

The **Thalidomide** Trust

LOSS OF EARNINGS AND PENSIONS AMONG UK THALIDOMIDE
SURVIVORS

Caroline Glendinning

Liz Newbronner

Martin Baxter

Mark Tempest

Acknowledgements

The Thalidomide Trust would like to thank the following people for their invaluable help with this study:

- The Advisory Group that oversaw the study:
 - Professor Karl Atkin, Professor of Health Sciences, University of York
 - Professor Karen Bloor, Professor of Health Economics and Policy, University of York
 - Professor Hugh MacPherson, Professor of Acupuncture Research, University of York
 - David Body, Trustee, Thalidomide Trust and former National Head, Product Liability Team, Irwin Mitchell
 - Liz Buckle and Stuart Kenworthy, Thalidomide Trust beneficiaries, who also interviewed other beneficiaries about their lifetime employment and earnings histories
 - Emma Harpur, Iain Dodd, Solicitors at Fletchers Solicitors and Jess Lissett-Jones, Trainee Solicitor, at Fletchers Solicitors, who contributed to the estimates of lifetime earnings losses
- All the above gave up their time to support the project on an unpaid, voluntary basis.
- Michelle-Jane Robinson, Health and Wellbeing Team Administrator, Thalidomide Trust, who interviewed beneficiaries about their lifetime employment and earnings histories as well as co-ordinating the research and final report

About the authors:

Liz Newbronner MA (Cantab), MBA (Leeds), DipHSM is Director of Firefly Research

Martin Baxter BSc Eng., MSc (York), PGCE is Senior Information Analyst at Firefly Research

Mark Tempest is Head of the Serious Injury and Medical Negligence Department at Fletchers Solicitors

Caroline Glendinning MPhil (York) ACSS is Emerita Professor of Social Policy, University of York, Trustee, Thalidomide Trust and Chair of the Trust's Research Committee

LOSS OF EARNINGS AND PENSIONS AMONG UK THALIDOMIDE SURVIVORS

CONTENTS

1. Introduction
 2. The extent of changes in employment and pensions among UK Thalidomiders: further analysis of the Thalidomide Trust's 2015 Health and Wellbeing Survey
 - Current work situations
 - Relationships between work and health
 - Changes in work situation since 2000
 - Anticipated changes in work situation in the next five years
 - Pensions
 - Conclusion
 3. In-depth personal accounts of the impact of Thalidomide impairments and health problems on work, earnings and pensions:
 - Introduction
 - Current/last job and salary
 - Work and health
 - Continuing work
 - Wider discrimination
 - Pensions
 - The impact of Thalidomide on family members' employment and earnings
 4. Estimated lifetime earnings losses for seven exemplar case study Thalidomiders
 - Introduction
 - Case Study 1
 - Case Study 2
 - Case Study 3
 - Case Study 4
 - Case Study 5
 - Case Study 6
 - Case Study 7
 - Conclusion
- Appendix A Detailed analysis of survey data according to types of Thalidomide impairments.
- Appendix B Questionnaire used to obtain detailed information on earnings losses

LOSS OF EARNINGS AND PENSIONS AMONG UK THALIDOMIDE SURVIVORS

1. Introduction

This report provides detailed evidence of the extensive challenges experienced by the 467 beneficiaries of the UK Thalidomide Trust¹ in sustaining paid work² and careers as they experience rapidly increasing health problems; and of the earnings and pensions entitlements they have consequently lost or foregone.

The original compensation settlement between Distillers Company and the parents of Thalidomide-damaged children reflected the generally lower expectations prevalent in the early 1970s of the potential educational and workplace achievements by disabled people. In fact the majority of Thalidomiders, both men and women, have far exceeded these expectations. They achieved similar levels of educational attainment as their general population peers and have subsequently worked full or part-time for much of their lives. However, as they reach their mid-50s, growing numbers of Thalidomiders are reporting increasing difficulties continuing in paid work (particularly in full-time work) because of their deteriorating health - the result of consequential Thalidomide damage³. At an age when most people would expect to be at the peak of their careers, with maximum earnings and well before the normal retirement age, Thalidomiders are therefore giving up work (or are planning to do so); reducing their working hours; or switching to less demanding jobs. This report documents the extent of these changes among UK Thalidomide survivors and assesses their costs, in terms of the incomes (and to a lesser extent pension entitlements) lost or foregone. The report also presents evidence on the psychological and emotional impact of these changes; and on the impact of consequential Thalidomide damage on the employment and earnings of other family members.

The report has three main sections; each draws on a different source of evidence.

1. Section 2 documents the **extensiveness**, across the whole UK Thalidomider population, of changes made by Thalidomide survivors to their work patterns since 2000. These changes have direct impacts on incomes and future pension entitlements. This evidence comes from a postal survey⁴ of the health and wellbeing of UK Thalidomide survivors conducted by the Thalidomide

¹ The vast majority of Thalidomide Trust beneficiaries currently live in the UK; a very small number, whose mothers took Thalidomide distributed in the UK by the Distillers Company, currently live overseas. The term UK Thalidomiders is used throughout this report to refer to the entire group of Trust beneficiaries, on whom this study is based.

² We use the term 'paid work' rather than employment in this report, as some Thalidomiders have pursued successful careers on a self-employed basis, for example as freelance consultants or as the owners and managers of small and medium-sized businesses.

³ In this report the term 'consequential damage' to refer to the health problems, such as pain, neuropathy, tiredness and loss of function, that Thalidomide survivors are now experiencing as secondary consequences of their original Thalidomide impairment.

⁴ Newbronner E and Baxter M (2016). *Changing Lives – The Health and Wellbeing of Thalidomide Survivors in Middle Age*. Thalidomide Trust. See <http://www.thalidomidetrust.org/wp-content/uploads/2014/01/HW-Survey-2015-FINAL-REPORT-20-May-20161.pdf>

Trust in August 2015. The aim of the survey was to obtain a comprehensive picture of the current health and wellbeing of UK Thalidomiders and their wider circumstances, including their current employment situation.

Three-quarters of the 467 Thalidomide Trust beneficiaries responded to the survey. The distribution of the severity of impairment⁵ of the 351 respondents almost exactly matched that of all beneficiaries, as did their gender and country of residence. We are therefore confident that the survey findings reflect the situations of the full cohort of UK Thalidomide survivors. (Appendix A contains additional analysis of the survey data according to types of Thalidomiders' impairments.)

2. Section 3 presents **in-depth personal accounts** from a subsample of Thalidomide survivors of how their work and earnings histories have been affected by their impairments and consequential damage. These Thalidomiders were drawn from the 351 respondents to the 2015 Health and Wellbeing Survey - specifically from the 115 survey respondents who reported changes in their working life since 2000 who were also willing to take part in further research. In April 2016 these 115 Thalidomiders were sent a further postal questionnaire by the Trust about their current and previous earnings and their views on how their Thalidomide impairments and consequential damage had affected their working lives, earnings, pension entitlements and the employment and earnings of other family members. Almost three quarters (64, 73%) responded; 29 were male and 35 female. Although these 64 Thalidomiders are not necessarily representative of the whole UK Thalidomider population, they do include men and women from all five impairment severity Bands. Their accounts give a rich picture of the impact of Thalidomide-related problems on careers, earnings and pensions.
3. Section 4 presents **estimates of the lifetime earnings losses of 7 exemplar case study** Thalidomiders. Twenty-three Thalidomiders were selected from among those who had provided in-depth personal accounts of the impacts of Thalidomide on their work and earnings histories. They were interviewed over the telephone using a standardised questionnaire (see Appendix B). Seven exemplar cases were then selected from among these 23 Thalidomiders, who:
 - Included the full range of Thalidomide Trust impairment severity Bands 1 – 5
 - Could provide sufficient data about their past work and incomes for detailed calculations of earnings losses to be conducted
 - Had lived 'ordinary' lives, or had 'ordinary' careers. This ensured that no outlandish claims were made about potential losses; the calculated losses can be regarded as modest. However, in any group there will be exceptional performers, so one 'high achiever'

⁵ When the original compensation agreement was made between the Distillers Company (which distributed Thalidomide in the UK) and the Thalidomide Trust, each Thalidomide survivor was assessed to determine the severity of their Thalidomide impairment. This assessment – termed the 6(iv)b figure (reflecting the clause of the level of compensation they would receive. This is the individual's 6(iv)b figure (referring to the clause of the Diageo-Trust agreement. The compensation is paid as an annual grant by the Thalidomide Trust. Since 2010 the 6(iv)b figure has also determined the level of the Health Grants paid through the Trust to Thalidomiders by the UK Departments of Health, to meet their exceptional health needs. For convenience, throughout much of this report, individual 6(iv)b figures are clustered into 5 broad Bands, from Band 1 (least severe impairments) to Band 5 (most severe impairments).

was included – a Thalidomider who had performed at a high level in her chosen profession (academia) and could demonstrate large losses in this arena. Moreover, when calculations were also carried out for her aspired alternative career - that is, the career she would have chosen but for her Thalidomide impairment (in this case, a hospital doctor) - the losses were even higher. This case study was included to show that the earnings losses of 'high achieving' Thalidomiders are likely to be significantly higher than the norm.

Well- established legal principles were applied to estimate lifetime earnings losses. However, a number of assumptions had to be made about past earning capacity because of gaps in information from Thalidomiders, who were of course looking back many years. Where these assumptions were made, they have been explained. In each case, publicly available data from Government and other sources were used; the assumptions are conservative; and credit is given for actual earnings⁶.

Two sets of figures are provided for each case study, one without and one with interest on past losses⁷. For three of the case studies, earnings losses for two working life scenarios have been calculated. The first is for the actual losses experienced during the Thalidomider's working life (taking into account work breaks for reasons due to Thalidomide-related health problems etc). The second calculation relates to a plausible alternative career that the Thalidomider had good reason to believe s/he may have been able to follow but for the Thalidomide impairment.

These schedules do not have the status of quasi-legal claims; however they do provide potent illustrations of the magnitude of financial losses sustained as a result of the diminished earning capacity caused by Thalidomide. The illustrations are based on conservative assumptions and tried and tested calculations accepted in the Civil Courts of England and Wales.

⁶ In an actual legal case there would be more future losses to calculate than past losses because the event causing an injury would be recent. In these exemplar case studies there are more past than future losses. Where future losses are projected (to retirement age) we have used Ogden (Government Actuarial) Tables, together with calculation methods approved by the Courts for working out the multiplier (the figure used to accurately work out future loss, taking into account all other contingencies).

⁷ In a personal injury claim, interest is always awarded on past financial loss at the full special account rate prevailing at the time. This is the method adopted in these example cases.

