

GYÖRGY KÖNCZEI¹

THE STORY OF THE POOR SOLDIER
(Or: people with disabilities in Hungarian society)

1 An introduction: the past

”Once upon a time, there lived a soldier; he had been serving in the king's army for long years, but when the war came to an end, there he was, unfit for service, due to his many injuries.

The king summoned him and said:

– You may go, wherever you like, I do not need you anymore.

– But how am I to earn my living from now on? – asked the soldier.

– That is up to you to manage – answered the king. – I do not need you and soldiers are entitled to a pay earned by service only.

As there was nothing else for him to do, the poor soldier started boldly for the World.”

(Grimm 1989, page 213)

The story has a great deal in common with the situation of people who have become disabled. There are several differences, however. Firstly, there is the fact that the soldier has the honor that the *king himself* deals with him: it is him, who drives the soldier away. Second, though the miraculous power of his blue gleaming lamp, the soldier not only takes revenge on the king for his derogation, but even marries his daughter eventually! That is in the tale. Nowadays however, people living in our country have no miracles to rely upon.

Institutions doing various deeds of philanthropy for people in dire straits – the poor, the orphans, the injured – began to proliferate in Hungary at the time when Christianity was adopted. (King István imposed mercifulness and good deeds on his son, Count Imre as royal virtues.) In the middle ages this line of

¹ The author – the head of the Secretariat for the European Social Charter: *Ministry of Social and Family Affairs*, and a Professor at Budapest University of Economics – is indebted to Mr. James Farral for his stylistic recommendations.

work was practised mostly in churches, chapels, and their affiliated hospitals. The nation-wide organisation of the institutions for charity took place at a considerably later time – in the eighteenth century, under the reign of Marie-Theresa. Immediately before this time and several years before the institution of the first orphanage, a privateer, Éva Bello, had endowed a foundation for the establishment of a home for the aged.

In the decades to follow, this foundation was supported by others (Mór Pausch, Zsuzsanna Szalay, Mihály Wieser) as well, with very substantial financial contributions.

The first institute intended explicitly for disabled people was founded by the lawyer András Cházár, after he had spent three years in Vienna, where he got the opportunity to visit the local institute for deaf-mutes. This shocking experience urged him to request an audience with King Ferenc, who supported his idea. At home, after a feverish campaign of fund-raising and organisation (a fund of 40 000 forints had been collected) the institution was inaugurated in 1902, in Vác. It provided home and training for its fostered and a bit later it could run its own bindery.

The period when the institutions for charity of this type became widespread in Hungary thus the nineteenth century. Let us quote the programme of the "Society of Women for Charity in Pest" as an example:

"The Society, having understood at the time of its foundation that only the salvation, proper in its extent and administration, can offer true and therefore most charitable help; the mere alms giving however, being an uncertain, expensive and mostly harmful method, not being compliant with the principles of Christianity, as it would supply for fraudulence, invoke idleness and eradicate diligence. As the following five articles: Catering, Clothing, Lodging, Medical Help in Illness and Meticulous Care provide for the inevitable needs of human life; those who are in need of one or other of the above are the poor and deprived and are the only beings deserving the attention of the institution for the poor. As far as the above principles are concerned the poor, deserving true salvation, may be classified into six, main categories:

a) Those who need only momentary help.

b) Those who... would be able and willing to earn their living if they could get a job suiting their circumstances [conditions], that they can not obtain, as – being old, disabled, or handicapped in other ways – nobody wants to employ them.

c) People who would be able to earn a part of their living, but not at the level necessary to satisfy their needs, due to their helplessness though senility or other circumstances.

d) Those who are old and ill to an extent that precludes earning their own living.

e) The poor and ill in need.

f) The abandoned, unsupported orphans”

(Béry, 1929, pages 17-34)

Soon after its foundation the Society established a nursing home in a rented building, but as the capacity of the facilities was far from sufficient, the accommodation of orphans, disabled or aged individuals was arranged for with reliable families, for an appropriate fee.

The committee, providing institutional care for the invalids of war, war-widows and orphans, was organised after the First World War, under the chairmanship of the prime minister, István Tisza. The activity of the H. R. Office on Disability is worth mentioning as well. Its primary function was to co-ordinate the functioning of the nation-wide network of schools for invalids (e.g. in Vác, Kolozsvár, Debrecen, Kassa, and in Budapest — on the left bank of the Danube in Pozsonyi utca, and on the right bank of the river in Szegényház utca) and nursing homes for invalids (e.g. in Besztercebánya, Alsótátrafüred, Pozsony, Kassa, Kolozsvár and in Budapest, at the Császár-fürdő, Bajza utca, and Fehérvári út). The H. R. Home for Invalids of War was in the Timót utca, running a brush- and a basket-making manufacture. One time soldiers not able to find reemployment could take part in professional rehabilitation at the department of disability of the "H. R. Vass József Institute for War-Orphans" in Székesfehérvár. The clients of this institute could train as a carpenter, shoemaker, house-painter or tailor, and could obtain a single grant in equipment at the end of the curriculum. Courses in apiary and hive-making were organised as well, with the help of the Society of Apiarists at Kolozsvár.

