The Social Security (Incapacity for Work) Bill [Bill 32 of 1993/94]

Research Paper 94/13

20 January 1994

The Social Security (Incapacity for Work) Bill was presented on 12 January 1994 and is due to have its Second Reading on 24 January 1994. It will replace the current sickness and invalidity benefits with a new benefit, incapacity benefit from April 1995. This will involve lower rates of benefit for certain groups and a more stringent medical test.

Patricia Strickland
Education & Social Services Section

House of Commons Library

CONTENTS

Part I Background

A. Introduction

From April 1995, the new incapacity benefit will replace two existing benefits. These are sickness benefit and invalidity benefit. The change will involve lower rates of benefit for certain groups of new claimants, although existing invalidity benefit claimants will have their rates of benefit protected. In addition, a new "objective medical test" will be introduced. Like new claimants, most existing invalidity benefit claimants will eventually have to undergo the new medical test, although some are exempted. Statutory sick pay, which is paid to most employees during the first 28 weeks of sickness and is administered by employers, will be simplified by abolishing the lower rate so that all claimants will get the higher rate. In other legislation currently going through Parliament,[1] the amount of reimbursement received by employers for statutory sick pay is to be cut, and invalidity benefit is to be brought into taxation, fulfilling a longstanding policy intention.

The Government also announced other changes at the same time as their plans for the new incapacity benefit. Incapacity benefit claimants are to be allowed to do up to 16 hours voluntary work without losing benefit. Disability working allowance claimants are to qualify for free prescriptions. The level of Government support for Motability (which helps some disabled people to buy or hire cars) is to be increased.

The Government's aims in reforming these benefits are to:

- curb the growing costs of sickness benefits
- provide a more rational structure of benefits
- encourage employers to improve the motivation and health of employees
- concentrate help on those genuinely incapable of work[2]

---

1 The Statutory Sick Pay Bill 1993/94 (see Library Research Paper 93/116) and the Finance Bill 1993/94.

2 Secretary of State for Social Security, Peter Lilley, HC Deb 1 December 1993, cc 1039-40.

The Bill will produce estimated gross savings of £550 million in 1995-96 and £1,450 million in 1996-97. Offset against these, there will be additional expenditure on income support and unemployment benefit of around £135 million in 1995-96 and £265 million in 1996-97.[3]

A description of the current benefits and how the new system will operate is given in Part II.

B. The rise in costs

1. Growth in invalidity benefit claims and expenditure

The number of invalidity benefit recipients has been growing ever since it was introduced in 1971. This is shown in the following table:

AVERAGE NUMBER OF PEOPLE CLAIMING
INVALIDITY BENEFIT in Great Britain

Financial year		Thousands
1972/73		430
1973/74		440
1974/75		450
1975/76		470
1976/77		510
1977/78		550
1978/79		600
1979/80		620
1980/81		620
1981/82		660
1982/83		700
1983/84		760
1984/85		825
1985/86		865
1986/87		935
1987/88		1,010
1988/89		1,100
1989/90		1,190
1990/91		1,265
1991/92		1,365
1992/93	estimated	1,490
1993/94	forecast	1,585

Sources: *Cm 2213 table 6*
Cmnd 8175
Cmnd 7049.ii
HC Deb 27/2/92 c587-597W

---

[3] Explanatory and financial memorandum to the Bill.

In 1992/3, £5,138m was spent on the basic element of invalidity benefit, with a further £962m on the earnings related element, making a total of £6.1bn. This compares with a total of £2,345 m in 1978/79 (at 1992/93 prices).[4]

2. Explanations for the growth

The Government has been concerned to investigate the possible reasons for the growth in invalidity benefit. The Prime Minister has said that it "beggars belief" that the rise in numbers is due entirely to health related reasons[5]:

> **The Prime Minister**: As I indicated earlier to the hon. Member for Edinburgh, Leith (Mr. Chisholm), we are considering invalidity benefit and I believe that it is entirely right that we should do so. Expenditure on invalidity benefit has risen from about £1.5 billion 10 years ago to more than £6 billion this year. No responsible Government could ignore an increase of that order. We have a duty to consider whether all that taxpayers' money is being wisely spent. The number of people receiving invalidity benefit has more than doubled during the past 10 years from 700,000 to more than 1.5 million. Frankly, it beggars belief that so many more people have suddenly become invalids, especially at a time when the health of the population has improved. I make no apologies for looking at this area of expenditure.