2. The extent of changes in employment and pensions among UK Thalidomiders: further analysis of the Thalidomide Trust’s 2015 Health and Wellbeing Survey

Introduction

This section documents the widespread experience of UK Thalidomiders, now in their early to mid-50s, of increasing difficulties in sustaining earlier patterns of paid work and earnings; their expectations of (further) difficulties in the coming years; and their anticipated shortfall in future pension entitlements. It draws on data from the Thalidomide Trust’s 2015 survey of the health and wellbeing of the whole UK Thalidomider population. Further analyses were conducted to see if there were any patterns in reported changes in paid work and earnings; for example, whether these were more prevalent among those with more or less severe impairments, among men or women, or among those with or without advanced education qualifications. We also examined the relationship between Thalidomiders’ health-related quality of life, current work situation and changes in their work situation. (Further analyses of Thalidomiders’ current work situation and type of impairment are contained in Appendix 1).

Current work situation

Overall just over one third of Thalidomiders were currently in work, 15.4% (54) full-time and 22% part-time.

Table 1 Current Work Situation

Work Situation – all respondents	Number	%
I’m unable to work because of my disability or health problems	145	41.4%
I work full-time	54	15.4%
I have chosen not to work in order to preserve my health/functioning	45	12.9%
I work part-time because of my disability or health problems	30	8.6%
I work part time in order to preserve my health/functioning	29	8.3%
I work part-time for family or personal reasons	17	4.9%
I’m not working at the moment but would like to	15	4.3%
I’ve chosen not to work for family or personal reasons	8	2.3%
Other (e.g. in education)	7	2.0%

Among those Thalidomiders not currently working, by far the biggest group were those who said they could not work because of their disability or health problems (145/41%). Most of those who had chosen not to work (45/13%) also said they had done so in order to preserve their health or functioning; only 8 (2.3%) said they had chosen not to work for family or personal reasons.

Comparisons with the general population and/or with disabled people as a whole are difficult, as different sources of data use different terminologies, definitions and age groupings. Furthermore, Thalidomide survivors themselves are a diverse group in terms of the severity and nature of their impairments. Nevertheless, comparisons with the general population are striking. Figures from the Department of Work and Pensions show that in 2015 the employment rate for people aged 50 to 54

in the general population was 82% (78% for women and 86% for men)⁸. This suggests that only 18% of this age group in the general population were ‘economically inactive’, compared to 63% of UK Thalidomiders. This is similar to data collated by the Papworth Trust, which suggests that disabled people are four times as likely as their non-disabled peers to be unemployed or involuntarily out of work⁹.

There were also marked differences between Thalidomiders and the general population in the proportions of those still working who were in part-time rather than full-time work (Table 2). Here the figures for men and women need to be considered separately, as gender has a major impact on the likelihood of full or part-time working. Of those male Thalidomiders who were still in work, just under three-fifths were working full-time, compared with over 90% of the general UK male working population aged 50-54. Conversely, male Thalidomiders were six times more likely to be working part-time than their peers in the male general UK working population. There was a similar (but slightly less striking) pattern among female Thalidomiders who were still working. They were also much less likely to be working full-time, but over twice as likely to work part-time, compared with working women in the general population¹⁰.

Table 2 Men and women in full and part-time work: general population and Thalidomiders compared

		UK working population aged 50-54	Thalidomider working population
Men	% working full-time	93%	59%
Men	% working part-time	7%	41%
Women	%working full-time	67%	23%
Women	%working part-time	33%	77%

We examined whether Thalidomiders’ current work situation was related to other factors such as the severity of their impairment or level of educational qualifications. The proportions of Thalidomiders who said they were unable to work at all clearly increased with the severity of impairment, from 35% for beneficiaries in Band 1 to 75% for beneficiaries in Band 5 (Table 3). Conversely, those with less severe impairments were more likely to be in full-time work than those whose impairments were more severe. The proportions of men and women not working were approximately equal.

⁸ Department of Work and Pensions (2015). *Employment statistics for workers aged 50 and over, by 5-year age bands and gender: From 1984 to 2015*. DWP, London.

⁹ Papworth Trust (2104). *Disability in the United Kingdom 2014: Facts and Figures*. Cambridge.

¹⁰ <https://stats.oecd.org/>

Table 3 Current work situation and impairment Band

	N° in group	I work full-time	I work part-time	I have chosen not to work	I am unable to work
Band 1	34	11 [32%]	6 [18%]	5 [15%]	12 [35%]
Band 2	79	15 [19%]	22 [28%]	17 [22%]	25 [32%]
Band 3	99	13 [13%]	24 [24%]	15 [15%]	45 [45%]
Band 4	50	4 [8%]	8 [16%]	9 [18%]	28 [56%]
Band 5	40	3 [8%]	5 [13%]	2 [5%]	30 [75%]
Band not known	49	8 [16%]	12 [24%]	8 [16%]	20 [41%]
Overall	351	54 [15%]	77 [22%]	56 [16%]	160 [46%]

Note: Percentages are of those in each Band

Formal educational qualifications could also affect the likelihood of remaining in work; for example, people with higher educational qualifications may be better able to secure non-manual occupations in which impairments can be accommodated. However, UK Thalidomiders have very similar patterns of qualifications as the general UK population of a similar age¹¹. Thus, as with the general population, there was an association between the level of education qualification and current working situation (Table 4). Almost 70% of Thalidomiders with degrees/higher degrees were in (full or part-time) work, compared with only 12% of those with no formal qualifications. However, each qualification group also contained Thalidomiders with a range of severity of impairment: for example, the 19 survey respondents with degree-level qualifications who were working full-time fell into all 5 impairment severity bands. This suggests that whilst Thalidomiders' ability to continue working is strongly related to the severity of their impairment, educational qualifications also have an important influence.

Table 4 Current work situation and educational qualifications

	N° in group	I work full-time	I work part-time	I have chosen not to work	I am unable to work
Degree or higher degree [e.g. MA, PhD]	70	19 [28%]	28 [41%]	6 [9%]	16 [23%]
Diploma or professional qualification [e.g. Reg. Nurse]	30	5 [17%]	8 [27%]	3 [10%]	14 [47%]
A Levels or Highers	37	4 [11%]	10 [28%]	5 [14%]	17 [47%]
O Level or GCSE equivalent [Grade A-C]	65	6 [9%]	13 [20%]	13 [20%]	33 [51%]
O Level or GCSE equivalent [Grade D-G]	21	6 [29%]	3 [14%]	3 [14%]	9 [43%]
Vocational Plus [e.g. HND]	35	10 [29%]	6 [17%]	7 [20%]	12 [34%]
Vocational [e.g. OND]	6	1 [17%]	0 [0%]	1 [17%]	4 [67%]
No formal qualifications	80	2 [3%]	7 [9%]	17 [22%]	52 [67%]

Note: Percentages are of those in the qualification group

¹¹ Office for National Statistics (2011). *Highest levels of qualification across England and Wales*. See: <http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/local-area-analysis-of-qualifications-across-england-and-wales/info-highest-qualifications.html>

Relationships between work and health

The Health and Wellbeing survey investigated in detail the physical and mental health-related quality of life of UK Thalidomiders. The SF12 Health Survey was used; this measures health status and is widely used in health research in the UK and internationally (including studies with Thalidomide survivors in Australia, Germany, Japan and Sweden). SF12 consists of eight scaled sections, which can be aggregated into two domains – mental and physical health-related quality of life. The results are presented here in ‘normalised form’ i.e. scores for the general population are adjusted so that the mean is 50. This facilitates easy comparisons between Thalidomiders and the general population.

There was a clear, but complex relationship between Thalidomiders’ current work status and their mental health-related quality of life (Table 5). Thalidomiders who were unable to work had the lowest average score – i.e. poorest mental health-related quality of life. This strongly suggests that giving up work well before retirement age – at the peak of a career and earning power - has had damaging effects on Thalidomiders’ morale and self-esteem. Conversely, those who had chosen not to work had the highest average score (i.e. best mental health-related quality of life) – although still below the general population average. However, the maximum and minimum scores for all groups showed a wide range.

Table 5 Current employment status and mental health related quality of life

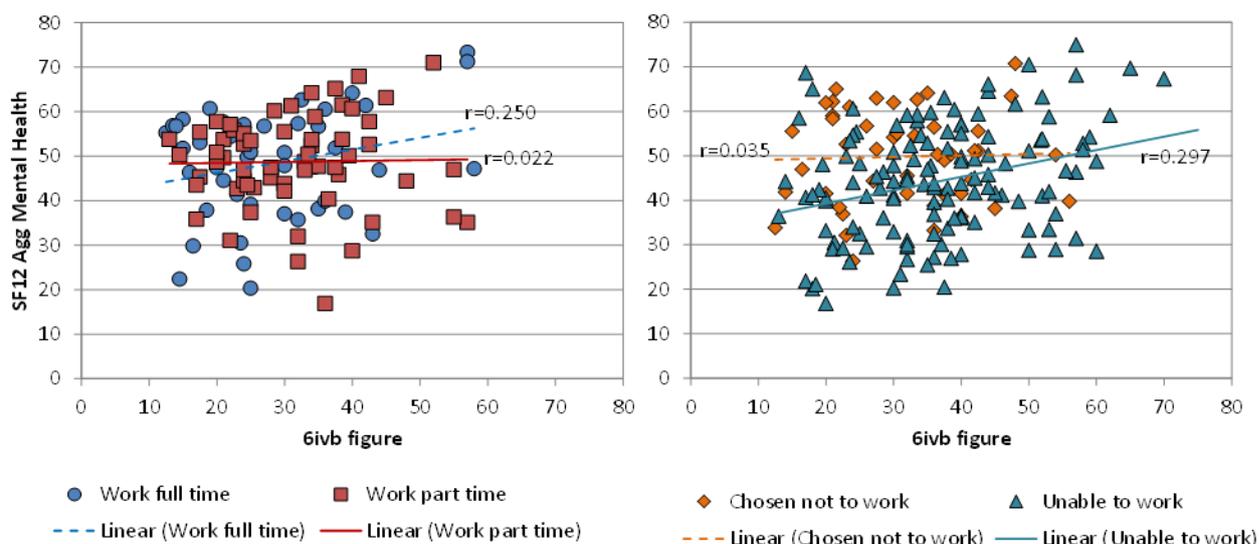
	I work full-time	I work part-time	I have chosen not to work	I am unable to work
Average SF12 Agg MH score	48.3	48.3	49.2	44.0
Max SF12 Agg MH score	73.3	71.0	70.7	74.9
Min SF12 Agg MH score	18.8	16.8	25.5	16.8
<i>Average SF12 Aggregate MH score (normalised) for general population aged 45 to 54 is 50</i>				

Figures 2 and 3 show the relationship between mental health-related quality of life and individual 6(iv)b¹² impairment levels for the four work status groups. For Thalidomiders who had either chosen not to work or who currently worked part-time, there appeared to be no relationship between the severity of their impairment and their mental health-related quality of life. However, among Thalidomiders who had lower levels of impairment (i.e. lower 6 (iv)b figures), both being unable to work and working full time appeared to be associated with lower SF12 scores i.e. poorer mental health-related quality of life¹³. The comments that Thalidomiders added to their survey forms suggested that some felt they had to continue working for financial reasons, despite finding it increasingly difficult to do so because of their deteriorating health. Conversely for others, especially those with less severe impairments who had hitherto been able to pursue a normal career, their deteriorating health may have forced them to stop working well before they otherwise wanted to. These situations are illustrated in more detail in the next section of this report.