Considering the circumstances, the H. R. Artificial Limb Works was an important link in the rehabilitation of war-invalids. Apart from prostheses, it produced all sorts of wheelchairs, spectacles, spine-supports and crutches as well.

Amongst the many societies of war-invalids, relevant political and economic movements, the state granted official accreditation and regular, monthly allowance only to the HADRÖA (National Alliance of War-Invalids, Widows and Orphans).

Exactly one hundred years after the foundation of the institution of András Cházár, the National Home of Disabled Children and its affiliated society was established in Budapest on Mexikói út. The Home, founded to alleviate the hardships of poor children and orphans, ran a school for professional training, providing six years' education in the production of fancy-leather goods, in book-binding, tailorship, shoe-making and in textile weaving.

The modalities of insurance, including the loss of working capability, began to develop in the 1870s. The General Sick-Relief Fund for Workers and for the Disabled (Általános Munkásbetegsegélyző és Rokkantspénztár) had been founded in this period. An Act of Parliament on this subject was passed in 1891 for the first time, and decentralised the various cash-desks – regional, corporate, professional, building-contractor and private. All these – 97 workers' insurance associations and 80 corporate sick-relief funds – were incorporated into the National Workers' Insurance Fund (Országos Munkásbiztosító Pénztár [OMP]) in 1907. The OMP was later succeeded by the National Institute for Workers' Insurance (Országos Munkásbiztosító Intézet). The activity of the Association of Workers for Disability and Pension (Munkások Rokkant- és Nyugdíjgyesülete) – founded in 1897 – was essentially different: despite its name, it had recruited its members from middle class as well.

"The institute provides support for the aged, and for those with premature disability – on the grounds of insurance policy, but without the objective of obtaining business yields – who can afford to lay up savings in the form of a certain, weekly due insurance fee at most...; Foreign experience shows... that this type of independent institution for insurance does not become obsolete with the introduction of social security but – as a form of supplementary insurance – it is further utilised. The formal objective of the Association is to provide pension and allowances for disabled members and for their orphans and widows"

– writes Sándor Szerdahelyi on the subject (Béri 1929, pp. 350-351). From its foundation, at the beginning of December 1928, the Association paid over 20

million pengő (pound) – a considerable sum in real terms as well – in allowances for disabled individuals. Its first two branches were established in 1893, with almost 700 paying members. After a period rapid florid development, the number of paying members approached 200 thousand by 1917, with 550 branches all over the country.

At the beginning, an allowance for disability (if the accident that caused disability had happened unintentionally) was available to members who were duly paying their fees for a year and to all members who had deposited the fee for a full ten years. There were three classes. The premium was 10 krajcár (“penny”) a week in the first, 12 in the second and 15 in the third class. The weekly allowances in these classes were 4.20, 4.90 and 8.50 Hungarian forints respectively. The pensions of the members, the support of their widows and orphans, the subsidies for the case of death and the payment of severance were managed in a slightly different way. The development of the money market after the First World War however, undermined the financial stability of the association. The modifications of the statutes in 1927, increasing the number of insurance classes to eight and raising the fees, were of no avail; there were no new members anymore, the old ones dropped out gradually. At this time, the allowances for disability were calculated according to the entrant's age and the duration of membership. The fees in the eight classes ranged from 30 fillér (penny) to 3 pengő a week. A membership of 40 years' duration entitled its owner to a pension of 30 pengő a month in the first class, and to 300 pengő a month in the eighth. The amount of the allowances allotted in the remaining classes was calculated between these extremes.

The institution of obligatory insurance against disability, old age, widowhood and orphanhood appeared in the Hungarian legislation in 1928. It was declared at this time that the obligatory insurance should not be based on charity and the insurance of workers should be extended to develop a social security system. The so called *limit of allowance* was set by Article XL of 1928 at 500 pengő a month, that is, at 6000 pengő a year. This sum was later increased to 800 pengő a month and 9600 pengő a year in 1942. Policy holders were stratified into two categories. In the first category, insurance was obligatory only if the total sum of monthly (annual) allowances stayed under the limit of the allowance, as in the case of clerks, shop assistants and foremen. In the

other category, however, insurance was compulsory, regardless of the magnitude of the allowances.