In order to investigate the growth in claims, the Government commissioned a series of studies, both by the Department of Social Security and by independent research establishments, in 1991. This programme of research resulted in the publication of five reports in the autumn of 1993. These are listed in Appendix 1.

Not surprisingly, these reports do not set out any single crude explanation for the rise in the numbers claiming benefit, whether it be that claimants are "swinging the lead" or that the Government is massaging the unemployment figures by encouraging claimants to switch from unemployment benefit to invalidity benefit. One of the reports[6] sets out some preliminary conclusions about the factors which may have led to the growth in IVB. However, the

---

4 *The growth of social security*, Department of Social Security, 1993, table 9b.

5 HC Deb 15 June 1993 c730.

6 *Invalidity benefit: A preliminary qualitative study of the factors affecting its growth*, Ritchie and Snape, Social and Community Planning Research, 3 September 1993.

authors stressed the tentative nature of their findings which they saw more as an agenda for further research than as evidence:

7.3 Possible influences on the of IVB

This final section of the report considers the various factors that may have led to the growth in durations of IVB claims. All the factors that have been indicated or identified as possible causes are listed with some suggestions as to the role they may have played. It must be stressed, however, that these suggestions are highly tentative and are not necessarily corroborated by other evidence. They are presented here as a set of hypotheses to be tested, either through the IVB surveys, through further analysis of existing Social Security or health statistics or through reviewing changes in policy or practice during the relevant period. It is therefore intended as an agenda for further research and discussion but not as definitive evidence in its own right.

Their findings were summarised as follows:

Possible Influnces on the growth of *IVB*

10. The study suggests that the growth in IVB durations, and hence the numbers of people receiving IVB, is the result of a compound or interaction of a number of factors. Those suggested as relevant and requiring further research or investigation are:

- **employment opportunities and services**
  - changes in levels of unemployment
  - decline of manual work
  - employers' responses to illness and disability
  - changes in procedures for receipt of Unemployment Benefit
  - priorities of the Disablement Resettlement Service

- **health, health services and social care**
  - the role of GPs
  - waiting lists for hospital treatment
  - increase of certain illnesses and conditions
  - care of dependant relatives

- **social security provision and administration**
  - the role of the Regional Medical Service
  - relative benefit levels
  - departmental guidance to GPs
  - conditions surrounding the interruption of IVB
  - the use of therapeutic work.

While the reasons for the growth in numbers are far from being perfectly understood, it is clear that it is due to people spending a longer time on IVB rather than to a large increase in new claimants.[7] This point is developed in a Research Briefing by the PSI[8]:

PSI estimates suggest that the increase in IVB claims overthe years has been made up as follows:

* 29 per cent of the extra cases have been people over pensionable age, drawing IVB rather than their pension for tax reasons. This increase hardly matters for public expenditure, because they would instantly become pensioners if they lost their IVB.

* 16 per cent of the extra cases have been due to the increasing number of women in the labour market, paying national insurance contributions, who qualify for IVB if they have to give up work.

* 13 per cent of the extra cases may have been due to a gradual increase over the years in the number of disabled people in the relevant age-groups.

* 42 per cent of the extra cases arise from genuine growth in the rate of claiming invalidity benefit among a stable population of disabled people.

According to these figures, less than half of the growth needs to be explained in terms of how and why any particular group come to be on benefit. Given that IVB is available for non-working disabled people, there are two possible explanations: either an increasing proportion of disabled people are being excluded from employment; or an increasing proportion of unemployed people are being judged to be incapable of work.