¹² See footnote 4 above.

¹³ Where the linear trend lines on the charts are, or very close to, horizontal, there is no relationship, whilst the steeper the trend line, with a higher ‘r’ value, the more significant the relationship

Figures 2 and 3 Mental health-related quality of life and 6(iv)b impairment figure for the four employment groups



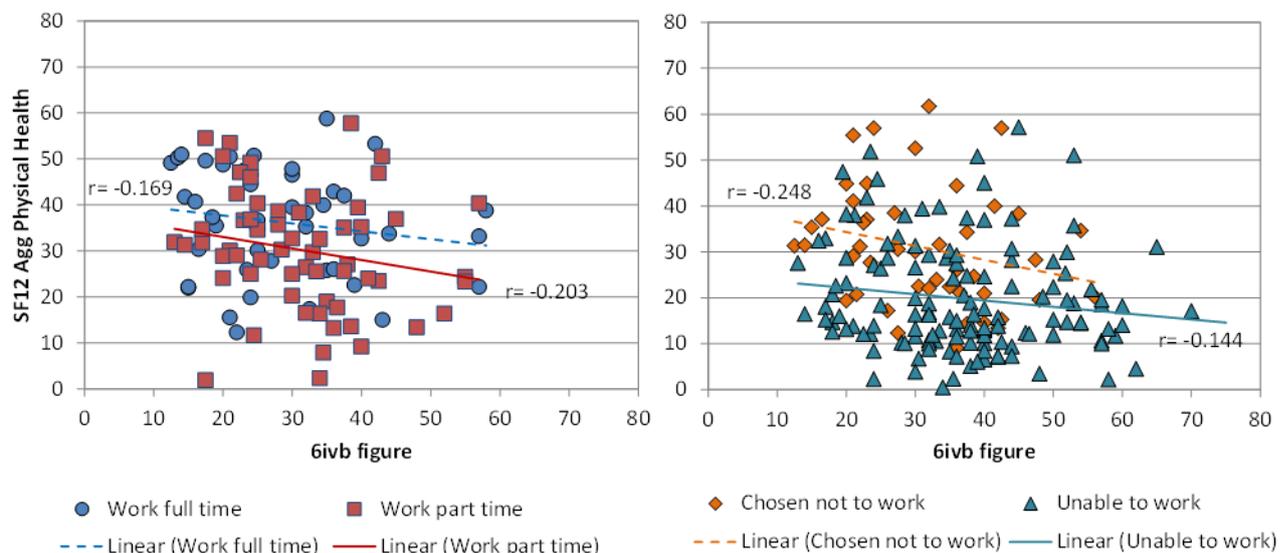
In relation to physical health-related quality of life (Table 6), Thalidomiders who were unable to work had markedly lower average SF12 scores (i.e. noticeably poorer physical health); those still working full-time had the highest average SF12 scores (i.e. better physical health-related quality of life). However, the average aggregate score for all groups was significantly lower than for people of a similar age in the general population and again maximum and minimum scores showed a wide range, regardless of current work status.

Table 6 Current employment status and physical health related quality of life

	I work full-time	I work part-time	I have chosen not to work	I am unable to work
Average SF12 Agg physical health score	36.4	30.7	30.8	19.7
Max of SF12 Agg physical health score	58.8	59.4	61.7	57.1
Min of SF12 Agg physical health score	12.3	1.9	9.1	0.5
<i>Average SF12 Aggregate physical score (normalised) for general population aged 45 to 54 is 50</i>				

Figures 4 and 5 show there was a relationship between physical health-related quality of life and individual 6(iv)b levels; the higher the 6(iv)b impairment figure, the lower the SF-12 physical health-related quality of life score. For all 4 work status groups this relationship was weak, but Thalidomiders who had chosen not to work and had lower levels of impairment tended to have better physical health-related quality of life.

Figures 4 and 5 Physical health related quality of life and 6ivb impairment figure for the four employment groups



Changes in work situation since 2000

The Health and Wellbeing survey asked Thalidomiders about changes they had made in their work status since 2000 (when they were entering their 40s). 2000 was chosen because:

- More evidence has emerged about the health problems Thalidomide survivors experience as they age and their associated difficulty of continuing to work, work full time, or do the type of work they have done for much of their lives.
- Both increases in annual grants from the Thalidomide Trust and the introduction of the Health Grant in 2010 have provided additional income that may have enabled some Thalidomiders to reduce or stop paid work.

In all, 59% (207) of all survey respondents had made one or more change to their work situation since 2000; 128 had stopped work, 62 had reduced their working hours and 35 had changed the type of work they did. Fifteen respondents had made more than one change (so appear in more than one category in Table 6 and Figure 6 below). Of this latter group, all had reduced their working hours and all except one had changed the type of work they did. As in the general population¹⁴, respondents with higher education qualifications appeared to have had more choice and flexibility in their work situations compared to those with only vocational or no qualifications, who were far more likely to have stopped working than reduced their working hours or changed the type of work they did.

¹⁴ UK Commission for Employment and Skills (2014) *The Labour Market Story: The State of UK Skills*. Briefing Paper July 2014. UKES: London.

Table 7 and Figure 6 show the associations between recent employment changes and severity of impairment. Beneficiaries in severity Bands 1, 2 and 3 were more likely to have reduced their working hours or changed the type of work they do. Greater proportions of those in Bands 4 and 5 had stopped working, although this change also occurred across all severity Bands.

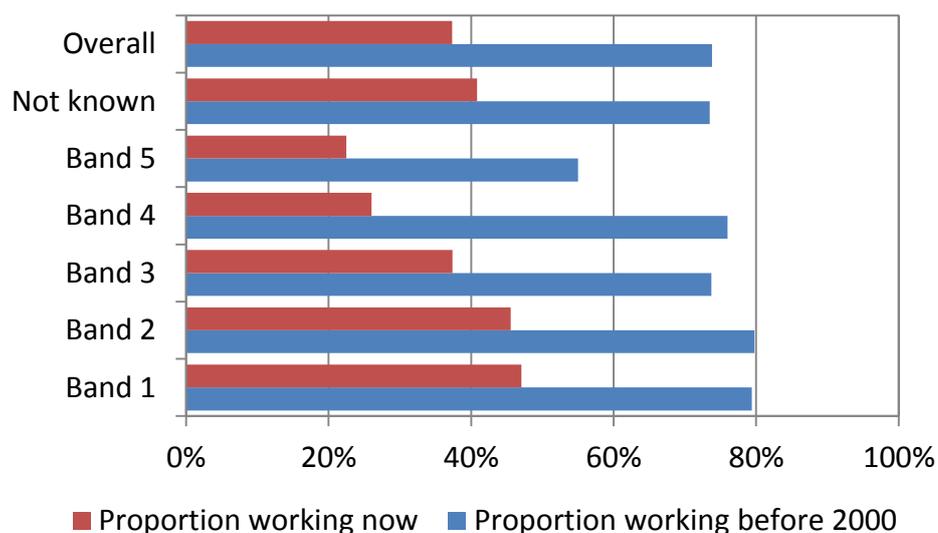
Table 7 Changes in work situation between 2000 and 2015 by impairment band

	N° in Band working in 2000	I have reduced my working hours	I have changed the type of work I do	Those who have stopped working
Band 1	27	8 [30%]	6 [22%]	11 [41%]
Band 2	63	19 [30%]	10 [16%]	27 [43%]
Band 3	73	18 [25%]	11 [15%]	36 [49%]
Band 4	38	5 [13%]	2 [5%]	25 [66%]
Band 5	22	4 [18%]	2 [9%]	13 [59%]
Not known	36	9 [25%]	5 [14%]	16 [44%]
Overall	259	63 [24%]	36 [14%]	128 [49%]

Notes: Percentages are of those in the Band who were working in 2000
Some respondents had made more than one change

Figure 6 compares the proportions of beneficiaries in each severity Band who were working before 2000 and at the time of the Health and Wellbeing Survey in 2015. Over three quarters of respondents in Bands 1 to 4 were working prior to 2000. By 2015, less than half of all beneficiaries were working and, as severity of impairment increases (i.e. moving from Band 1 to Band 5) there is a gradual decrease in the proportions still working.

Figure 6 Proportions of respondents working pre-2000 and 2015 by severity Band



Anticipated changes in work situation in the next five years

The Health and Wellbeing Survey asked Thalidomiders whether they anticipated making (further) changes in their work situation in the next five years (again some respondents appear in more than one category if they anticipated more than one change). This data needs treating with some caution, as respondents only reported what they thought *might* happen, not what *would definitely* happen.

Over two thirds of Thalidomiders in severity Bands 1 to 3 anticipated making (further) changes to their work situation; indeed, of those in Bands 2 and 3, over 40% thought they would have to stop working altogether (Table 8). Fewer Thalidomiders in Bands 4 and 5 expected to make changes, but only a quarter of them were working at the time of the Survey anyway. There was very little difference between men and women.

Table 8 Anticipated changes in work situation by severity Band

	All those working full or part time	Those who think they might have to reduce their hours	Those who think they might have to change the type of work	Those who think they might have to stop working	Those who think they might make any changes
Band 1	16	7 [44%]	3 [19%]	4 [25%]	11 [69%]
Band 2	36	9 [25%]	5 [14%]	16 [44%]	24 [67%]
Band 3	37	10 [27%]	8 [22%]	15 [41%]	25 [68%]
Band 4	13	2 [15%]	2 [15%]	3 [23%]	6 [46%]
Band 5	9	4 [44%]	1 [11%]	1 [11%]	5 [56%]
Band not known	20	6 [30%]	3 [15%]	6 [30%]	11 [55%]
Overall	131	38 [29%]	22 [17%]	45 [34%]	82 [63%]

Note: Percentages are of those in the Band who are currently working

Overall, this suggests Thalidomiders with less severe impairments (i.e. severity Bands 1 - 3), are finding work, especially full-time work, increasingly difficult and as a result they anticipate having to make changes in their work situation in the relatively near future.

Pensions

The Health and Wellbeing Survey asked Thalidomiders whether they had contributed to an employers'/company or private pension and, if so, how many years' contributions they had made. Less than two-fifths (39%, 137) said that they had contributed to an employers'/private pension, suggesting that over 60% of Thalidomiders have no pension provision over and above their state pension. This is much higher than the general population pre-retirement cohort; only 35% of men aged 50 to 64 and 39% of women aged 50 to 59 are estimated to be without any private pension

savings¹⁵. However, research by the Pensions Policy Institute¹⁶ into the likely future pension incomes of disabled people has found that disabled people have many of the characteristics associated with lower pension incomes. The Health and Wellbeing survey suggests that Thalidomiders share at least two, and possibly three, of the five characteristics associated with lower pension incomes: they are less likely to be in work; are less likely to be saving for a private pension; and they may have lower earnings when in work.