The expenses of the insurance policy were covered by contributions from each insured individual, the amount of which was calculated by advanced methods of insurance mathematics. It may seem strange nowadays, but the prevalent key for these calculations was determined by a decree of the Department of Interior. The employer had the right to charge the employees with half of the expenses by deducting it from their salary, but was obliged to pay the rest himself. Under the limit of allowance, the amount of the contribution was not to exceed 4.3%; over the limit of allowance it was 3.5% of the daily rate of the salary. According to the Act on Disability, disabled employees over the limit of allowance were considered as invalids, if they had become unable to earn one-third of the income of healthy employees with similar qualification and experience. Under the limit of allowance this rule concerned individuals who could not earn half the average income of healthy employees (See in detail: Országos, 1943).

In addition to the medical rehabilitation of soldiers with severe war injuries, victims of Heine-Medin paralysis and patients with neoplastic disease, the rehabilitation of patients with pulmonary and psychiatric disease is also important. Prominent Hungarian pioneers in this field were Alajos Orthmayer and Imre Vas (who has the credit – along with numerous other deeds – for the foundation of a social establishment in Újpest).

Additional data. As long as the activity of Churches and denominations was not restricted (they enjoyed significantly greater freedom before the late 1990s), they could engage in the rehabilitation of convicts and individuals released from prison. The missionary activity pursued in the prisons could become a part of the rehabilitation by interpretation, as well as being in accordance with tradition and usual practice. Along with the monks, clergymen and theologians, a great variety of associations were engaged in this field for the patronage and support of prisoners. As they had visited the prisoners regularly, managed their affairs, taught penmanship to illiterates and strove to support their families, they often succeeded in developing a fruitful relationship with individuals convicted or released from prison, in spite of the occasionally delivered moral sermons. Released individuals got assistance with their lodging, and gifts of

food and clothing. And primarily by efforts to find an employment for them, their adaptation to the free, civil life was supported as well.

2 Who are they and how are they living?

The political and economical metamorphosis of the country, hardly effecting the lower layers of the society yet, has produced radically new conditions in the labour market. The perspectives of people living with disability have been - clouded significantly and this trend is far from being concluded. Neither conclusions, nor exact analyses can be drawn for the time being, but the prognosis for a vast proportion of the society, highly significant in numbers, seems definitive. Considering people with disabilities and handicapped together, the already difficult, unstable and financially desperate situation of about 1-1.5 million people will inexorably deteriorate further.

A significant portion of disability and permanent health damage in Hungary is attributable to the explosive changes in the society and in the economy, that have recreated the whole world of the people along with their and mentality. They were driven to accept not only new technologies (industrialisation), a new environment for their homes, jobs (urbanisation), but to comply with new values, knowledge and standards; a very unpleasant and rough process indeed. The old network of self-organised communities was not replaced by a new, strong and orderly communal system. These fundamental changes took the people unprepared, both in the physical and in the mental sense. The effects of this process caused extensive damage to the health and the tolerance of people, especially amongst the handicapped. Disabled people themselves attach great importance to the staggering blows of misfortune in human life. A study, based on interviews has shown (Novák 1983, p. 22), that most of people with disabilities (50.8%) attributed their invalidity to health loss resulting from their jobs, one-fifth of them to partially congenital diseases and a lesser portion of them to shocking events in their lives (6.2%), to conflicts in the family (5.2%), or to other factors such as existential problems, blunders in health care, etc. (16.2%). Most of these people had worked overtime and spent their weekends working, before they became disabled. One-third of them have taken up some kind of job again since they were declared invalid.

The changes in criteria for disability along with the above problems, have resulted in an approximately 1500% increase in the issue of disability pensions! (See detailed statistics in Könczei, 1987). In recent years, and in the years to come, the population of disabled people in Hungary is expected to grow by at least 60 000 a year. The trend is on the rise all over the world but surveying several statistics, I could not find one country with an increase of this magnitude.

