of whole or part of the tongue with marked impairment of mastication and inability to communicate by speech to be disabling. Cirrhosis of the liver was considered disabling if accompanied by “ascites requiring frequent tapping” or “frequent recurring hemorrhage from esophageal varices” with “marked loss of weight and impairment of general body vigor.” Severe persistent jaundice, with a steadily increasing icterus index was considered disabling regardless of the cause. Cholecystitis and cholelithiasis were disabling if severe, chronic and accompanied by frequent episodes of pain and gastrointestinal symptoms or jaundice and unrelieved by surgery. Ulcerative colitis was disabling if severe and accompanied by “marked malnutrition, anemia, and general debility” or “serious complications.” Persistent intestinal fistulas “with copious, frequent fecal discharge” were disabling. Complete loss of rectal sphincter control and rectal stricture requiring colostomy were disabling. Postoperative ventral hernias which could not be treated by additional surgery or prostheses were disabling. Hiatal hernia was disabling “with severe symptoms.” Any malignancy of the digestive tract was disabling. There was no mention of endoscopy, shunt operations for esophageal varices, the measurement of serum bilirubin, albumin, prothrombin time or liver function tests (enzymes). There were also no tables of weight by which to judge malnutrition, nor any mention of liver transplantation, as there is now.

Genito-Urinary System: The 1955 listings considered the loss of one kidney with moderate-to-severe disease in the other to be disabling. Severe chronic nephritis with various features (edema, cardiac complications, etc.) was disabling. Active tuberculosis of the kidney (s) with constitutional symptoms or with bladder ulcerations and tuberculosis of the prostate or seminal vesicles accompanied by bladder dysfunction were disabling. Advanced nephrolithiasis, hydronephrosis and polycystic disease were disabling. Persistent bladder fistulas with suprapubic cystotomy were considered disabling, as were multiple urethroperineal fistulas. All malignancies of the genito-urinary system were considered disabling. There was no mention of dialysis or kidney transplantation, as there is now.

Hemic and Lymphatic System: The 1955 listings considered polycythemia vera, agranulocytosis, any leukemia, Hodgkin's disease and lymphosarcoma to be rapidly fatal disabling diseases, if accompanied by moderate-to-severe constitutional symptoms. Pernicious anemia was considered disabling if acute, "rapidly progressive, with few or brief remissions, and resistant to therapy." Miliary tuberculosis and active cervical tuberculous adenitis were considered disabling. There was no mention of chronic anemia, sickle cell disease, coagulation defects, multiple myeloma, bone marrow transplantation or stem cell transplantation, as there is now.

Skin: The 1955 listings considered leprosy disabling for at least one year after discharge from the hospital. "Grave and protractive" types of exfoliative dermatitis and some pemphigus were considered disabling. There was no mention of ichthyosis, chronic infections of the skin, hidradenitis suppurativa, or genetic sensitivity disorders, as there is now. Burns were evaluated on the basis of their musculoskeletal impairment. Advanced malignancies of the skin with constitutional symptoms or evidence of metastasis were considered disabling. It was noted that "Disfiguring scars and repugnant skin disease will not ordinarily be found in themselves to be totally disabling."

Endocrine System: The 1955 listings considered severe alterations of thyroid, parathyroid, pituitary, adrenal, pancreatic function disabling if untreatable and accompanied by specified signs and symptoms. The signs and symptoms were characteristic of severe disease states which we rarely encounter today. Diabetes with uncontrollable hyperglycemia, gangrene or retinopathy was considered disabling. All malignancies of endocrine organs were considered disabling.

Nervous System, Neurology: The 1955 listings considered paralysis agitans (Parkinson's disease) disabling if accompanied by a well developed tremor, rigidity and festination (involuntary rapid gait). The criteria for seizures were essentially those which we use today. Any bulbar palsy was considered disabling. Multiple sclerosis was considered disabling if two or more "members" were affected, and eyes were considered "members." Amyotrophic lateral sclerosis, syringo-myelia and poliomyelitis were to be evaluated on the basis of unspecified symptoms and signs. Myasthenia gravis and "allied rare progressive dystrophies" were all considered disabling. Cerebrovascular accidents (strokes) were to be evaluated on the basis of residual impairment, at least six months after onset. The required degree of impairment was not specified. All brain and spinal cord malignancies were considered disabling.