Of those Thalidomiders who reported having contributed to an employers’/private pension, 58 (33%) were women and 79 (45%) were men, with an average 16.4 and 19.8 years of contributions respectively. The proportions who had contributed to an employers’/private pension decreased as the severity of impairments increased; this gradient was greater for women than men. However, the relationship between impairment band and average years of contributions was less clear (Table 9).

Table 9 Average years of pension contributions by severity Band

	All respondents		Number in group with pension provision		Proportion of group with pension provision		Average years of contribution	
	Female	Male	Female	Male	Female	Male	Female	Male
Band 1	19	15	9	10	47%	67%	13.2	25.2
Band 2	37	42	14	23	38%	55%	15.7	19.9
Band 3	44	55	15	23	34%	42%	17.7	20.5
Band 4	27	23	6	9	22%	39%	18.9	15.2
Band 5	22	18	4	6	18%	33%	13.6	9.6
Band n/k	25	21	10	8	40%	38%	17.9	26.8
Overall	174	174	58	79	33%	45%	16.4	19.8

Conclusions

A representative survey of UK Thalidomide survivors, now in their mid-50s, shows widespread changes in work situations since 2000 when they were in their early 40s and some 25 years before statutory retirement age.

Around three-fifths of Thalidomiders have made changes to their work situation since 2000 – giving up work, reducing hours or changing jobs. Those with less severe impairments are more likely to have reduced their working hours or changed the type of work they do; those with more severe impairments are more likely to have stopped work altogether. Over three-quarters of Thalidomiders in severity Bands 1 to 4 were working prior to 2000, but by 2015 less than half of all beneficiaries were working; as severity of impairment increased, there was a gradual decrease in the proportions still working.

¹⁵ Office for National Statistics (2014) Statistical Bulletin: *Characteristics of People and Households without a Private Pension*. ONS London.

¹⁶ Pensions Policy Institute (2009) *The under-pensioned: disabled people and people from ethnic minorities*. Briefing Note Number 50. PPI London.

Currently, only just over one third of Thalidomide survivors are in work, either full-time or part-time. This is in striking contrast to the general population aged 50 to 54, of whom 82% are in full or part-time work. Conversely, only 18% of the general population aged 50 – 54 are economically inactive, compared with 63% of Thalidomiders. Among those Thalidomiders still in work, far smaller proportions of men or women were in full-time work and far higher proportions in part-time work than men and women of a similar age in the general working population.

Thalidomiders with more severe impairments are less likely to be able to work and, if they are, less likely to be in full-time work, than those with less severe impairments. Those with degree-level qualifications are also much more likely still to be economically active than those with no qualifications.

Relationships between current work situations and physical and mental health are complex. Thalidomiders who are unable to work have the poorest mental health-related quality of life; those who have chosen not to work have the best mental health-related quality of life – though still below average for the general population. Among those Thalidomiders with less severe impairments, giving up work appears to have damaging consequences for mental health-related quality of life, as does maintaining a full-time job despite deteriorating health.

Thalidomiders who are unable to work also have markedly poorer physical health-related quality of life. Conversely, those still working full-time have better physical health-related quality of life, as do those with less severe impairments who had chosen not to work. Even so, again their average scores are significantly lower than those of people of a similar age in the general population.

More than two-thirds of Thalidomiders in severity Bands 1 to 3 expect to make (further) changes to their work situation during the next five years. Fewer Thalidomiders in Bands 4 and 5 expect to make changes, but only a quarter of them are currently working anyway.

Less than two in five Thalidomide survivors have contributed to a private or employers' pension, suggesting that over 60% of Thalidomiders have no pension provision over and above their state pension; this is much higher than pre-retirement men and women in the general population. Those with more severe impairments are less likely to have contributed to a private or employers' pension.

3. In-depth personal accounts of the impact of Thalidomide impairments and health problems on work, earnings and pensions

Introduction

Further detailed information on Thalidomide survivors’ work, earnings and pensions was obtained from a subsample of beneficiaries who responded to the 2015 Health and Wellbeing Survey. A total of 115 survey respondents reported changes since 2000 in their work situation because of Thalidomide impairment or consequential damage were willing to be contacted again for further research. They were sent a follow-up questionnaire by email and/or post from the Trust in April 2016 asking for more details of these changes; their current and previous earnings; and how Thalidomide had affected their working lives, earnings, future pension entitlements and the work situation of other family members. Sixty-four Thalidomiders (29 men, 35 women) responded. They covered all 5 severity Bands (Table 10) and included 6 who had changed jobs since 2000; 42 who had stopped work altogether (sometimes preceded by a period of part-time work); and 16 who had reduced their hours since 2000¹⁷.

Table 10. Severity Bands of respondents to follow-up in-depth survey

Impairment severity Band	Number
1	9
2	20
3	18
4	12
5	5
Total	64

These 64 Thalidomiders are not necessarily representative of the total UK Thalidomide group. However, their accounts give rich insights into the multiple ways in which their Thalidomide impairments and consequential damage have affected their labour market participation, earnings and pension entitlements – and, to some extent, those of their families too. These effects do not appear to be directly related to severity of impairment, with Thalidomiders across all 6iv(b) impairment severity Bands describing how their work status, earnings and pensions had been adversely affected.

Current/last job and salary

The 64 respondents to the follow-up survey had a very wide range of jobs, which they were either currently still engaged in or had held immediately prior to stopping work. These are clustered together and included:

¹⁷ Three of the latter group had subsequently stopped work altogether and 2 had changed jobs as well as reducing their hours of work.

Self-employed/own business: including public speaking/presentation training; journalism and writing consultancy/coaching; print supply and delivery; farm and estate supplier; electronic component supplier; sports management.

Manual: postman/delivery driver; HGV driver; welder/sheet metal fabricator; car valeting; taxi driver; classroom support assistant/lunchtime supervisor; catering assistant; production line worker.

Professional and senior management: senior speech and language therapy services manager; consultant clinical psychologist; senior child protection officer; local authority IT training officer; specialist sensory impairment social worker; specialist teacher; welfare rights officer; police regional support services manager; theatre company tour manager; apprenticeship assessor; senior fostering and adoption practitioner; teacher; university project manager.

Clerical/senior admin: customer services advisor; bank call centre advisor; medical secretary; hospital ward clerk; payroll manager; local authority clerical assistant; data entry clerk; telesales worker.

IT-related: computer programmer; data entry assistant; police CCTV operator; IT hardware and software technician; telecoms software engineer; financial services administrator.

Follow-up survey respondents were asked about their current or last salary/wage levels. These are difficult to summarise, as their answers referred variously to full or part-time hours and a range of earlier dates. However, among those who had reduced their hours of work since 2000 were the following:

[Current] salary £7,752 annually plus a £5,000 dividend part-tax year. I have reduced my hours considerably over 2 years. I get tired quite quick with the physical side of doing parcels, I do what's needed every day but work about 3-5 hours a day (man, Band 4, self-employed selling electrical components)

One Thalidomider described how he had reduced his hours of work before stopping work altogether and the impact on his income:

..in recent years [I earned] under £5,000. However, up to 2006/07 my income was between £40,000 and £60,000.... I have just stopped and will draw down a small pension in September (man, Band 2, self-employed print delivery firm)

Those who had changed the type of work they did since 2000 also reported reduced incomes, including one man (Band 5) whose annual income had dropped from £65,000 as a senior journalist to £7,428 as a self-employed consultant. Another man (Band 2) had both reduced his hours and changed jobs:

I took ill health retirement from my main employment circa 3 years ago. I get a pension from that. I was an HR director. I currently do part-time work (2-3 days/month) as an employment tribunal member. [I currently receive] £180 plus expenses per day.... As HR director it was 50-60 hours per week, £95,000 per annum.

Some of the Thalidomiders who had stopped work altogether since 2000 reported very considerable drops in income, including losses of:

- £33,000 (man, Band 3, police area support services manager)
- £12,500 plus profit sharing, Christmas bonus, 2.5% of salary plus assessment of work bonus (woman, Band 4, customer services advisor)
- £36,000 (man, Band 2, software engineer)
- £28,000 (man, Band 3, local government welfare rights officer)

Work and health

Reasons for changing or stopping work

Follow-up survey respondents described how Thalidomide-related health problems had forced them to change jobs, reduce their working hours and/or stop work altogether. These problems invariably involved pain, fatigue and/or loss of function:

I've just this week dropped my working hours down to 2 days a week as I am suffering severe pain in my spine. I'm not sure if even 2 days a week will help (woman, Band 2, NHS specialist speech therapist)

I currently work in [airport] business support unit (admin), having had to stop front-line duties due to ill-health. I would like to have continued working on front-line carrying out immigration and customs work (man, Band 2, currently working 20 hours per week)

Prior to my existing job I worked in the admin field. I was no longer able to do this job because of back issues due to Thalidomide. Sitting in front of a computer at a desk was a big health issue for me (woman, Band 3, now self-employed public speaking trainer).

I left [former employer] in part so that I would have more autonomy over my working pattern and am now able, for example, to rest during the day if necessary (man, Band 5, former senior journalist, now self-employed consultant)

I can no longer do any work due to pain (man, Band 1, former office manager)

I had back surgery in 2004/5. This can clearly be linked to my [Thalidomide] damage. This made driving for long periods and lifting heavy print materials harder and harder, resulting in loss of contracts (man, Band 2, former self-employed print supplier, whose annual income dropped from £40,000-£60,000 to £5,000 over 10 years before he gave up work entirely)

Due to my own fight for independence and trying to live a normal life, I have risked my body to the limits and now I'm 56 years old and things due to my Thalidomide damage have made it impossible to carry out working and being able to look after myself with everyday tasks and personal hygiene has become a struggle (woman, Band 1, former apprenticeship assessor who reduced her working hours before stopping altogether)

As a company director from 1992 to 2004, [I worked] anything up to 70+ hours per week. As a direct result of the debilitating effects of Thalidomide, this gradually reduced between 2000/01 and 2004 as health-related issues took over. At peak [I earned] £45,000 pa, including directors' remunerations plus an excellent expenses package. Income began

gradually to reduce from 20000/01 onwards (man, Band 3, reduced hours before retiring altogether)

I can no longer do any work due to pain (man, Band 1, former office manager who had previously also experienced a drop in income from £16,000 to £13,000 after giving up his earlier self-employed white goods repair business)

I have retired from work due to health problems ... I did want to work on, but got chance of redundancy and I took it. I was stressed and not coping (woman, Band 2, former data entry clerk)

I've always done manual work and feel I am paying for it now (man, Band 2, former HGV driver)

Only had 2 jobs since leaving college and had to give up both jobs due to my condition (man, Band 3, former IT technician)

I took very early retirement (age 50) due to finding typing/ordering software was affecting my fingers (man, Band 2, former telecoms software engineer)

I have not been able to work since December 2015 due to my hand and arm being hurt as a result of trying to carry learners' portfolios from my car to their places of work (woman, Band 1, apprenticeship assessor who reduced her hours before stopping work altogether)

I was happy in the [former] sales director job but had to change due to problems driving and keyboard work I could no longer stay in sales due to Thalidomide wear and tear on hands and wrists (man, Band 1, who gave up sales director post (£40,000pa) to become a driving instructor (£12,000) before stopping work altogether)

Psychological effects of stopping work

As well as impacting on their income and pensions (see below), for some Thalidomiders giving up work had major psychological consequences:

I found it very difficult to accept that I could no longer work. I don't think I was depressed exactly, but it was a close call and I was lucky to be able to find a voluntary job to get me out (woman, Band 1, former customer services advisor in bank call centre).