Many of people with disabilities are living on the margins of society already. A preponderant portion of them is insufficiently educated, poor (deprived) and often handicapped not only due to disability but to other causes as well. *Two-thirds of people with disabilities do not own real estate and their household lacks items of the more expensive category. Only about one-fourth of the households is able to deposit money (usually a small amount) for future needs!* (These data are almost ten years old but, considering the prevailing tendencies in Hungary, the situation is more likely to have changed for the worse than for the better: compare Novák 1983, p. 67.) The hopelessness of their life is enhanced by their exclusion and the prejudice against them occurring at every moment in our country as well. As their income is constantly losing its value, people on disability pension are driven out to the labour market, but most of them return home having experienced just another failure. On the one hand, declaring their invalidity and doling out their pensions, the society acknowledges that most of their working ability was lost working for the community. On the other hand it is precisely the artificially low value of disability pension, that the society uses to exert a permanent and significant pressure to drive them back to the labour-market. The way out of this situation (be it diverse, and intricate, or the "only redeeming solution") is hidden by an impenetrable dusk of uncertainty. *The old questions are therefore to be asked again.*

3 The responsibility of the profession in the narrow sense

The staff, working in the field of rehabilitation numbers several hundred altogether. Taking all the doctors, civil servants, stray researchers, teachers for handicapped children, gymnast-therapists and the predominantly voluntary experts together, the group thus gathered will be rather small. (In English-speaking countries it is called the *rehabilitation family*. This expression is very apt in Hungary as well.) Most of its members are socially sensitive, of developed

conscience, facing the ever mounting multitude of problems in steadily dwindling numbers. Their prime motivation being individual vocation, money is somewhat less important to them. The saying, "Glory uncertain, payment – nil!" holds good for rehabilitation. The profession was also unprepared for the Great Transformation. There is still no comprehensive conception either for putting the situation of the field in proper order, or for the development of social security. We were, and still are, far from the optimism of a central figure in Ervin Sinkó's novel the *Optimists* who, having just marched into his office under the Commune in 1919, produced the ready sentences from his attaché-case. Some are new to the field, some have changed sides or kept themselves busy describing and analysing the problems, some are bound to managing troublesome personal business of individuals from the ministerial office, others have taken up minor ventures in rehabilitation and wasted five or ten of their creative years holding their ground against change, because of distrust of the new, fear of losing power and on everyday skirmishes. Even today, only few believe in the possibility of large-scale enterprises.

3.1 The situation

As has been adequately shown in many analyses, rehabilitation as a whole – together with its regulation – has evolved in Hungary in a random fashion. It does not constitute a system and does not function like clockwork as would be desirable as far as the principles of the normative theory are concerned. The *measures* taken in various *specialities* (medical, social, professional, etc.) to improve the welfare of a given individual are not tailored to his needs but are incidental, and several important phases are often omitted. Amongst the multiple causes of these phenomena are the economic and social scales of values that have been pushed hard from "above" for decades: the only true values are those that are provided by the state, that are central; the so called personal, private, independent, or civil values, however, are worthless. Many individual initiatives were wasted due to this judgement, as it prevented the development of independent and self-governed humanitarian programs in the field of rehabilitation. The central offices of the state, governing the economy, had rigorously tapped the local resources accumulated in the community or in private hands and by applying rigorous restrictions and financial regulations on the modes for accumulation, made the development of such resources virtually impracticable. That is why the present initiatives, overdue now for decades,

have been appearing only recently. The multiplicity of its missions makes the "Motivation" Foundation for the Support of people with disabilities a good example. The aim of this foundation is to help disabled people with their adaptation to society, to enable them to become citizens with even chances again. Following the principles of the movement for "independent life", the foundation wants to teach its fostered to take responsibility for their own lives. Its services consist of counselling on ways of life, on self-support for example, they provide courses in decubitus-prevention and the control of bladder function, counselling in matters of sexuality, law, building, education, support and employment, and also psychological training. The foundation maintains extensive relations with the institutions concerned: with hospitals, nursing homes, local authorities, associations of people with disabilities, churches, companies manufacturing and repairing therapeutic devices, ministries, terminal companies, and others. As for its staffing, there is a social worker, a lawyer, a psychologist, a computer expert and a gymnast-therapist amongst its employees.

As from time immemorial, the education and training of professionals are completely tacking from the field of rehabilitation: *almost the whole staff of rehabilitation is made up by self-educated activists*. Not a penny has been invested from the central budget on training or research into methods. The lack of the radical reform of the system – now long overdue – has resulted in several serious consequences. Rehabilitation has become one of the fields in health care, or manpower-management, that produces the biggest deficit; most of the foreign examples show however that rehabilitation can prove itself at least cost-effective. (In her 1981 analysis of profitability, Maria Major showed the true extent of the financial damage to the economy caused by the lack of rehabilitation of a single worker.)