Nervous System, Psychiatry: The 1955 mental listings were less than one-tenth the length of the current mental listings. The listings expressed the Freudian view that neuroses were “the individual’s external expression of inter-personal conflicts” and that obsessive compulsive reactions were “an inadequate attempt to allay deep-seated anxiety.” Acute brain disorders (associated with infections, drugs, trauma, etc.) were to be evaluated on the basis of permanent psychotic residuals. Chronic brain disorders were evaluated primarily according to the “severity of symptoms in relation to occupation,” with *severity* not further defined. Mental deficiency was to be evaluated “according to severe industrial inadaptability.” The listings stated that “The intelligence quotient alone is not sufficient for a diagnosis of mental deficiency, nor is a low I.Q. incompatible with employment.” Psychotic disorders were divided into (1) affective reactions, (2) schizophrenic reactions and (3) paranoid reactions. These were disabling if the individual required institutional care or if he or she was “definitely deteriorated” or had other severe symptoms. Psychosomatic disorders were to be evaluated according to the severity of accompanying physical symptoms and anxiety. Anxiety reactions were disabling if “persistently and continuously severe and deep-seated; with persistent insomnia, neuro-muscular asthenia, emaciation, gastro-intestinal atony; with instability, inability to concentrate; depression.” Conversion reactions (hysteria) were considered disabling if accompanied by physical symptoms which essentially met the requirements of other listings. Phobic and obsessive compulsive reactions were disabling if accompanied by extreme symptoms. Personality disorders were explicitly *not* considered disabling.

The 1955 listings included eight “representative cases” to demonstrate (a) meeting a listing, (b) equaling a listing, (c) problems with the determination of onset (four cases), (d) the lack of need for current medical evidence in a case with an onset years previously and no improvement expected, and (e) the concept that reports from chiropractors were to be considered “lay evidence.”

THE 1967 LISTINGS

A revision of the listings, dated July 4, 1967, has been published in the Social Security Administration’s *Program Operations Manual System* (DI 34101.015). This was probably the last revision of the listings prior to their becoming available to the public, in August 1968, after the signing of the *Freedom of Information Act*.

During the 1955 to 1967 interval, the listings probably underwent more change than at any other time since. Art Hess, the first Director of the Bureau of Disability Insurance, described this change when he said, “They weren’t the meat-axe kind of things that they were in the beginning.” (Hess 1993) The 1955 listings were very disease-oriented and general in their descriptions. The 1967 listings were much more like those which we have today, with fewer disease specifications and more highly-specific criteria involving signs, symptoms and laboratory findings.

Between 1955 and 1967, the total length of the listings increased by about one-half. The greatest expansions were in the special senses and respiratory systems. A brief new

section was added for malignant neoplastic diseases. The code numbers were discontinued and the listings were numbered from 380 to 393.04. The numbers to the left of the decimal point were section numbers in the *State Manual*. Although the 1955 listings contained no illustrations, tables or diagrams, the 1967 listings included an illustration of visual fields, two tables for central visual efficiency as a function of central visual acuity (for distance and near vision), a table for percent remaining visual efficiency as a function of central visual efficiency and visual field efficiency, three tables for exertional capacity (disabled, light, medium, or heavy)⁶ as a function of maximum voluntary ventilation (MVV) and one-second forced expiratory volume (FEV₁), a table for disability as a function of height and vital capacity, and a table for disability as a function of arterial carbon dioxide (pCO₂) and oxygen saturation (pO₂).

In general, the listings became less disease-specific and more dependent on specific observations. For example, the 1955 listing 00R for arthritis was divided into six disease categories: (a) infectious, rheumatoid or atrophic arthritis, (b) neurogenic arthritis, (c) gout, (d) hypertrophic arthritis, (e) spondylitis and (f) active tuberculous arthritis, with one-sentence descriptions in most cases. The comparable 1967 listings 381.02 – 381.04 used only three categories (1) rheumatoid arthritis, (2) neurogenic arthritis, and (3) hypertrophic, gouty, infectious or traumatic arthritis but the descriptions were much more complex. For example, the 1955 listing 003 for hypertrophic arthritis, spoke of “only advanced stages ... 10-15 years duration ... multiple parts involved.” The 1967 listing 381.04 required a “history of pain and stiffness in involved joints, x-ray evidence of joint space narrowing and osteophytosis or extosis, or bony destruction with erosions and cysts or subluxation or ankylosis of involved joints” and one of seven additional, specific criteria involving range of motion.