The consensus in the public debate appears to be that the latter of these hypotheses must be true: that more and more people have been obtaining sick notes to enable them to claim IVB rather than unemployment benefit. The blame has been variously attached to the claimants themselves ("malingers", "swinging the lead"), on doctors ("going soft") and on the goverrnnent and/or employment service ("massaging the unemployment figures"). If it were true that 1,000,000 people who would previously have been regarded as fit for work are now claiming IVB, then the true unemployment statistics would be nearer 4,000,000 than 3,000,000.

There is virtually no direct evidence that the threshold between being judged 'fit for work' and 'incapable' has changed over the years. There is, however, some evidence that the chances of employment have declined for people on the borderline.

---

[7] *Invalidity Benefit A longitudinal survey of new recipients*, Bob Erens and Deborah Ghate, DSS Research report No 20, 15 October 1993, p8.

[8] *Invalidity benefit Where will the savings come from?*, Policy Studies Institute Research Briefing, Richard Berthoud, June 1993, pp5-6.

The level of a lake will rise *either* if there is an increase in the flow of water in the streams leading into the lake; *or* if the river leading out of the lake is dammed. Research commissioned by the Department of Social Security has clearly shown that the rise in the total number of IVB payments each week has not been caused by an increase in the number of people claiming for the first time. It has been caused by a reduction in the number of people leaving the register. It is difficult to explain this in terms of more and more men and women obtaining sick notes from their doctors; those who have had sick notes seem less and less likely to get better, and back to work.

What seems to have happened is that there has been a fairly constant number of people having to leave work on health grounds over the years. But as the labour market has tightened, they have found it more and more difficult to get back into work. This leads to what the DSS policy paper refers to as a 'ratchet' effect The number of invalidity benefit claimants rises when unemployment goes up; but does not fall when unemployment goes down.

The explanation for the increasing cost of IVB lies in the economy as a whole, and in the hiring and firing practices of employers, rather than in a change in the behaviour of individual claimants or their doctors. The increase has not been caused by excessive ease of entry to the system, but by difficulty of exit. What is perceived as a problem for the government (increased costs) may actually be a problem for the claimants (inability to find appropriate work).

The underlying difficulty is in defining what is meant by 'incapable of work'. Clearly some disabled people could not possibly sell their labour. But there are two other groups of people for whom the answer is not so clear. One consists of those who might work if the opportunity arose, but whose chances of actually being offered employment in the current or immediately foreseeable state of the labour market are very small indeed. The other consists of those people who, though they may have some functional impairment, consider themselves as capable of work as anyone else; but they are consistently rejected by employers because they do not fit in with the firm's work practices. Both of these groups may be capable of work in the most literal interpretation of the phrase, but their disability prevents them from working. Should they be entitled to invalidity benefit? Or should they be labelled unemployed, expected to live on the lower-level short-term benefits, and asked to demonstrate that they are actively seeking work?

One concern which has been given media attention is the role of General Practitioners as the "gatekeepers" of invalidity benefit. The Government, drawing on evidence from its research programme, described some of the problems it had identified with this role in its consultation document:

Case law and the lack of a precise definition of incapacity

The decisions of the Commissioners and the Courts over many years have broadened and blurred the definition of incapacity for work far beyond the original policy intention. For example, in decision R(S)11/1951, a Tribunal of Commissioners explained that: 'a person is incapable of work within the meaning of the National Insurance Act 1946, section 11(2)(a)(ii) [now re-enacted as section 57(1)(a)(ii) of the Social Security Contributions and Benefits Act 1992] if, having regard to his age, education, experience, state of health and other personal factors there is no type of work which he can reasonably be expected to do.' The effect of this decision and others has been to reduce the impact of medical condition on the award of the benefit.

These decisions and the consequent lack of a clear definition of what constitutes medical incapacity have led to problems for adjudication officers, SSATs and doctors who issue statements to their patients. The broadening of the definition has increased the scope for adjudicating authorities to reach different conclusions in similar cases. Additionally, adjudication officers are required to show why a person is considered to be no longer incapable of work and demonstrate before an SSAT that the wide range of factors that tribunals are obliged to consider have been taken into account in their decisions. Many of these factors are not directly related to the question of incapacity. Under these circumstances, it is not possible to be completely confident that all claimants who are being awarded benefit are not capable of work.