The first step and logical starting point in the mechanism of rehabilitation in Hungary is the "leszázalékolás" "down rating" on percentages. Though this term expresses the process by a linguistic twist, it is apt, all the same. This inhumane mechanism, which recalls the world of Kaffka's novels, has evolved due to the blissful functioning of the Great Bureau, commissioned to asses the extent of the damage to the individual's working ability. Examples of its operation could be enumerated by the score. "They examined [me] and said: – Trash! Literally so! -" recites a skilled workman from the provinces (Novák 1984, p. 242). The

whole process is defective in its premises already: the intention is to *down-rate* the working ability of the individual, to show the *activities he can not perform*, instead of finding the ones he could pursue! This is the reverse of the problem although, the real task would be to *up-rate* disabled individuals, to strengthen their damaged self-esteem by giving real hope. (Not to mention the fact that the whole process – as far as its essence is concerned – remains concealed from the individuals on their pilgrimage to the Országos Orvosszakértői Intézet. They are often poured into the "production line" denuded, they are occasionally willing to pay their footings – as it is usual in the health care system in our country – just to obtain a top secret phone-number for inquiries about the result.)

The second step is the system of motivation, or interest. The inexcusable inadequacy of the whole mechanism strikes as eyes again here: the individual must be incited artificially for something good, moreover, he is *to be made interested against his own, well-comprehended interest!* No individual can be blamed for this scandal: this system has been functioning for decades in Hungary. It is just about time for it to undergo a thorough overhaul. Just as in previous decades, the key factor today is the institution of disability pension. Its original function would have been to induce the companies, organisations and individuals needy to effect rehabilitation themselves. On the contrary, the disability pension is traditionally failing in this function. Under the influence of the regulations, the companies are actually eager to get rid of their disabled employees and to replace them with able ones. On the other hand, the employees are interested in backing out of the process by obtaining a disability pension for themselves. The provisions of law, created in the last two and a half decades, imposed the rehabilitative employment of workers with impaired working ability but did not supervise the execution of the regulations or even keep a check on it, and did not encourage the process at all. Rehabilitation thus hardly meant *training for a new job* with perspectives, or *adaptation of the job* for the individual, recommended in the literature as the best advanced methods. Most of the time it meant that the underpaid, hard-to-man vacancies with a low prestige, but necessary for the company (lift-boy, paper-bag sticker, night-watchman, overseer of miner's trucks or production lines, doorman, swimming-bath attendant etc.), were filled with inexpensive personnel. These people would have been disadvantaged by the discrimination amongst their employers and colleagues anyway, even without their disability.

However, it is not the *employment in a normal job* as described above but rather the jobs created explicitly for rehabilitated workers that are the most important in Hungary. There were only four companies and co-operatives organized for this purpose in 1980, and more than the half of their employees were rehabilitated people. The number has been multiplied by eight in the last ten years, along with the number of their disabled employees. If Vance Packard, the great expert on American society had known about the financing of these companies, he would have surely mentioned it in *The Waste Makers*. The direct, pecuniary assistance for these institutions was allotted and looted at individual discretion at the Ministry of Finances; the essential factor in the decision was simply the amount needed by the given organisation for its survival. The humanism of this procedure can hardly be doubted, but it was this type of bad, socialist humanism that resulted in subsidies that varied by as much as 650% between eligible enterprises. This victory of mediocrity had a more than unfavourable effect on the support of good ideas, true development and innovation. The practice had not changed at all by 1991, however.

There is only one kind of so-called *protected sphere* for the purposes of rehabilitation, namely the telephone operators' job for blind people. In theory this means that if an individual with impaired vision applies for employment as an operator, that job has to be given to him. This institution resembles the tobacconist shops of the period after the First World War, when the licence for the tobacco shop was issued only to war invalids. There are other kinds of *protected jobs* as well, such as the social workshops and specialised social homes but as with the whole system of professional rehabilitation, their relentless and thorough reformation is more than overdue. To understand this necessity, it is sufficient to recite the internationally accepted definition of protected jobs: A rehabilitative service purposely designed for work-activity, where the environment of the employee is constantly controlled, individual rehabilitative objectives are set and fulfilled, with the aim of helping individual with disabilities to lead a normal life and obtain productive employment. Rehabilitative jobs of this sort – either normal or protected – are non-existent in Hungary.

As far as the number of the individuals of adequate age and impaired working capacity is concerned, we are left to rely upon rough estimations. The number

of invalids exceeds half a million and more than 200 000 of them are in their able years. These are only the invalids, however. Besides them, there are those people who had been assessed by the Committee, but were not down-rated as invalids (their loss of working ability is 66% or less) and those, who did not even try to take advantage of this procedure that is, 600 to 700 thousand people altogether. Only an insignificant minority of them are white-collar (8.8%, 15% and 13% in three separate studies) and a minute fraction of them has finished graduate training (1.8, 3.1 and 4%). The Hungarian studies thus confirm the results of those conducted abroad: the qualified workers in stable circumstances, the employees with good salaries in prestigious jobs are rare guests in the institutions of rehabilitation. Disability is a problem predominantly among people, living on the margins of the society battling their difficulties in a multiply handicapped position. If the working class exists at all, then this population is certainly a significant contribution to its numbers. The situation was the same even in the era when the notion of the *leadership of the working class* was a central element of the ideology. The study conducted by Maria Novák gave a picture of the situation: "their lives are characteristic to the particular ecology of the existence of people with disabilities. Due to their very brief range of mobility, secluded world and poor health, they are living in "social isolation". Their range of activity is predetermined... diminished... most of them are short on adequate and acceptable jobs or even lacking those". (Novák 1983, p.79)