Comparable changes can be seen in the other listings. For example, 1955 listing 26R was, “Emphysema – Which has reached the stage of less than 50% vital capacity; otherwise consider according to etiology and degree of dyspnea.” The comparable 1967 listing for chronic obstructive airway disease (382.02) was three pages in length and included three tables.

By 1967, the section entitled *Nervous System* had been divided into sections entitled *Neurology* and *Psychiatry*. The listings for mental disorders had become less dependent on symptoms and more dependent on function. For example, the 1955 listing PR0 for psychotic affective disorders was,

Affective reactions (manic depressive psychosis) – Including manic type, depressive type, other types. (a) requiring institutional care or (b) definitely deteriorated or (c) with increased or decreased psychomotor or (d) a combination of these findings, with any one of the following: – hypomania, simple retardation, superficiality, circumstantiality.

The most comparable 1967 listing 392.03 for psychotic mood disorders was,

6 There was no table indicating a capacity for sedentary work. Vocational factors were considered only in cases of light and medium work.

Mood disorders (involitional psychotic reaction, manic-depressive reaction, psychotic depressive reaction, psychomotor disturbance, hallucinations (rare), or delusions, resulting in marked constriction of daily activities and interests, deterioration in personal habits, and seriously impaired ability to relate to other people.

A caution that non-psychotic mood disorders “generally respond well to psychiatric treatment, although relapses may occur” was included. Compared to today’s listings, the mental disease listings of the 1955 and 1967 were both quite brief.

SECRECY AND CONTROVERSY

Prior to the passage of the Freedom of Information Act in 1966 (Public Law 89-487, signed July 4, 1966), government secrecy was much more the norm than it is today. In the late 50’s and early 60’s, the Social Security Administration felt that the listings should be kept secret because public knowledge would lead to abuse of the disability program. The official statement of the Medical Advisory Committee said,

The Committee believes that the medical guides, standing alone, are inadequate to communicate fully the bases for decisions and should, therefore, be restricted to official uses. Accordingly, they are not available to medical sources of clinical evidence or to the general public. (Medical Advisory Committee 1960, p. 13)

It was felt that making the guides public would lead to the creation of medical records which were biased by the requirements of the guides in order to favor of disability applicants. As stated more bluntly by Art Hess, the evaluation guides were felt to be “the key to the bank.” (Hess, 1993) When, on June 20, 1957, the Bureau of Old-Age and Survivors Insurance published a “new Subpart P” of Title 20, Part 404 of the *Code of Federal Regulations*, entitled “Rights and Benefits Based on Disability,” (*Federal Register*. 22 (119): 4362-3) only nine very brief examples of conditions “which would ordinarily be considered as preventing substantial gainful activity” were given. The entire set of examples constituted only about one-seventh of one page of the *Federal Register*. In revisions of Subpart P, published in the *Federal Register* on August 24, 1960 (*Federal Register*. 25 (165): 8100-1) and on January 3, 1968, (*Federal Register*. 33 (1): 15-18) the examples were essentially unchanged.⁷

In 1958, a more extensive discussion of the criteria for finding disability was published in the form of a booklet, but almost all of the specific details of the listings were omitted (BOASI 1958). The body of the booklet consisted of 23 small pages, of which only nine pages referred to specific body systems and medical conditions. It had the same nine sections as the *Freeze Manual*, except that there was no section for skin impairments. The

⁷ By 1968, however, more detailed descriptions of the medical evidence needed to establish the presence and severity of various impairments had been added.

sections on the brain and nervous system, including mental impairments, (2½ pages) and on cardiovascular diseases (2 pages) were the longest, and the section on hemic and lymphatic diseases was the shortest (8 lines). Only two conditions were said to automatically lead to a finding of disability: the loss of two limbs and blindness. There were many statements that certain conditions “may be disabling.” For example, where the *Freeze Manual* described six subcategories of arthritis, with specific x-ray findings, joint ranges of motion and other details, the booklet merely stated that arthritis could result in disability if it interfered severely with standing, walking or manipulation or if there were severe constitutional complications. Without being more precise, the booklet mentioned multiple conditions which could be disabling. For example it stated that “Persons with a mental age of 7 or less and those requiring institutionalization *may* be disabled.” [italics added] The discussion of most other impairments was much less specific and less detailed in the booklet than it was in the *Freeze Manual*.