Medical controls

The Department of Social Security has been concerned to understand the causes of the growth in the numbers of people receiving Invalidity Benefit. Over the last fourteen years, they have risen by nearly one million-from 600,000 in 1978/79 to nearly 1.5 million in 1993/94. Research has been carried out, both by the Department and by independent research establishments, to try to identify the factors involved. (Annex 3 lists the full research programme.) The preliminary evidence collected from *Invalidity Benefit: A preliminary qualitative study of the factors affecting its growth* (published by Social Community and Planning Reseach on 3 September 1993), suggested that the criteria for issuing statements of incapacity are difficult for General Practitioners to interpret. A more extensive qualitative study among General Practitioners' has shown the following:

(i) Forty General Practitioners were interviewed, all of whom believed that the majority of their patients receiving Invalidity Benefit woulld remain on it for the rest of their working lives. Those who took part in the study were generally unaware that the basis for issuing statements should change after six months of incapacity from judging capacity for the patient's normal work to capacity for any work.

(ii) Some thought that, by the time patients were on Invalidity Benefit, they had become confirmed as long-term sick and that, to be effective, any

control action needed to take place during the first six months of incapacity. Although in some cases the patient's medical condition clearly ruled out working, General Practitioners often found it difficult to judge how far capacity for work was limited by specific health problems rather than by a mix of factors including demoralisation and limited job opportunities.

(iii) It was clear that General Practitioners were not given enough information either about individual claims or the medical control system; this meant that they were unable to carry out their role as effectively as they should or, indeed would wish to do. There is no mechanism to tell them when a claimant moves from Sickness Benefit to Invalidity Benefit. General Practitioners made limited use of asking the Reference Service provided by BAMS for a second opinion for incapacity for work due to lack of awareness and understanding of its role. Some General Practitioners were reluctant to use the service because it called into question a judgement made on evidence supplied by the patient which they considered ran against the grain of the doctor-patient relationship. Some were unwilling to stop issuing medical statements if they felt it would place undue stress on the patient or if there was no real prospect of finding work.

(iv) General Practitioners were uneasy about their ability to consider a number of complex and interrelated factors and hence to assess capacity for work accurately. The loose definition of incapacity also created difficulties for General Practitioners who, consequently, had adopted a looser approach to assessing incapacity before issuing statements.

(v) The General Practitioners involved in the study made several useful suggestions as to how the current arrangements could be improved. They suggested a range of changes to existing procedures. These included a strengthened role for the BAMS Reference Service, or limiting the General Practitioner's decision to confirming the medical condition. General Practitioners believed that they needed more information about adjudication of claims in local offices, Reference Service procedures and employment services.

C. The Government's response to the increase

1. Tighter medical controls

The Government launched its research programme into invalidity benefit in 1991. In February 1993, the Chief Secretary to the Treasury, Michael Portillo, announced a general review of public expenditure focusing on the four Departments with the largest spending programmes including the Department of Social Security[9].

In April 1993, following a pilot exercise, the Government introduced administrative procedures (which did not require legislation) to tighten medical control procedures. The Government expects these to save £240 million over a three year period.[10] People invited for medical examinations are given more notice and asked to give reasons if they cannot attend. A revised medical form has been issued to Examining Medical Officers which is designed to give Benefits Agency Adjudication Officers more information about the effect of a claimant's medical condition upon their bodily functions. This improved information is intended to reduce the numbers of people invited to attend second interviews.