The liquidation of companies and jobs made the difficulties in employment general. Job standard are now set to comply with the quest for performance. The inflation is undermining salaries to an ever-increasing extent. As the appropriate forms of employment have not been developed, the primary victims of this – essentially positive – process are people with disabilities. For them and for rehabilitation as a whole, the *seven lean years* have already begun. However, will it be only seven years or significantly more? This question can not be answered with certainty at the moment. The future developments of the economy and the economic and welfare policy – both contained by social policy – will naturally exert an essential influence on the problem.

Considering the state of the affairs prevailing in Hungary, we are facing not only urgent tasks, but a certain amount of hopelessness as well. In one of the closing stages of my research I could not see *any sign of a network in the community*

to support individuals in need. Or at least, that was my conviction in 1987. Studying the subject further, I had to modify my opinion to some extent.

3.2 Urgent work to be done

But what can be done? The problem is undoubtedly beyond the scope of traditional social science; it is unavoidable though. To reel up the endless, almost inextricably entangled thread of problems in rehabilitation seems nearly impossible at present. Suggestions can be put forward only if the thread is cut here and there, without regard for its connections beyond the sphere of rehabilitation. That is the only way to form a viewpoint at all. This method is of course fraught with the danger of joining the suggestions in a random, accidental fashion, resulting in an agenda with no logical order. Only the lessons drawn from past results can serve as a starting-point for further investigation. New legislation is due, as the system of rehabilitation is badly in need of rehabilitation itself.

1. Physical obstacles to the people with disabilities must be brought down: ramps are necessary at every relevant site, as are suitable lavatories. Services should be made available for disabled people as well. Perhaps Hungary could be turned into a "Mecca of people with disabilities" as well? (The first signs of transition are visible already: on the prompting of deputy member, Mr. Gábor Zalabai, the general assembly of the municipal authority of Budapest has made a unanimous decision to use the reserve budget for 1991 for the reconstruction of both of its townhalls, to make them accessible for individuals with wheelchairs or crutches. On completion of this reconstruction, at least the exercise of climbing the stairs will not impede people with disabilities from going about their administrative business. A fund for expenditures of this kind will be separated in 1992; from that time, the construction of buildings will have to comply with the regulations ordaining accessibility. Recommendations in this context will be soon mailed to the district community authorities as well.)

2. To bring down the walls separating the worlds of normal and disabled citizens, all the respectable interactions and communication between these worlds, that are suitable to reduce stigmatisation significantly, must be encouraged. (If I had a friend "of this kind" for instance, I could make efforts not to treat him and his fellow sufferers in a denouncing fashion.)

3. The means to make the best of their essential human and citizens' rights must be guaranteed for people with disabilities. We do not even have to consult the Court of the Constitution to realise that polling-stations, medical consulting rooms, churches, schools, workplaces and buildings are inaccessible to wheelchairs. In Hungary, people bound to lead this way of life – together with the patients of closed institutions – are thus deprived of their most essential rights, encoded in the Constitution as well, not to mention the right to security of existence!

4. The society has to make all reasonable efforts to integrate disabled people into the field of education, economy and all others, understanding at the same time, that full remedy is impossible: the associations for self-assistance of the similarly stigmatised individuals are good examples of the limitations.

5. The media (television, radio, press) must be used to form a more realistic image of disability and people living with disability. It would be a great mistake to show them as sadly dependent, dull, emotionally incontinent victims – as is usual in fund-raising campaigns in the USA – just to appeal to the pity of the population.

6. The ingenuity of advertising can be put to good use as well. The advertisement of BENETTON, the famous manufacturer of sports goods is a good example, taken from a rather different field: in the nicely composed picture the tiny, black hand of a black child rests peacefully in the vast hand of a white man.

7. The programme of rehabilitation must draw on the strength of the family unit, to the greatest extent practicable.

8. The replacement of the huge institutes by small homes for groups of 40-60 should be encouraged. (Small is really beautiful.) The antiquated doss-houses and large nursing-homes-massive, isolated, ghetto-like structures-should be gradually closed up and forgotten forever.