During the 1960s there was increasing concern that most of the details of government operations, including disability determinations, should be open to the public. Attorneys felt that the listings should be available to them and to their claimants (CWM 1960, p. 16). The Subcommittee on the Administration of the Social Security Laws of the House Committee on Ways and Means agreed, pointing out that the listings were often treated as binding on adjudicators and that “basic considerations of fairness” called for their publication (CWM 1960, p. 17, 18, 33-35).

THE FIRST PUBLISHED LISTINGS – AUGUST 20, 1968⁸

With the signing of The Freedom of Information Act (Public Law 89-487) on July 4, 1966 the public gained greater access to government records, including the disability listings. The first listings were published in the *Federal Register* on August 20, 1968, as an Appendix to Subpart P of 20 CFR 404 (*Federal Register*. 33 (162): 11749-63). A new numbering system was adopted, which was similar to that which we have today. Many minor changes involving refinements in wording, rearranging, minor additions and minor deletions were made. Respiratory Tables II and III, relating to light, medium and heavy work were deleted. Persons whose maximum voluntary ventilation (MVV) and one-second forced expiratory volume (FEV₁) were less than or equal to the values specified in the remaining table were still considered disabled (under listing 3.02). Vocational analysis was required for those whose MVV and FEV₁ were not. A discussion of exercise testing and numerous details relating to electrocardiograms were added to the cardiovascular section. Four weight-for-height tables were added for the evaluation of malnutrition. The previous listing 385.07 for cholecystitis and cholelithiasis was deleted. A multiple body systems section (10) was added to include Hansen’s disease (leprosy), polyarteritis nodosa, disseminated lupus erythematosus, scleroderma, miliary tuberculosis and tuberculosis

⁸ Prior to 1997, revisions of the listings became effective on the dates they were published in the *Federal Register*, with the exception of the general revision which was published on December 6, 1985 and which became effective on January 6, 1986. Since 1997, most revisions have become effective on a specified date after the date of publication. In the text, two dates are noted only when the publication date differed from the effective date.

adenitis. Substantial detail was added to the section on mental impairments. The statement that “personality disorders by themselves are not disabling” was deleted with the admission that, “some cases may have been denied in the past despite the presence of findings indicative of a severe impairment, because the ‘label’ of personality disorder was attached.” However, the Social Security Administration still advised that personality disorders would rarely be disabling (POMS DI 34105.001(L)). Dozens of specific diagnoses were added to neoplastic section 13, which had previously mentioned very few.

The 1968 version of listing 12.04 was worded in such a way that a person who was addicted to alcohol or drugs, had marked behavioral impairments and evidence of irreversible organ damage could be considered disabled. On July 18, 1975 the listing was revised to state clearly that addiction to alcohol or drugs would not, by itself, be the basis for finding that a person was (or was not) under a disability (*Federal Register*. 40 (139): 30262-3).

FIRST TITLE XVI LISTINGS – JULY 29, 1975

On October 30, 1972, Public Law 92-603 was signed into law, creating the Supplemental Security Income (SSI) Program (Solomon 1986: 70-71). On July 29, 1975 the first listings for Supplemental Security Income (Title XVI) were published as an appendix to Subpart I of 20 CFR 416 (*Federal Register*. 40 (146) 31778-91). Although the Title XVI listings were published separately from the Title II listings, they were identical.

THE FIRST LISTINGS FOR CHILDREN (PART B) – MARCH 16, 1977

With the enactment of the Supplemental Security Income program, disability benefits could be awarded to children. Operating instructions were issued which were effective until the first listings specifically for children were published on March 16, 1977 (*Federal Register*. 42 (51) 14705-13). The major categories of impairment were the same as for the adult listings except for the addition of a category for growth impairment and the deletion of the category for skin impairments. They were numbered from 100 to 113. Although the general style of the childhood listings was similar to the style for the adult listings, the details were specialized for the evaluation of children. A child whose condition met the requirements of an adult listing was still considered disabled. The childhood listings included ones for scoliosis, kyphosis, lordosis, retrolental fibroplasias, cystic fibrosis, cyanotic congenital heart disease, sickle cell disease, pituitary dwarfism, adrenogenital syndrome, Turner’s syndrome, catastrophic congenital abnormalities, meningomyelocele, neuroblastoma and retinoblastoma. With the inclusion of a listing for renal transplantation, organ transplantation was mentioned for the first time. The adult listings were referred to as *Part A* listings and the childhood listings as *Part B* listings.