Concern has been expressed by the Disability Alliance and the Royal Association for Disability and Rehabilitation (RADAR) about the effects of the new medical controls[11]:

Revised medical report (RM9)

> The main change is the standard form completed by EMOs-RM9- when examining IVB claimants. The new RM9 contains more detailed questions about the effect of a claimant's medical condition on their bodily functions. This is intended to provide sufficient information for AOs to make a decision on the basis of one medical examination, rather than two. The wording of the form places more emphasis on purely medical factors. EMOs are now asked to state whether the claimant is either 'medically incapable of work' (as opposed to just 'incapable' in the previous forms) or 'medically capable of suitable alternative work' (as opposed to 'fit within limits'). Thus, the onus for taking into account all relevant non-medical factors now rests with the AO.

---

9 HC Deb 8 February 1993 cc 681-688.

10 See Peter Lilley, 1992 Uprating Statement, HC Deb 12 November 1992, c1016.

11 *Worried sick: reactions to the Government's plans for invalidity benefit,* Angela Hadjipateras and Marilyn Howard, RADAR and Disability Alliance on behalf of the Disability Benefits Consortium, September 1993, p12.

Attendance at medicals

Claimants referred for examination are now given longer notice (four weeks instead of three) of the date of the examination. This, together with the threat of benefit suspension for falling to attend a medical without 'good cause', is aimed at reducing non-attendance at medicals.

FINDINGS

Given that these changes had only been operating for a few months at the time of the survey, the findings are necessarily tentative. Overall, they suggest that the direct impact on benefit entitlement has been limited (presumably because the vast majority of claimants are genuinely incapable of work). However, these changes, together with press speculation about the future of the benefit, have contributed to a climate of fear and insecurity among claimants entitled to benefit today, but unsure of qualifying tomorrow.

The National Association of Citizens Advice Bureaux are also very concerned about the effects of the new procedures[12]:

The CAB Service wishes to express its deep concern that the process of reducing the number of invalidity benefit claimants appears to be already taking place. CAB evidence suggests that so-called 'administrative changes' introduced in 1993, are already leading to a narrower definition of incapacity - even before the changes have had parliamentary scrutiny.

At the present time many CABx are appealing against inappropriate invalidity benefit withdrawals and having their clients' invalidity benefit reinstated. The experience of one CAB in the West Midlands which writes "On one day the CAB represented at eight invalidity benefit cut off tribunals and won seven" is typical of the large number of reports NACAB is receiving on this issue. This evidence suggests that people are wrongly being denied invalidity benefit by the Benefits Agency in the first place. The consequences are a huge amount of anxiety for disabled people, severe hardship from the loss of income and an inefficient and wasteful use of the Benefits Agency's resources.

---

12 *CAB Briefing on the Social Security (Incapacity for Work) Bill*, National Association of Citizens Advice Bureaux, 18 January 1994.

2. The leaked proposals

On 10 June 1993, a draft letter and policy paper ostensibly from Peter Lilley to John Major, were reportedly issued to the press by mistake. Amongst the proposals which were allegedly under consideration were the following:

- to extend the qualifying period of IVB from six months to twelve months
- to introduce a stricter incapacity test based on medical criteria only
- to abolish the earnings related additional pension for all new invalidity benefit claimants
- to reduce the amount of IVB if the claimant receives an occupational or private pension
- to means-test IVB
- to tax IVB[13]

[13] Source: *Invalidity Benefit - Where will the Savings Come From*, Policy Studies Institute Press Release, 15 June 1993.

Part II The changes

A. The announcement

The Government's final plans for changes to benefits for those incapable of work were announced by the Secretary of State for Social Security, Peter Lilley, in his annual Uprating Statement[14]:

There has been a particularly marked increase in the number of people claiming invalidity benefit in recent years. The number on this benefit has more than doubled in the past 10 years and trebled in the past 15 years. That growth is particularly surprising, given improving health and better health care.

I therefore propose to introduce, from April 1995, a more objective medical test of whether people can work. I am issuing a consultation paper today, copies of which are available in the Vote Office, and I am forming a panel of medical experts and representatives of disabled people. They will be asked to help define what constitutes incapacity to work and how it should be measured.

The new test will apply to new applicants. Those drawing invalidity benefit are already subject to regular review. Under the present test, about 100,000 people each year are found to be fit for work and have their benefit withdrawn.