I feel I have been robbed of a career and lost a lot of earnings by both my husband and I, all due to such a drastic deterioration in my health (woman, Band 4, former local authority IT training officer)

I loved my work. I really miss it. I was ill and struggling when I came out of work in 2004, using large amounts of painkillers and not understanding why my body was collapsing and in so much pain. Psychologically it has been a catastrophic disappointment that I cannot work and I have lost a lot of confidence since then and have been using counselling and psychiatric

services regularly since (I did not need these previously) (woman, Band 3, former university project manager)

Continuing work

Many of those who were still working described the increasing difficulties they were experiencing and anticipated they would have to stop in the near future, well before statutory retirement age:

Finding it more and more difficult to keep job due to the pain my hands and forearm (man, Band 1, telesales advisor)

I have taken partial retirement but will be ceasing work completely in 2017 (man, Band 2, business support/admin)

Highly supportive employer but poor mobility, pain and exhaustion now forcing me to consider giving up my post and working as an independent consultant for the same organisation [leading to] loss of earnings (woman, Band 3, now working 15 hours a week as senior fostering and adoption practitioner)

May have to retire earlier than otherwise due to health limitations (woman Band 2, consultant clinical psychologist)

Wider discrimination

Most respondents clearly linked their decision to change jobs, reduce hours of work or stop work altogether to the direct impact of their deteriorating physical health and associated stress.

However, a few also noted the impact of wider, lifelong experiences of direct discrimination, the stigmatising effects of their unusual impairments, or a failure by employers to accommodate their needs within the workplace. They acknowledged that some of these barriers were psychological but had nevertheless limited their opportunities and career options:

Had they [employers] supplied me with the adaptation Access to Work suggested so I did not have to bend right forward to see the screen and suitable trolleys for moving coinage, it would have been unlikely I would have had back problems at 37 years old (woman, Band 4, former customer services advisor)

I stopped working because of pressure of having Thalidomide in the workplace. Could not go to the toilet in the time allocated to people (man, Band 3, former mortgage customer service advisor)

While my disability is not major, it is visible and prevented me from becoming a manager in [major national retail chain]. I have evidence to prove this (woman, Band 1, former financial services administrator)

Pain, discrimination and various psychological barriers have always placed me at a disadvantage (man, Band 3, now self-employed trainer/coach)

I would have liked to work abroad but ... psychologically I was never brave enough to go abroad and work in case I got rejected because of the way I looked (woman, Band 1, part-time supply teacher)

Pensions

Of the 64 Thalidomiders who responded to the in-depth follow-up survey, 43 said their future employers'/company or personal pension entitlements had been adversely affected; a further 6 said they weren't yet sure (many of the remainder did not answer the question). Those who had already stopped work had made fewer years' contributions:

My pension is based on 23 years service rather than the 40 I should have worked (woman, Band 1, former call centre team leader/manager)

As I've had to give up work aged 50, there is a shortfall in not only pension contributions by me and my employer but also no earnings for 18 years, given state retirement age is now 68 (man, Band 2, former assistant payroll manager)

It [pension] has already been capped and I can access it now but it will be a fraction of what I should be entitled to at 60 (woman, Band 2, former special needs teacher who moved from full-time to part-time teaching before stopping work altogether)

Yes, because obviously not paying into work pension scheme any more (woman, Band 1, former pizza production line worker)

Yes, have had to retire early and take reduced pension at 55 rather than 60 (man, Band 2, former administration worker)

Others referred to the effect of reduced earnings on their pension entitlements:

If I could have got higher paid positions, it would have made a difference to what I could have saved (woman, Band 1, former financial services administrator)

Yes [my pension has been affected] purely due to earnings being low and having to give up my personal pension at one point, then being so far behind I never re-started it (man, Band 4, self-employed selling electronic components)

A few noted that their reduced earnings had meant they simply could not afford to contribute to an employers'/company or private pension:

As reduced hours, I felt I could not continue to contribute to pension as required my salary (woman, Band 3, senior speech/language therapist)

One respondent noted that the adverse impact of Thalidomide on his own employment had also prevented him safeguarding his family's future security through pension dependents' benefits:

Lack of a proper job has meant there is no pension for loved ones after my death... This is giving me concern (man, Band 3, former teacher)

The impact of Thalidomide on family members' employment and earnings

The follow-up survey asked whether Thalidomide damage and/or related health problems had affected the employment or earnings of other family members. A number of respondents referred to the sacrifices made by their parents – particularly mothers – whose careers had been seriously affected in the past:

My parents were severely affected due to looking after me as a child. We were exceptionally poor (woman, Band 5, gave up working as customer services advisor)

... My mother of course, who left work in the 1960s to support me through operations/hospital stays (man, Band 3, gave up work as IT technician)

However, it is not possible now to estimate the lifetime earnings lost by parents.

Additionally, almost a third of the 64 Thalidomiders reported that the career opportunities and earnings of their partners had been adversely affected. For a few, these effects had been long-term:

Completely – my wife has been on a low self-employed salary for ever (man, Band 3, currently part-time self-employed)

Husband has never worked any overtime, only the basic working hours.... All the other employees on his shift work overtime to make up their money. He is needed at home to help me (woman, Band 3, part-time NHS admin assistant)

My husband has had to move with me to the north of England, partly because of my health issues, some of which were Thalidomide-related. This has affected his chances of employment as ... we would have been better off nearer London (woman, Band 1, gave up work as financial services administrator)

Others reported more recent decisions by partners to reduce their work commitments. These decisions were sometimes partly made for other reasons, such as the partner's redundancy or poor health. However, they all also took into account the increasing support needed by the Thalidomider:

Yes, my husband went part-time 10 years ago as I needed more help with daily living tasks (woman Band 5, gave up local authority clerical job)

My husband 'retired' early to be more with me (woman, Band 5, gave up work as computer programmer)

My husband was made redundant in 2009 and decided not to seek other formal employment as he fulfils caring roles for me throughout the day (woman, Band 3, formerly sales/marketing analyst, now self-employed dressmaker)

My wife has lost out on work positions and promotions to work around me (man, Band 2, recently gave up self-employed business)

Without a doubt, and the impact of this is ever-increasing as we age and our care/disability-related needs rapidly grow over time. My partner gave up a full-time management position in 2007 in order to focus on my then current, and now much greater, daily care needs (man, Band 3, former company director)

One woman (Band 4), now only doing voluntary work, explained:

I finished working because my husband, also a Thalidomider, needed more support at home. We have no family support.

Finally, a few follow-up survey respondents anticipated that their partners might need to reduce their hours of work or give up work altogether in future as their own support needs increased.

4. ESTIMATED LIFETIME EARNINGS LOSSES FOR SEVEN EXEMPLAR CASE STUDY THALIDOMIDERS

Introduction

This section presents estimates of the lifetime earnings lost by seven Thalidomiders, referred to as 'Case studies', all of whom have found it increasingly difficult to continue with their former jobs and hours of work as their health deteriorated. The seven case studies are not necessarily typical or representative, but cover the five severity Bands. Six of the seven had relatively ordinary careers; their calculated losses can therefore be regarded as modest. However, in any group there will be exceptional performers, so a seventh case study who had performed at a particularly high level in her chosen career (and would have achieved even higher had it not been for her impairment) has been included.

The case studies include men and women from all five severity Bands. They suggest there is no clear relationship between severity of impairment and levels of actual or potential lost earnings. Significantly, however, they do suggest that women Thalidomiders may be as likely to incur major earnings losses as men. Although it has not been possible to estimate the future pensions lost by these seven Thalidomiders, it is very likely that significant future losses will arise because of the reduction and/or loss of earnings at what would otherwise have been the high points of their careers.

The illustrative figures have been prepared using the principles employed in personal injury compensation claims. For each case study, two sets of figures are presented: the first set estimates loss of earnings without interest; the second includes estimates of the interest foregone on past losses. Three of the seven Thalidomiders (case studies) (1, 3 and 7) considered that their actual work and career histories were not what they would have chosen. They had evidence of attempts early in their lives to secure training and careers in more skilled - and higher paid - occupations; these attempts had been frustrated by Thalidomide impairments. For these three Thalidomiders, additional estimates are presented of the earnings lost as a result of being unable to pursue their desired occupation/career, because of their Thalidomide damage.

Case study 1: woman, impairment Band 1

Case study 1: Career summary

Case study 1 commenced full-time employment aged 20 in 1982 as an administrative/clerical officer earning between £9,000 and £11,000 gross p.a. Thereafter, from 1988 - 2008 she was employed full-time as a team manager in a bank, earning up to £23,000 gross p.a. at her peak.

In December 2008, because of consequential Thalidomide damage, Case Study 1 was unable to continue in her full-time team manager post. She moved to working in the bank call centre for 18 hours a week for a gross annual salary of £11,000 – a loss of £12,000 p.a. In 2011, Case Study 1's health problems became unmanageable and she was forced to be off sick for six months. During this time she received half pay. Case Study 1 retired on medical grounds in December 2011.

Case Study 1’s loss of future earnings is estimated on the assumption of Case Study not being disabled but continuing to work full-time in the bank as a team manager, without any salary increase, until the statutory retirement age of 67.