GENERAL REVISION OF PART A – MARCH 27, 1979

A general revision of the Part A (adult) listings went into effect on March 27, 1979 (*Federal Register*. 44 (60) 18170-91). There were many small changes, refining previous criteria and adding new ones. Some of the more notable changes were the expansions of some of the introductory sections, a revision making active tuberculosis no longer automatically disabling, increased attention to exercise testing, the deletion of the serum blood urea nitrogen and non-protein nitrogen levels and the addition of serum creatinine level as a measure of kidney disease, the addition of a listing (6.02A) for chronic dialysis, the addition of a listing (10.10) for obesity, and increases in the threshold IQ levels in the mental retardation listings (12.05 B and C) by ten points.

The Social Security Administration received only one comment about the new listing for obesity. The person commenting suggested that “the criteria for obesity would have little effect because the required findings are sufficient to establish disability without obesity.” Little did anyone know that the listing would become so controversial that it could not be revised substantially along with the revision of the other listings in 1986. The obesity listing lasted for 20 years, until it was deleted, on October 25, 1999, because it was felt that too many persons whose condition met the requirements of the listing were still able to work.

REVISION FOR OPERATION COMMON SENSE – AUGUST 20, 1980

On August 20, 1980, in response to Operation Common Sense (Executive Order 12044), the Title II and Title XVI listings were combined into one Appendix 1 to Subpart P of 20 CFR 404 (*Federal Register*. 45 (163) 55566-634). Although changes were made to the regulations, the individual listings were not changed.

MENTAL DISORDERS REVISION – AUGUST 28, 1985

On June 7, 1983, the Secretary of the Department of Health and Human Services announced a “top-to-bottom” review of all disability program policies and procedures. Public Law 98-460, Section 5 required a revision of the rules used for the evaluation of mental impairments. On August 28, 1985 the revisions became effective for the Part A (adult) mental listings (*Federal Register*. 50 (167) 35038-70). Medical terms were updated to conform to the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition*, published by the American Psychiatric Association in 1980 (APA 1980). The number of major categories was increased from four to eight. A new procedure for the evaluation of mental impairments was introduced in 20 CFR 404.1520 and 20 CFR 416.920, along with a new Psychiatric Review Technique Form. The revised listings were given an expiration date, three years from the date of publication. This was the first that any listings were given an expiration date.

GENERAL REVISION – JANUARY 6, 1986

Many small changes were made in a revision published December 6, 1985 (*Federal*

Register. 50 (235) 50068-107), effective on January 6, 1986. Eleven of 13 body systems in Part A were affected. Only minor changes were made to Part B. Expiration dates were established for all listings except the Part A mental listings, for which an expiration date had already been established. Extensive changes were made to the respiratory listings. These included the addition of an extensive discussion of the purchase and use of arterial blood gasses obtained during exercise. (The test has been criticized as being impractical and rarely has been used.) A new listing (7.17) was added for bone marrow transplantation for the treatment of hematologic disease. The evaluation of serum anticonvulsant levels became a requirement in the evaluation of seizures.

LIMITED REVISIONS SINCE 1986:

Since 1986, revisions of the listings have involved selected body systems only. Because each revision included many small changes, it is not possible to discuss each one here. Only the most significant changes are discussed below. The dates shown in bold print are the dates each revision became effective. In the *Federal Register* citation, the date of publication is given only if it was different from the effective date.

December 12, 1990 – Congenital Abnormalities and Mental Impairments in Children: A new listing (110.06) was added for Down syndrome in children and listing 110.07 was created for the evaluation of congenital abnormalities (*Federal Register*. 55 (239): 51204-8). The listings for mental disorders in children were revised (*Federal Register*. 55 (239): 51208-36). In the process, the childhood mental disorders section expanded to about ten times its previous size. Terminology was updated to conform to the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders, Third Edition – Revised* (APA 1987). For children, age groups were more precisely defined. Seven new listings were added: 112.06 for anxiety disorders, 112.07 for somatoform, eating and tic disorders, 112.08 for personality disorders, 112.09 for psychoactive substance dependence disorders, 112.10 for autistic and other pervasive developmental disorders, 112.11 for attention deficit hyperactivity disorder and 112.12 for developmental and emotional disorders of newborn and younger infants. Except for listing 112.05 (mental retardation) and 112.12 (developmental and emotional disorders of newborn and younger infants), the listings had a two-paragraph form. The first paragraph (the paragraph A criteria) described the characteristics necessary to substantiate the existence of a listed mental disorder, while the second paragraph (the paragraph B criteria) described the applicable restrictions and functional limitations.