9. It is unavoidable and several decades overdue that the experts give a thorough consideration to the sexual problems of people with disability.

10. A curriculum in *rehabilitative medicine* needs to be established. The intellectual knowledge necessary is essentially present, or could be gathered at the cost of a relatively insignificant professional and financial investment (the publication of a textbook, compilation of the subject-matter for instruction, creation of an institute). There is a parallel condition, however: the professional and financial acknowledgement of the physicians working in the field of rehabilitation – a problem, that is unlikely to be solved in a short time. (Let us take a man from Veszprém, Attila Sisak for a positive example.: Having spared no expense he announced a competition jointly with the Foundation against Cancer, for Mankind and for Tomorrow, for the postgraduate training of haematologists and oncologists. Both the essential idea and a portion of the funding were his private contribution; the provisions were drawn up and the applications were invited by the Foundation. Many young doctors have applied for the scholarship of the Sisak Foundation in the last two years; the scholarships are awarded annually, by a jury. Why could not there be a similar private foundation created jointly with the Hungarian Society for Rehabilitation? The precondition for this would be the theoretical possibility of achieving specialist degree in rehabilitative medicine.)

11. The training of the various professionals in rehabilitation (for counselling, assessment and development of ability) has to be started at *secondary school*. All these professions can be integrated into one, general qualification in the framework of counselling in professional rehabilitation.

12. Explicit training in rehabilitation has to be incorporated into the curriculum of gymnast-therapists, clergymen, psychologists, social workers and teachers of handicapped children, where the students would have to study the fundamentals of rehabilitation as one separate subject at least.

13. An *essentially new economic regulation and legislation* (or perhaps an Act) are also needed, that concentrate on individual with disabilities. The exact content of these measures can only be outlined at present but, the essential principles are as follows:

- The interest in obtaining a disability pension has to be eliminated.

- It is essential that people in need of rehabilitation get assistance from society through the application of these regulations, *to help their own rehabilitation*. This assistance would cover the cost of living, adjusted to the prevailing inflation. The individual, however, would be interested in finding re-employment at the end of a high-quality programme of professional rehabilitation.
- The regulations must provide for a selective control, adjusted to the difficulty of rehabilitation: there are individuals with severe, or multiple disability, but there are problems that are easily solved as well. Differing situations obviously need different economic and legal solutions; the appropriate combination of the market-motivated and altruistic (providing services or assistance) regulations is necessary to accomplish this objective. The appropriate starting-point of this process can be the market as all the performers on the scene *must be interested* to participate in the process. Research in this field suggests that other sources of motivation are not important. As the *state* can obtain its share from the income tax of its citizens only if the income of these citizens is significant and thus taxable; as the *contractor* can make profits only, if his enterprise in rehabilitation is flourishing; so the future *employer* will employ rehabilitated individuals only, if they will be able to fulfil the economic requirements of their employment; and so also if rehabilitated individuals themselves need to be satisfied with their income.
- If employment on commercial terms is impracticable due to the severity of the disability, the altruistic components of the regulation must compensate for the deficiency.
- Despite its drawbacks, the maintenance of the system of quotas seems worthwhile, but the quota should be increased significantly, i. e. doubled at least (at present it is still 3%!), together with the amount of the accompanying compensation, which should be trebled.
- A well founded, nation-wide programme is necessary for rehabilitation. Our era is often spoken of as the age of great humanitarian programmes. The developed countries are sparing no efforts to solve a myriad of human problems by specialised, humanitarian programmes. Once developed, the national programme should be divided into local modules, with key phases exactly defined as far as the financial resources are concerned and a careful assignment of *private, community based* and *state* spheres of activity.

– New, up-to-date social security systems are needed, with the option of having an insurance against disability built in them as well. People must be made interested in health, not in illness.

14. A key element for transformation in the economy is the *entrepreneur in rehabilitation*. If the enterprises in the field of rehabilitation will have become profitable indeed – as they already have in many developed countries – the number of *agencies on rehabilitation* can be expected to increase. Strictly speaking, there are no organisations of this kind in Hungary at present. These structures, together with their training centres, the mainstream of blood-flow, these are the sites would be where the essential activities (assessment, training for a new profession, re-employment) of principal importance to the individual take place. These institutes, using high-quality methods and equipment and quaffed personnel for the assessment of ability and for training and development of abilities, would function as professional centres. Assessment and development of ability, professional counselling and training, services in psychology and re-employment, protected employment and follow-up after re-employment would all be included in their activity. They would provide training for new jobs, and creative solutions of job-adaptation, as well as courses in housekeeping for disabled mistresses; moreover, in the case of severe injuries, they could instruct individual with disabilities on the basic skills needed in domestic life. Naturally, special training of appropriate professionals for the fulfilment of these tasks is naturally required. The list of social workers, specialist nurses, counsellors on professional matters and problems of rehabilitation, gymnast-therapists, psychologists and professionals assessing and developing abilities is still far from complete. The rationalisation of rehabilitation will demand extra expenditures as well.