Case Study 1: Estimated actual earnings losses

Table 11. Case Study 1: Estimated actual earnings loss without interest

Head of Loss	Loss	Interest	Value
1. Loss of full-time wage from 2008-2011	£30,677.72	£0.00	£30,677.72
2. Loss of earnings from 2011-2016	£84,774.32	£0.00	£84,774.32
3. Loss of earnings due to 6 months at half pay	£3,950.05	£0.00	£3,950.05
Past Loss Total	£119,402.09	£0.00	£119,402.09
4. Future loss of earnings had LS continued working full-time in the same employment	£166,255.65		£166,255.65
Future Loss Total			£166,255.65
Total Past and Future Loss			£285,657.74

Table 12. Case Study 1: Estimated actual earnings loss with interest added

Head of Loss	Loss	Interest	Value
1. Loss of full-time earnings from 2008-2011	£30,677.72	£997.54	£31,675.26
2. Loss of earnings from 2011-2016	£84,774.32	£969.85	£85,744.17
3. Loss of earnings due to 6 months at half pay	£3,950.05	£105.03	£4,055.08
Past Loss Total	£119,402.09	£2,072.42	£121,474.51
4. Future loss of earnings had LS continued working full-time in the same employment	£166,255.65		£166,255.65
Future Loss Total			£166,255.65
Total Past and Future Loss with interest			£287,730.16

Case study 1: Estimated earnings loss without interest had she been able to pursue her desired career as a pharmacist

Case Study 1 had originally wanted to be a pharmacist. On leaving school, she applied for pharmacy training courses but was rejected on the grounds that her Thalidomide-impaired hands would prevent her handling pharmaceuticals. Her past and future earnings losses, had she been able to achieve her desired occupation and career are estimated below (Table 12)

Table 13. Case Study 1: Projected earnings loss without interest had she been able to pursue desired career as pharmacist

Projection of earnings	Projection	Interest	Value
1. Projected earnings 1984 - 1986	£9,859.20	£0.00	£9,859.20
2. Projected earnings 1986 - 1991	£47,805.85	£0.00	£47,805.85
3. Projected earnings 1991 - 1992	£11,580.59	£0.00	£11,580.59
4. Projected earnings 1992 - 1993	£13,160.36	£0.00	£13,160.36
5. Projected earnings 1993 - 2000	£106,650.76	£0.00	£106,650.76
6. Projected earnings 2000 - 2010	£229,088.81	£0.00	£229,088.81
7. Projected earnings 2010 - 2016	£178,350.08	£0.00	£178,350.08
Projected Past Loss Total	£596,495.65	£0.00	£596,495.65
8. Further career earnings as a Pharmacist from date of calculation	£261,340.81		£261,340.81
Projected Future Loss Total			£261,340.81
Projected Career Earnings Total as a Pharmacist			£857,836.46

Case Study 1: Summary of earnings losses

Had Case Study 1 not had to work part-time before stopping work altogether, but continued to work full-time in her original occupation until statutory retirement age, she could have earned an additional £285,657.74 (without interest), or £287,730.16 (interest added).

Alternatively, had Case Study 1 been able to become a pharmacist as she originally wanted, she could have earned approximately £857,836.46 over her lifetime. This is £540,836.46 more than her actual lifetime earnings of £317,000.00.

Case Study 2: Woman, impairment Band 2

Case Study 2: Career summary

Case Study 2 commenced full-time work in 1987 at age 26, as a teacher for autistic children and continued in this capacity until 2007. Then, because of Thalidomide-related health problems, she cut her hours to part-time, in the same job, until 2014 when she stopped work altogether.

As a teacher, Case Study 2 would normally have obtained her degree and teacher training qualification and secured employment by approximately age 23 (3-year degree course, 1 year teacher training and a short period in the open labour market before securing employment). However, Case Study 2 did not commence employment until 1987, age 26, thus experiencing 3 years loss of potential earnings. Case Study 2's salary in 1987 was £10,000. It is likely therefore that her salary would have been in the region of £10,000 p.a. had she commenced employment in 1984.

As a result of Thalidomide-related health problems, Case Study 2 had to cut her hours to part-time in 2007. Her income was reduced to £12,000 gross per annum. Again as a result of Thalidomide-

related problems, Case Study 2 retired in 2014 at the age of 52; her statutory retirement age would normally have been 67.

Case Study 2: Estimated actual earnings loss

Table 14. Case Study 2: Estimated earnings loss without interest

Head of Loss	Loss	Interest	Value
1. Loss of earnings 1984 - 1987	£21,900.00	£0.00	£21,900.00
2. Loss of earnings 2007 - 2014	£103,483.68	£0.00	£103,483.68
3. Loss of earnings 2014 - date of calculation	£62,180.28	£0.00	£62,180.28
Past Loss Total	£187,563.96	£0.00	£187,563.96
4. Future Loss of earnings	£231,067.36		£231,067.36
Future Loss Total			£231,067.36
Total Past and Future Loss			£418,631.32

Table 15. Case Study 2: Estimated earnings loss with interest added

Head of Loss	Loss	Interest	Value
1. Loss of earnings 1984 - 1987	£21,900.00	£3,917.91	£25,817.91
2. Loss of earnings 2007 - 2014	£103,483.68	£4,618.89	£108,102.57
3. Loss of earnings 2014 - date of calculation	£62,180.28	£357.95	£62,538.23
Past Loss Total	£187,563.96	£8,894.75	£196,458.71
4. Future Loss of earnings	£231,067.36		£231,067.36
Future Loss Total			£231,067.36
Total Past and Future Loss with interest			£427,526.07

Case Study 2: Summary of earnings losses

Case Study 2 entered the labour market 3 years later than would normally be expected for a teacher. Because of Thalidomide-related health problems, she stopped working full-time at age 46 and worked part-time for seven years. Again as a result of Thalidomide-related problems, Case Study 2 retired in 2014 at the age of 52, although her statutory retirement age would have been 67. It is estimated that her lifetime earnings losses amount to £418,631.32 (without interest) and £427,526.07 (with interest added).

Case Study 3: woman, impairment Band 3

Case Study 3: Career summary

Case Study 3 commenced full-time employment in 1983 in a management role. She continued full-time employment until 2005 in managerial roles; between 2002 and 2005 Case Study 3 was project manager of a multi-partner EU-funded project, with a gross salary of £37,000 per annum plus free accommodation, company car and free utility/council tax bills.

In 2005 Case Study 3 took 12 months unpaid leave and thereafter 12 months sick leave as a result of increasingly severe Thalidomide-related pain and loss of co-ordination. Having already taken 12 months sick leave, she was given 6 months full pay for further sickness absence followed by 6 months at half pay. She therefore lost £9,250 gross earnings for her 6 months at half pay.

Case Study 3 retired in 2006 at age 45 as a result of loss of stamina resulting from her Thalidomide-related health problems. Had she continued in paid work it is assumed that she would have continued to receive regular pay increases.

Case Study 3: Estimated actual earnings loss

Table 16. Case Study 3: Estimated actual earnings loss without interest

Head of Loss	Loss	Interest	Value
1. Loss of earnings 2005 - 2006	£27,079.38	£0.00	£27,079.38
2. Loss of earnings 2006 - 2007	£8,118.04	£0.00	£8,118.04
3. Loss of earnings 2007 - 2010	£86,086.90	£0.00	£86,086.90
4. Loss of earnings 2010 - 2016	£202,713.12	£0.00	£202,713.12
Past Loss Total	£323,997.44	£0.00	£323,997.44
5. Future loss of earnings	£258,832.74		£258,832.74
Future Loss Total			£258,832.74
Total Past and Future Loss			£582,830.18

NB This Scenario has not factored in the potential loss of earnings from 1981 – 1983 when Case Study 3 found it difficult to find employment upon leaving university as interviews were often about her disability. Case Study 3's first job in 1983 paid a salary of approximately £5,000 gross per annum, so 2 years' loss generates an additional potential loss of approximately £10,000 gross.

Table 17. Case Study 3: Estimated earnings loss with interest added

Head of Loss	Loss	Interest	Value
1. Loss of earnings 2005 - 2006	£27,079.38	£6,669.66	£33,749.04
2. Loss of earnings 2006 - 2007	£8,118.04	£1,512.39	£9,630.43
3. Loss of earnings 2007 - 2010	£86,086.90	£6,620.71	£92,707.61
4. Loss of earnings 2010 - 2016	£202,713.12	£3,194.67	£205,907.79
Past Loss Total	£323,997.44	£17,997.43	£341,994.87
5. Future loss of earnings	£258,832.74		£258,832.74
Future Loss Total			£258,832.74
Total Past and Future Loss with interest			£600,827.61

Again these estimates do not include a further £10,000 gross loss because of difficulties EB experienced in obtaining employment between 1981 and 1983.

Case Study 3: Estimated earnings loss without interest had she been able to pursue her desired career as a doctor

Case Study 3 had wanted to become a doctor. While still at school she explored options for medical training but received written responses outlining the risks and reasons why she could not become a doctor, because of her Thalidomide impairment, for example because she would be unable to lift patients.

We have therefore estimated what Case Study 3 could have realistically earned had she qualified and pursued a career as a doctor, with projected incomes for each phase of her career as a medical practitioner. Table 17 estimates indicate Case Study 3's lost earnings had she practiced as a physician.

Table 18. Case Study 3: Estimated earnings loss without interest had she been able to pursue her desired medical career and work as a physician

Projection of Earnings	Estimate	Interest	Value
1. Projected earnings 1983 - 1985	£11,995.36	£0.00	£11,995.36
2. Projected earnings 1985 - 1987	£14,394.43	£0.00	£14,394.43
3. Projected earnings 1987 - 1993	£67,462.51	£0.00	£67,462.51
4. Projected earnings 1993 - 2000	£171,198.56	£0.00	£171,198.56
5. Projected earnings 2000 - 2006	£194,704.06	£0.00	£194,704.06
6. Projected earnings 2006 - 2016	£428,226.76	£0.00	£428,226.76
Projected Past Earnings Total	£887,981.68	£0.00	£887,981.68
7. Future projected earnings as a Physician/medical practitioner	£333,571.54		£333,571.54
Future Projected Earnings Total			£333,571.54
Total Projected career earnings as a Physician			£1,221,553.22

Case Study 3 had a good academic background and strong (non-medical) career until Thalidomide-related health problems forced her to retire. It is therefore reasonable to assume significant career progression would have occurred had she been able to become a doctor (had she not been dissuaded from a medical career as a result of her Thalidomide condition). Table 18 shows the earnings lost had Case Study 3 become a consultant.

Table 19. Case Study 3: Estimated earnings loss without interest had she been able to pursue her desired medical career and progress to consultant

Projection of earnings	Estimate	Interest	Value
1. Projected earnings 2000 - 2006	£254,558.44	£0.00	£254,558.44
2. Projected earnings 2006 - 2016	£610,531.07	£0.00	£610,531.07
3. Projected earnings 1983 - 2000	£265,050.86	£0.00	£265,050.86
Projected Past Earnings Total	£1,130,140.37	£0.00	£1,130,140.37
4. Future projection as a Consultant	£536,563.94		£536,563.94
Projected Future Earnings Total			£536,563.94
Total Projection for a career as a Consultant			£1,666,704.31

Case Study 3: Summary of earnings losses

Case Study 3 was unable to pursue her original ambition of training to be a doctor. She was unable to obtain work for 2 years after graduating because of her disability. She worked full-time for 22 years as a project manager, with increasingly substantial additional benefits. As a result of taking unpaid leave and sick leave, and then retiring early because of Thalidomide-related health problems, it is estimated she has lost or forgone earnings of £582,830.18 (without interest)/ £600,827.61 (with interest).