July 2, 1993 – Immune System Disorders: New categories of impairment were established for immune system disorders in adults and children (*Federal Register*. 58 (126) 36008-59). These included new listings for human immunodeficiency virus infections. The listings for polyarteritis nodosa, systemic lupus erythematosus, scleroderma and similar disorders were moved from category 10 and incorporated in the new category 14, and new listings were created for children as parts of category 114. Obesity listing 10.10 was moved from category 10 (Multiple Body Systems) to category 9 (Endocrine System and Obesity) to become listing 9.09. The weight requirements were unchanged. Former listing 10.02 for

Hansen's disease (leprosy) was deleted. Over 7,000 letters with comments on the proposed rules had been received.

October 7, 1993 – Respiratory Impairments: The respiratory listings for adults and children were revised to place less emphasis on diagnoses and more emphasis on function (*Federal Register*. 58 (193): 52346-67). Many small additions and changes were made. The introductory sections were greatly expanded. Guidance was added for the evaluation of sleep-related breathing disorders in adults (3.00H). The validity of imaging techniques other than x-ray were recognized. Maximum voluntary ventilation (MVV) measurements were deleted because they were considered to be effort-dependent, infrequently used in clinical practice and poorly standardized among laboratories. A listing was added for cystic fibrosis in adults.

For children, a new listing 103.02 was created for chronic pulmonary insufficiency. Guidance on the use of pulse oximetry as a substitute for arterial blood gas testing in children under age 12 was added. The cystic fibrosis listing was expanded.

February 10, 1994 – Cardiovascular Impairments: The cardiovascular listings for adults and children were revised to place less emphasis on diagnoses and more emphasis on function (*Federal Register*. 59 (28): 6468-6504). Many small changes were made. A new listing (4.09) was added providing for a finding of disability following a heart transplant. References to the New York Heart Association functional classes were replaced with descriptions of functional impairments. Listings were added for hyperlipidemia (104.14) and Kawasaki syndrome (104.15) in children.

April 14, 1997 – Childhood Listings: the listings for children were revised in response to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193) and "Interim final rules" were published (*Federal Register*. 62 (28): 6408-32, February 11, 1997). Prior to the enactment of Public Law 104-193, childhood disability was defined in terms of impairments of "comparable severity" to impairments that would make an adult disabled. Public Law 104-193 defined disability in children in terms of "marked and severe functional limitations" which could be expected to result in death or last for a continuous period of not less than 12 months. Under the law, more serious impairments were required for a finding of disability. The greatest changes mandated by Public Law 104-193 came in the form of the cessation of the use of individualized functional assessments (IFAs), a technique which was felt to have created too many allowances, and the reevaluation of all children who had been found disabled on the basis of IFAs. All references to "maladaptive behaviors" were removed from the childhood mental listings. Other changes to the listings were generally minor. The final rules were published on September, 11, 2000 (*Federal Register*. 65 (176): 54747-90) and became effective on January 2, 2001.

October 25, 1999 – Deletion of the Obesity Listing: The obesity listing (9.09) was deleted because its criteria "did not represent a degree of functional limitation that would prevent an individual from engaging in any gainful activity" and because "the listing was difficult to administer, subject to misinterpretation, and required findings of disability in some cases

in which the claimants were clearly not ‘disabled’ as defined in the Act.” (*Federal Register*. 64 (163): 46122-9, August 24, 1999) Changes were made to other listings to emphasize the fact that obesity can be a medically determinable impairment. The deletion of listing 9.09 would probably affect more future claimants than any other single listing change. It was also one of the most controversial, as evidenced by the receipt of comments from over 500 individuals and organizations.

June 19, 2000 – Down Syndrome in Adults: A new listing (10.06) was created for Down syndrome in adults (*Federal Register*. 65 (98): 31800-2, May 19, 2000).

September 20, 2000 – Traumatic Brain Injuries and Mental Disorders: Recognizing that the course and extent of improvement after traumatic brain injury can be highly unpredictable, the guidelines for evaluating traumatic brain injury in adults and children were revised (*Federal Register*. 65 (162): 50746-83, August 21, 2000). Under the new rules, evidence of a profound neurological impairment could permit a finding of disability within three months after injury. If this was not possible, a decision was not to be made until at least three months after injury. If a finding of disability was still not possible, a decision was not to be made until at least six months after injury. Additional small changes were made to the listings for adult and child mental disorders.