15. Conflicts between the profit-oriented, pure interests of the employers-economists and ethically "higher" principles seem inevitable. Considering the unbelievable pollution of the environment, the destruction of forests, the alternative movements, and the rising incidence of disability this problem is not at all unexpected. American researchers in the social sciences have developed a reasonably proven method to resolve conflicts between the antagonistic initiatives. Let us suppose that the unit of economic activity is adequately small, consisting of so-called *profit-centres*, that perform everyday economic activity by egoistic motives. These are counterbalanced by *human-centres*, con-

sisting of at least partially independent scientists, dilettantes, experts on the protection of the environment and professionals of rehabilitation, to guard the "higher", i.e. substantive, altruistic and value-oriented interests. There is an incessant dispute, reconciliation and dialogue between these human and profit centres. If conflicts arise, the achievement of a summerising reconciliation, or the development of a compromise is the responsibility of the management of the company. In our concrete example, the mechanism is works as follows: individual profit-centres decide to dispose of the slop water into the river, or to fire the surplus of disabled or able employees. The human-centres on the other hand take into account and protect the interests of all parties concerned. They try to develop organisational solutions to settle the conflicts. If their negotiations with the profit-centres are unsuccessful, the problems are disclosed to the management of the company for reconsideration and the neglect of the interests of either party becomes impossible at this level. The "higher principles" such as the protection of disabled employees, the prevention of environmental pollution and the responsibility for the community that are considered totally external in the present system of economic organisation, can be assimilated into the problems of the company. The condition for this solution to work, however, is the thorough reconstruction of the traditional power-structure of the companies pursuing economic activity (Zsolnai 1986).

16. Though it is six years since the idea of a Bank of Rehabilitation was been submitted for the first time (Józsa – Kovács 1985), a detailed analysis of the subject has not been carried out yet. A banking institution, specialising in the sponsorship of enterprises in the field of rehabilitation, would be a significant development, as it would be unprejudiced, and at the same time deeply interested in the profitable operation of the sphere. Entrepreneurs in this field will need to borrow on more advantageous terms, than other banks could provide for. The precondition for this banking strategy to function is the continuous, external infusion of capital into the bank concerned. How else could it lend out credits at advantageous terms – with the interest rate prevailing on the market – without risking bankruptcy? As Pál Juhász pointed out years ago, it would be important to invest the shares, representing the original capital of the bank into *enterprises outside the sphere of rehabilitation*, as in the case of a substantial crisis of the sphere the risk of bankruptcy would be enormous.

LITERATURE

- BÉRY László 1929 (szerk.): *A magyar filantrópia könyve. (The book of Hungarian Philanthropy)*. Légrády Testvérek, Bp.
- GRIMM, Jacob és Wilhelm: *Gyermek- és családi mesék. (Tales for Children and Families)*. Magvető, Bp. 1989
- JÓZSA Miklós – Kovács Zoltán 1985: A foglalkozási rehabilitáció szervezeti megoldásai. Egyetemi doktori disszertáció. (Organizational Solutions of Locational Rehabilitation, University Doctoral Dissertation). MKKE, Bp.
- KÖNCZEI György 1987: *A nem orvosi rehabilitáció elméletéhez. A rehabilitáció néhány sarkkérdése Magyarországon 1968 - 1986. (To the Theory of Non-medical Rehabilitation)*. Szövetkezeti Kutató Intézet Közlemények 200, SZKI, Bp.
- NOVÁK Mária 1983: *A tartós egészségkárosodáshoz, rokkantsághoz vezető okok. (Causes of disability)*. Szakszervezetek Elméleti Kutató Intézete, Bp.
- NOVÁK Mária 1984 (szerk.): "Így lettem rokkant." Szerkesztett interjúk. („The way of my becoming disabled” – edited interviews) Szakszervezetek Elméleti Kutató Intézete, Bp.
- ORSZÁGOS Társadalombiztosító Intézet 1943: *A magyar társadalombiztosítás ötven éve 1892 - 1942*. OTI, Bp. é. n.
- ZSOLNAI László 1986: "A gazdaság társadalomökológiai megközelítése." ("The Social Economic Approach of the Economy"). *Közgazdasági Szemle*, 4. sz.