Had Case Study 3 been able to pursue her original career plan of becoming a doctor, it is estimated she has lost earnings of £1,221,553.22 had she practiced as a physician, or £1,666,704.31 had she progressed to consultant status. Her actual lifetime earnings were approximately £475,000. Her net lifetime earnings losses were therefore £746,553.22 had she practiced as a physician; or £1,191,704.31 had she progressed to consultant.

Case Study 4: man, impairment Band 3

Case Study 4: Career summary

Case Study 4 began employment in 1977 at age 16 in a cotton factory and was made redundant in 1982. By then he was earning £15,000 gross per annum.

Thereafter, he had a 3 year gap in employment and considered that prospective employers were deterred from employing him because of his Thalidomide impairment. Indeed, he attended approximately 100 interviews during the 3 years from 1982 – 1985 but was unable to get a job. His

lost earnings during these 3 years have been estimated on the basis of his last wage of £15,000 per annum, less tax and NI.

Between 1985 and 1990 Case Study 4 worked as a sheet metal handler and welder for an engineering firm. He was made redundant in 1990 and subsequently retired on health grounds. His loss of future earnings has been estimated on the assumption that, without his Thalidomide impairment, he would have continued working up to the statutory retirement age of 67.

Case Study 4: Estimated actual earnings losses

Table 20. Case Study 4: Estimated actual earnings loss without interest

Head of Loss	Loss	Interest	Value
1. Loss of earnings from 1990 to date of calculation	£395,546.39	£0.00	£395,546.39
2. Loss of earnings during 1982 - 1985	£38,152.32	£0.00	£38,152.32
Past Loss Total	£433,698.71	£0.00	£433,698.71
4. Future loss of earnings	£141,682.84		£141,682.84
Future Loss Total			£141,682.84
Total Past and Future Loss			£575,381.55

Table 21. Case Study 4: Estimated earnings loss with interest added

Head of Loss	Loss	Interest	Value
1. Loss of earnings from 1990 to date of calculation	£395,546.39	£183,207.00	£578,753.39
2. Loss of earnings during 1982 - 1985	£38,152.32	£93,217.54	£131,369.86
Past Loss Total	£433,698.71	£276,424.54	£710,123.25
3. Future Loss of earnings	£141,682.84		£141,682.84
Future Loss Total			£141,682.84
Total Past and Future Loss with interest			£851,806.09

Case Study 4: Summary of earnings losses

Case Study worked in semi-skilled manual jobs. He had a period of unemployment where he was unable to get work because of his disability. He was made redundant in 1990 and subsequently retired on health grounds. His lifetime earnings losses are estimated as £575,381.55 (without interest) and £851,806.09 (with interest added).

Case Study 5: woman, impairment Band 3

Case Study 5: Career summary

As a child, Case Study 5 was deterred from taking up a grammar school place as her parents were advised by her GP that she would be unable to manage the daily train journey. She subsequently wanted to obtain employment in medicine but was not permitted to study Chemistry in school - she was told it was too dangerous because of her Thalidomide impairment. Case Study 5 therefore trained in the closest subject she could find – speech and language therapy - which would still enable her to work in a medical environment.

Case Study 5 commenced employment in 1983 as a Speech and Language Therapist and continues in this role to date (2016). However, since 2013 Case Study 5 has reduced her hours to 4 days per week because of Thalidomide-related health problems. She currently earns £48,000 gross per annum, but was previously earning £60,000 gross per annum working full-time.

Because of Thalidomide-related pain, Case Study 5 anticipates retiring in 2019, approximately 8 years before her statutory retirement age. She anticipates continuing to work 4 days a week until then.

Case Study 5: Estimated actual earnings loss

Table 22. Case Study 5: Estimated actual earnings loss without interest

Head of Loss	Loss	Interest	Value
1. Loss of earnings 2013 - 2016	£39,524.12	£0.00	£39,524.12
Past Loss Total	£39,524.12	£0.00	£39,524.12
2. Future Loss of earnings	£277,630.82		£277,630.82
Future Loss Total			£277,630.82
Total			£317,154.94

Table 23. Case Study 5: Estimated actual earnings loss with interest added

Head of Loss	Loss	Interest	Value
1. Loss of earnings 2013 - 2016	£39,524.12	£350.83	£39,874.95
Past Loss Total	£39,524.12	£350.83	£39,874.95
2. Future Loss of earnings	£277,630.82		£277,630.82
Future Loss Total			£277,630.82
Total Past & Future Loss with interest			£317,505.77

Case Study 5: Summary of earnings losses

From secondary school, CD was deterred from working in her chosen occupation of medicine as she was not allowed to study chemistry. She therefore trained as a speech and language therapist and worked full-time in this role until 2013. She now works 4 days a week and plans to retire 8 years before statutory retirement age. It is estimated that her lifetime earnings losses amount to £317,154.94 (without interest)/£317,505.77 (with interest added).

Case Study 6: woman, impairment Band 4

Case Study 6: Career summary

Case Study 6 began work in 1979 at age 17, employed full-time as an administrative clerk. She continued in full-time employment in administrative roles until June 2000 when she was made redundant, with a gross salary including bonus of £14,000.

Case Study 6 retired in February 2005 because of increasing Thalidomide-related health problems.

Case Study 6: Estimated actual earnings loss

Table 24. Case Study 6: Estimated actual earnings loss without interest

Head of Loss	Loss	Interest	Value
1. Loss of earnings 2000 - 2016	£184,143.00	£0.00	£184,143.00
Past Loss Total	£184,143.00	£0.00	£184,143.00
2. Future Loss of earnings	£109,871.15		£109,871.15
Future Loss Total			£109,871.15
Total Past and Future Loss			£294,014.15

Table 25. Case Study 6: Estimated actual earnings loss with interest added

Head of Loss	Loss	Interest	Value
1. Loss of earnings 2000 - 2016	£184,143.00	£29,705.64	£213,848.64
Past Loss Total	£184,143.00	£29,705.64	£213,848.64
2. Future Loss of earnings	£109,871.15		£109,871.15
Future Loss Total			£109,871.15
Total Past and Future Loss with interest			£323,719.79

Case Study 6: Summary of earnings losses

Although Case Study 6 did not have a high paid job, she worked full-time for 21 years until she was made redundant. She then had 5 years without paid work before deciding to retire in 2005 because of increasing Thalidomide-related health problems. Her lost earnings are estimated to be £294,014.15 (without interest)/ £323,719.79 (with interest added).

Case Study 7: Woman, impairment Band 5

Case Study 7 Career summary

Case Study 7 worked as an audio typist from 1981-1989 with a salary of £3,000 gross per annum. From 1989 and 1996 she worked full time as a clerical assistant in a social work department with a salary of £17,000 gross per annum. In 1996, because of Thalidomide-related health problems, Case Study 7 reduced her hours to 18.5 per week, earning £7,700 gross per annum. She continued working part-time for a further 14 years.

Case Study 7 stopped work in 2010 because of Thalidomide-related health problems. Her loss of earnings are estimated on the assumption that she would have continued to work full-time and receive a salary of £17,000 gross per annum plus inflation until she reached her statutory retirement age of 67 in 2028, had she not experienced these problems.

Case Study 7 : Estimated actual earnings loss

Table 26. Case Study 7 Estimated earnings loss without interest

Head of Loss	Loss	Interest	Value
1. Loss of earnings from 2010-2016	£88,732.08	£0.00	£88,732.08
2. Loss of earnings from 1996-2010	£183,988.48	£0.00	£183,988.48
Past Loss Total	£272,720.56	£0.00	£272,720.56
3. Future loss of earnings	£120,173.95		£120,173.95
Future Loss Total			£120,173.95
Total Past and Future Loss			£392,894.51

Table 27. Case Study 7 Estimated earnings loss with interest added

Head of Loss	Loss	Interest	Value
1. Loss of earnings from 2010-2016	£88,732.08	£1,369.10	£90,101.18
2. Loss of earnings from 1996-2010	£183,988.48	£5,740.44	£189,728.92
Past Loss Total	£272,720.56	£7,109.54	£279,830.10

3. Future loss of earnings	£120,173.95		£120,173.95
Future Loss Total			£120,173.95
Total Past and Future Loss including interest			£400,004.05

Case Study 7: Estimated earnings loss without interest had she been able to pursue her desired career

Case Study 7 would have liked to have been a speech therapist. This was a realistic aspiration; her brother is a quantity surveyor and her sister is a radiographer. Instead she held an administrative/clerical post for the 29 years she was able to work.

Table 28. Case Study 7: Estimated earnings loss without interest had she been able to pursue her desired career as a speech therapist

Head of Loss	Projected Earnings	Interest	Value
1. Projected earnings between 2010-2016	£153,888.48	£0.00	£153,888.48
2. Projected earnings between 1989-2010	£340,535.90	£0.00	£340,535.90
3. Projected earnings between 1981-1989	£43,307.28	£0.00	£43,307.28
Past Loss Total	£537,731.66	£0.00	£537,731.66
4. Future projected earnings as a speech therapist	£204,848.64		£204,848.64
Future Loss Total			£204,848.64
Total Projection			£742,580.30

Case Study 7: Summary of earnings losses

Case Study 7 missed the opportunity of potentially earning £392,894.51 (without interest)/ £400,004.05 (with interest) as a result of reducing her working hours to part-time and then retiring 18 years before her statutory retirement age. Had Case Study 7 been able to train and work as a speech therapist, her lifetime net earnings would have been £742,580.30. Her actual lifetime net earnings were approximately £187,243.28 (i.e. gross earnings of £250,800 less tax and NI at 25.34%). Her net earnings loss because of being unable to pursue her desired career was therefore £555,607.00.

Conclusions

The seven Thalidomiders whose lifetime earnings losses have been calculated, using well-established assumptions and methodologies applied in personal injury compensation claims, are not necessarily representative or typical of all UK Thalidomiders. However, they do include women and men who have pursued relatively ordinary careers and whose impairments cover the full range of severity

Bands. They illustrate the difficulties described by Thalidomiders throughout this report, of gaining initial entry to the labour market (particularly in the occupations they aspired to do); re-entering the labour market after redundancy or periods of unemployment; and – increasingly common - remaining in full-time work until statutory retirement age. The calculations summarised here show the impacts of these difficulties on their lifetime earnings, with losses ranging from £285,657.74 (without interest) to £851,806.09 (with interest). Alternative scenarios, where lifetime earnings have been estimated on their desired or aspired rather than actual occupations, generate even larger net losses, of up to £1,191,704.31.

Significantly, there appears no clear relationship between level of impairment and levels of earnings losses. Significant lifetime losses are apparent across all five impairment severity Bands, and for women and men. Where Thalidomiders experienced long periods out of work earlier in their careers, the interest on past losses significantly increases their total earnings loss.

Appendix A. Thalidomide Trust Health and Wellbeing Survey: Additional Analysis by Type of Impairment

The Health and Wellbeing Survey also looked at the impacts of different types or clusters of impairments on Thalidomiders' current and changing work situations.