January 2, 2001 – Childhood Listings: The final revision of the listings for children in response to Public Law 104-193 were published (*Federal Register*. 65 (176): 54747-90, September 11, 2000). Only minor changes were made since the “interim final rules” had been published on February 11, 1997 (*Federal Register* 62 (68): 6408-32).

February 19, 2002 – Musculoskeletal Listings: In the first major revision of the musculoskeletal listings since January 6, 1986, the listings were revised to place less emphasis on diagnosis and more emphasis on function (*Federal Register*. 66 (223): 58010-46, November 19, 2001). Additional guidance was added concerning the evaluation of the ability to manipulate and ambulate. Some impairments which had previously been considered disabling, such as double amputations, were now to be evaluated based on the ability to ambulate effectively. Listings were added for spinal arachnoiditis, spinal stenosis and burns. The listings for rheumatoid arthritis were moved to the immune systems section (14 and 114) and expanded.

May 24, 2002 – Multiple Technical Revisions: Multiple “technical revisions” were made (*Federal Register*. 67 (79): 20018-28, April 24, 2002). These included changes defining imaging techniques in addition to x-ray, such as computerized tomography, magnetic resonance imaging and nuclear scans, as appropriate medical documentation. Listings 2.05 for homonymous hemianopsia and 11.15 for tabes dorsalis were deleted. Listings were created for lung transplants (3.11 and 103.05), liver transplants (5.09 and 105.09), T-cell lymphoblastic lymphoma (7.11 and 107.11) and for anaplastic (undifferentiated) carcinoma of the thyroid (13.08A). A documentation requirement for an electroencephalogram in seizures was deleted except in cases of non-convulsive epilepsy in children.

August 28, 2003 – Amyotrophic Lateral Sclerosis: Listing 11.10 was changed to allow a

finding of disability on the basis of an established diagnosis of amyotrophic lateral sclerosis. The previous requirement of significant bulbar signs or disorganization of motor function was deleted. (*Federal Register*. 68 (167): 51689-93).

July 9, 2004 – Skin Impairments: The listings for skin impairments were revised (*Federal Register*. 69 (111): 32260-72, June 9, 2004). The introductory text was expanded, medical terminology was updated, criteria were clarified and more skin disorders were included in each category. Listings were added for genetic photosensitivity disorders and burns that do not meet the requirements of listing 1.08.

December 15, 2004 – Malignant Neoplastic Diseases: The listings for malignant neoplastic diseases in adults and children were revised (*Federal Register*. 69 (219): 67018-38, November 15, 2004). Most of the listings for children were given numbers which corresponded to similar categories for adults (e.g. 113.09 for thyroid malignancies in children and 13.09 for thyroid malignancies in adults). All listings for malignant neoplastic diseases were placed in sections 13 and 113, with the exception of certain ones associated with human immunodeficiency virus (HIV) infection. Listings that were met by satisfying the criteria of other listings (reference listings) were deleted. Numerous minor changes were made.

DISCUSSION

The listing-equivalents of the Civilian War Benefits Program were so brief that it is doubtful that there was any serious attempt to create a comprehensive list of conditions which were incompatible with gainful employment. Since the number of cases adjudicated under the Civilian War Benefits Program was very small (at least by today's standards), a comprehensive set of listings was probably not needed.

The 1955 listings were much more comprehensive, and since 1955 the length of the listings has grown with each revision. Over the years, thousands of additional details have been added, deleted and changed in an effort to increase the sensitivity and specificity of the listings.

Perhaps the largest change in the listings took place between 1955 and 1967. Both experience adjudicating cases and economic factors probably contributed to this change. Although we have no way of measuring the "experience" which came from adjudicating cases, the economic change in the disability program between 1955 and 1967 is clear. Prior to the introduction of pre-retirement cash benefits in 1956, the program was only a promise that retirement benefits would not be reduced by a period of disability. Since about half of disabled persons would not live more than four years (Smith and Lilienfeld 1971), many of those who were granted disability benefits would die without receiving any disability payments. The addition of pre-retirement cash benefits to the program in 1956 changed the economic impact of the disability program a great deal, as reflected in the 437 percent increase in the cost of the program between 1957 and 1958 (SSA 2002, Table 4.A6) with only a 57 percent increase in the number of beneficiaries (SSA 2002, Table 5.D4) at the same time. The relative importance of experience and economics in the large 1955-to-1967 change in the

listings is unknown.

The 1955 listings were heavily dependent on diagnosis and placed relatively little emphasis on function. With many of the revisions, diagnostic requirements have been replaced with requirements based on signs, symptoms, laboratory findings. In addition, functional requirements, such as the inability to ambulate effectively, have replaced diagnostic requirements, such as the loss of two feet. In response to the decrease in the incidence of certain diseases, most notably infectious diseases (active tuberculosis, leprosy, late-stage syphilis, and others), the diseases mentioned in the listings have changed. The listings have also changed in response to changes in diagnostic technology, such as the increase in the use of coronary angiography and exercise testing, and the introduction of computerized axial tomography and magnetic resonance imaging.

In the late 50's, about 93 percent of persons who were found to be disabled at the time of their initial application had conditions which met or equaled the requirements of the listings. By 1983 the portion had decreased to 82 percent, and by 2000 it had decreased to 58 percent (Social Security Advisory Board 2003, p. 7). Although the requirements of a few of the 1955 listings appear to be relatively easy to meet by today's standards (e.g. hypertension with the beginning of established congestive heart failure, rectal stricture requiring a colostomy and most malignancies of any stage), this does not appear to be the case for most of the 1955 listings. Therefore other factors must have been responsible for the large decrease in the portion of initial allowances which were based on listings. A decrease in the importance ascribed to the listings and an increase in the importance ascribed to vocational factors is the most likely explanation.

Despite the large increase in the total volume of the listings and the hundreds of technical changes, some problems remain. These include,

(1) *findings of disability in persons who could work:* It has long been observed that some persons who meet the requirements of one or more listings are gainfully employed. Examples are some legally blind persons, some profoundly deaf persons and some wheelchair-bound spinal paraplegics. All would still be considered disabled if not working. Workplace accommodations for disabled persons have also made successful employment possible for some who were not previously able to work. These observations suggest that perhaps we should not have listings, but depend entirely upon functional and vocational analysis. Although the role of the listings in adjudicating applications for disability benefits continues to be questioned (Social Security Advisory Board 2003, p. 16-18), with the current large backlog of disability applications awaiting decisions, any effort to eliminate them entirely in favor of purely functional analysis seems impractical.

(2) *a relative lack of scientific supporting data:* The listings have been criticized because, instead of having a completely objective scientific basis, they represent the consensus of committees and could be politically-influenced. For example, a group convened by the National Research Council concluded recently that much work needed to be done to develop the scientific basis for the evaluation of visual impairments (National Research Council 2002). In response to suggestions by the Social Security Advisory Board (Social

Security Advisory Board 1998) and the Institute of Medicine (Mathiowetz and Wunderlich 2000), Heinemann et al. have developed criteria for evaluating the validity of the listings (Heinemann 2001a and 2001b). Validation of all the listings is an enormous task and, to date, no validation studies have been completed.

(3) *delays in revising the listings*: All the current listings have published expiration dates ranging from three to eight years, depending on the body system. Although the Social Security Administration is required to review the listings to keep up with changes in medical diagnosis and care, in the last 18 years (since January 6, 1986) this has been accomplished for only the musculoskeletal, respiratory, cardiovascular, skin, mental, neoplastic and immune system listings. Proposed revisions for several other listings have been published in the *Federal Register* but have not been completed despite the best efforts of some individuals.

(4) *a lack of clinical data for decision making*: Some listings are criticized because specified data is often not available when a decision has to be made. The cardiovascular listings, for example, refer to exercise tests, Doppler echocardiographic studies, coronary arteriography, left ventriculography and radionucleotide perfusion studies. All are expensive. Since the state disability determination services have very limited funds for clinical testing, and since some of tests are invasive, many claimants do not get the clinical tests specified in the listings. This places some applicants for disability benefits at a disadvantage.

(5) *a lack of listings for combinations of diseases*: Most of the listings consider *single* diseases only. The listings as a whole cannot account for the many combinations of diseases and impairments which are commonly encountered in disability applicants. Examples are the combinations of coronary artery disease and chronic obstructive pulmonary disease and combinations of physical and mental impairments. Unfortunately, the creation of listings for hundreds or thousands of combinations of impairments is impractical.

Despite their shortcomings, for almost fifty years, the listings have helped to provide uniformity in the determination of disability and to speed millions of disability decisions. Although the listings have been very helpful in the administration of the disability program, much work needs to be done. Their revision and improvement will require a great deal of additional funding and years of work yet to come. With the problems which currently face the Social Security Administration, additional funding for listings research is sorely needed so that the work can be done.

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