Current Work Situation

Thalidomiders with lower limb impairments, either with or without an upper limb impairment, were most likely not to be working. Those with no limb damage were most likely to work full-time (26%); all of this group were deaf/partially deaf and/or had facial damage, including 12 who were also partially sighted.

Table A1 Current employment status and type of impairment

	N° in group	I work full-time	I work part-time	I have chosen not to work	I am unable to work
Lower limb only	14	2 [15%]	1 [8%]	2 [15%]	8 [62%]
Upper & Lower limb mild/mod	39	4 [10%]	7 [18%]	11 [28%]	17 [44%]
Upper & Lower limb severe	50	3 [6%]	8 [16%]	6 [12%]	33 [66%]
Upper limb mild	23	6 [26%]	3 [13%]	5 [22%]	9 [39%]
Upper limb moderate	69	11 [16%]	23 [34%]	11 [16%]	23 [34%]
Upper limb severe	61	8 [13%]	13 [22%]	7 [12%]	32 [53%]
Upper limb very severe	52	8 [15%]	15 [29%]	5 [10%]	24 [46%]
Sensory impairment and/or facial damage but no limb damage	42	12 [29%]	7 [17%]	9 [21%]	14 [33%]

Note: Percentages are of the impairment group

Changes in Work Situation between 2000 and 2015

Thalidomiders with upper and lower limb impairments were most likely to have stopped working - closely followed by those with sensory impairment and/or facial damage, but no limb damage (Table A2 and Figure A1).

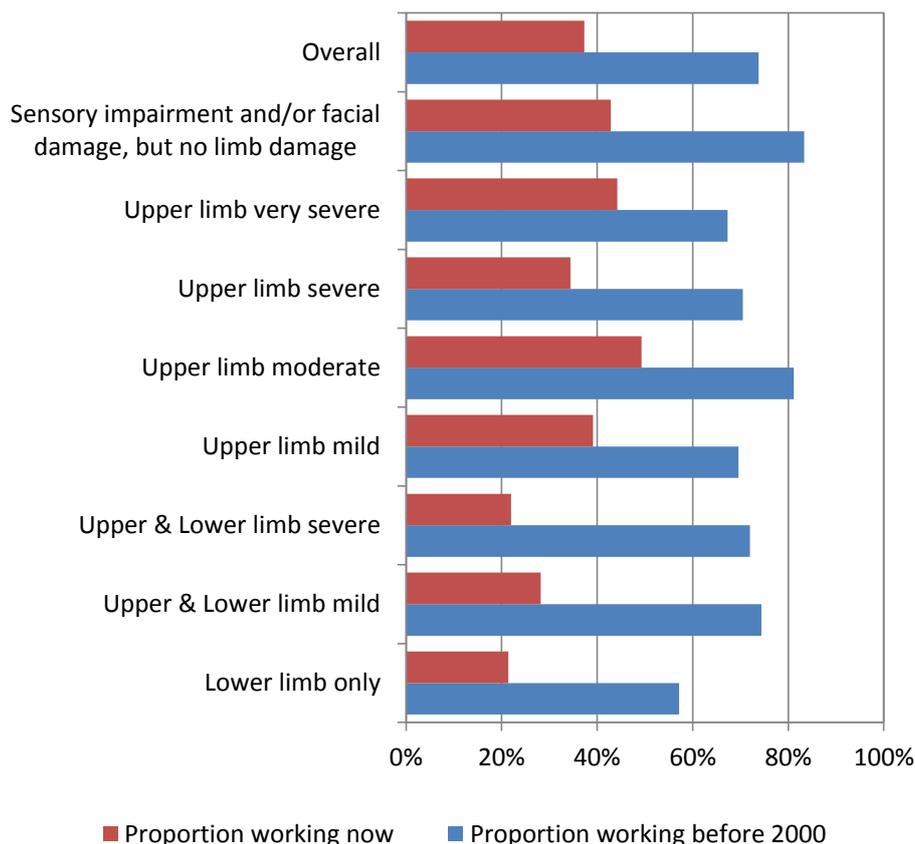
Table A2 Changes in work situation between 2000 and 2015 and type of impairment

	N° in group	I have reduced my working hours	I have changed the type of work I do	Those who have stopped working since 2000
Lower limb only	14	0 [0%]	1 [8%]	5 [38%]
Upper & Lower limb mild/mod	39	9 [23%]	3 [8%]	18 [46%]
Upper & Lower limb severe	50	7 [14%]	2 [4%]	25 [50%]
Upper limb mild	23	2 [9%]	1 [4%]	7 [30%]
Upper limb moderate	69	21 [31%]	13 [19%]	22 [32%]

Upper limb severe	61	12 [20%]	4 [7%]	22 [37%]
Upper limb very severe	52	7 [13%]	6 [12%]	12 [23%]
Sensory impairment and/or facial damage, but no limb damage	42	5 [12%]	5 [12%]	17 [41%]

Note: Percentages are of the number in the impairment group

Figure A1 Proportion of survey respondents working pre and post 2000 by type of impairment



Anticipated Changes in Work Situation in the Next five Years

Although numbers are small, of those currently working, almost four-fifths of Thalidomiders with only mild upper limb impairments anticipated making some change to their work situation over the next five years (Table A3). Again this illustrates the non-linear relationship between severity of impairment and the impact on work situations.

Table A3 Anticipated changes in work situation by type of impairment

	All those working full or part time	Those who think they might have to reduce their hours	Those who think they might have to change the type of work	Those who think they might have to stop working	Those who think they might make any changes
Lower limb only	3	1 [33%]	1 [33%]	2 [67%]	2 [67%]
Upper & Lower limb mild/mod	11	3 [27%]	2 [18%]	8 [73%]	8 [73%]
Upper & Lower limb severe	11	3 [27%]	1 [9%]	2 [18%]	5 [45%]
Upper limb mild	9	3 [33%]	1 [11%]	3 [33%]	7 [78%]
Upper limb moderate	34	9 [26%]	7 [21%]	10 [29%]	20 [59%]
Upper limb severe	21	7 [33%]	0 [0%]	10 [48%]	15 [71%]
Upper limb very severe	23	5 [22%]	3 [13%]	7 [30%]	13 [57%]
Sensory impairment and/or facial damage - no limb damage	18	6 [33%]	7 [39%]	3 [17%]	11 [61%]

Note: Percentages are of those in the Band who are currently working

Appendix B Pro Forma for obtaining detailed loss of earnings information

The Thalidomide Trust

(In association with Mark Tempest of Fletchers solicitors)

Lifetime Earning Loss and Pension Provision / the Experience of a Selection of Beneficiaries

Schedules of Loss (using UK legal principles applied in personal injury cases)

Questions to Beneficiaries for the Selection of Exemplar Cases

[Any reference to employment includes self-employment – if self-employed please respond to the loss of income question by providing an estimate of your loss of net profit for the specified period, NOT loss of turnover of your business]

1.	DoB
2.	Gender
3.	Which best describes where you currently live? London, South (other), Midlands, North West, North East, North Wales, South Wales, Scotland
4.	If you have lived in one or more other areas since leaving full time education, please state the area and years of residence.
5.	Do you have children? If yes, please provide dates of birth.
6.	What most accurately describes your work history to date :
7.	Are you currently in paid employment? If so, please specify your job title or occupation.
8.	Are you full time or part time? If the latter, please state how many hours per week on average you work.
9.	What is your current annual salary? (Include any employment benefits).
10.	When did you start in your current employment?
11.	Have you suffered disruption in your current employment due to your Thalidomide impairment? If so, please provide approximate dates of Thalidomide related absences.
12.	Did you lose income as a result? If so, please state approximately how much.
13.	What was your previous employment before your current employment? Please specify job title or occupation.
14.	Was this full time or part time? If the latter, please state how many hours per week on average you worked.

15.	What was your annual salary in your previous job (approximately)? Include any employment benefits.
16.	When did you start in your previous employment? If there was a gap between previous and current employment please state how long this was and whether it was Thalidomide related.
17.	Did you suffer disruption in your previous job due to your Thalidomide impairment? If so, please provide approximate dates of Thalidomide related absences.
18.	Did you lose income as a result? If so, please state approximately how much.
19.	Did you experience any absences in either your current or previous jobs which were NOT Thalidomide related. If so, please give approximate dates and reasons.
20.	Using the following key which category best describes job (please answer separately for your current AND previous job);
	<ul style="list-style-type: none"> ○ Manual – non skilled ○ Manual – skilled ○ Administrative / clerical ○ Professional – junior / intermediate / senior ○ Officials or Management (all levels) ○ Sales ○ Academic (all levels) ○ Other – please specify
21.	In respect of your working life prior to starting your previous job, please provide a summary of your work history in the following format, since finishing in full time education (this can be drawn from memory but please be as accurate as you can);

Years from / to	Job Title	Occupation Using key	Full / Part time	Salary	T related absences from / to	Income Loss	Other absences from to

22.	Using your best assessment, do you believe that your career path has stalled at any stage due to your impairment? Please summarise.
23.	As a result of your Thalidomide impairment, do you experience any of the following problems at work;
	<ul style="list-style-type: none"> • Access • Special equipment needed • Travel/commute • Require regular assistance from colleagues – e.g. personal care • Any other, please specify
24.	Has your current employer adapted your working conditions to accommodate your impairment (e.g. alterations to work space, or flexi time)?
25.	If you were to lose your current job, for any reason, do you regard yourself at disadvantage on the labour market in relation to finding replacement employment? If so please give brief reasons specific to your field of employment.
26.	In your best assessment, are you likely to be able to work up to your normal retirement age for your age group, or do you anticipate having to retire or down shift (i.e. go part time, reduce your responsibilities or restrict your range of operation) earlier? If so, by how many years?
27.	Have you ever been in a defined benefits pension scheme? I.e. one that provides a pension based upon your final salary. These are usually if you have worked in the public sector or could be some company schemes. If so, please provide approximate dates from and to.
28.	If so, (defined benefits) please provide your approximate monthly (or yearly) contribution AND that of your employer
29.	Have you ever been in a money purchase pension scheme? This an individual contract which you pay into and which pays a lump sum and annuity, based upon the value of the investment on the date you retire. If so, (money purchase) please provide approximate dates from and to. If not please go to question 30.
30.	If so, (money purchase) please provide your approximate monthly (or yearly) contribution. Please also state whether your employee has also paid in and if so approximately, how much.
31.	If so, (money purchase), do you have a recent valuation of the capital sum to your credit in your pension? If so, please provide.
32.	In your best assessment, but for your Thalidomide related impairments, do you think that you would have taken a different career route? If so, please state what it is likely to have been. Please also provide some evidence or justification. For example, by reference to what your siblings, or other relatives have done; or due to an aptitude that you are aware of in yourself which you have been unable to develop and/or any specific loss of opportunity that you can point to.

33.	Has the employment or earnings of any of your family members been affected by them taking caring responsibilities arising from your Thalidomide damage and/or health problems? If so please tell us more about this, explaining which family members, what type of work was affected and over what time period