After April 1995, those on the highest "care" rate of DLA, those with terminal illnesses, those on a list of specified severe or chronic conditions and those currently on invalidity benefit who are by then 58 or over will no longer be subject to any review. But the new test will be used in reviews of other existing claimants. No one who is genuinely unable to work for medical reasons has cause for concern.

I am also simplifying the structure of all sickness benefits for new claimants from April 1995. At present, there are two rates of statutory sick pay. I propose to abolish the lower rate, which means that lower-paid workers will receive the higher rate of benefit, worth an extra £3.70 a week.

I shall also replace sickness and invalidity benefit by a new incapacity benefit that will be payable at three rates - the longer the period of sickness, the higher the rate. The lowest rate will apply during the first 28 weeks; the middle rate for the rest of the first year; and the highest rate after a year.

Those who are incapacitated early in life will receive extra help because they will have had less time to make additional personal provision for ill health. Additional payments will be made to those whose spouses are caring for children or are over 60.

New claimants will no longer be entitled to a state earnings related addition. Incapacity benefit will cease at pension age. Those already drawing invalidity benefit when the new incapacity benefit is introduced will continue to draw their benefit at existing rates and will not be taxed on it. Only those who come on to incapacity benefit from April 1995 will be liable to tax.

I am making a number of valuable changes for sick or disabled people. First, people on incapacity benefit will be free to do up to 16 hours voluntary work without losing their benefit. That will be widely welcomed by potential volunteers, voluntary organisations and those they help.

Secondly, from April 1995, people taking jobs with the help of disability working allowance will automatically qualify for free prescriptions and free dental charges. Thirdly, I am increasing the level of support to Motability, whose help for disabled people is so extensive that it now runs the biggest car fleet in the country. I am making a £1 million increase in the grant to the mobility equipment fund, which adapts vehicles for use by severely disabled people.

Overall, those reforms of sickness benefits will curb their rapidly growing cost; provide a more rational structure of benefits; encourage employers to improve the motivation and health of employees; and concentrate benefit on those genuinely unable to work. I believe that they will command widespread support.

---

[14] HC Deb 1 December 1993 cc 1038-9.

On the same day, a consultation paper was issued[15] setting out the Government's proposals for a new system for the medical assessment of incapacity for work. Comments on this have to be submitted by 11 February 1994.

B. How the current benefits work

1. Short term benefits: Sickness benefit and statutory sick pay

Sickness benefit is a national insurance benefit paid to some people during the first 28 weeks of sickness. In fact most employed people would not claim this benefit. Instead they would claim statutory sick pay from their employer. However, sickness benefit is available for those who cannot claim statutory sick pay and who have an adequate national insurance contribution record.

The main rate of sickness benefit is £42.70. Higher rates are available for those over pensionable age, and additions can be paid for adult and child dependents.

Statutory sick pay is currently paid at two rates - £46.95 for those earning between £56 and £194.99 per week and £52.50 for those earning £195 per week or more.

2. Invalidity benefit

This is the long term benefit which replaces statutory sick pay and sickness benefit after 28 weeks. It has been at the centre of considerable controversy over the past year, and there has been much speculation about the Government's plans for it.

The benefit has a rather complicated structure which reflects the historical accumulation of different components since its introduction in 1971[16]. The three components are:

---

[15] *A consultation on the medical assessment for Incapacity Benefit,* DSS, December 1993.

[16] For an account of the history of invalidity benefit, see *The law of social security,* Ogus & Barendt, 1988, pp 141-2.

- **Invalidity pension**

  This is the basic benefit which is paid at the same rate as the full basic retirement pension - currently £56.10. People have to be incapable of work and must normally have paid enough national insurance contributions to have qualified for sickness benefit before.

- **Invalidity allowance**

  This is paid to people who became incapable of work five years or more before reaching pensionable age. It is structured so that the younger a person was at the time they became incapacitated, the higher the allowance. It is £11.95 for people who were under 40, £7.50 for those who were aged 40-49 and £3.75 for men who were aged 50-59 and women who were aged 50-54.

- **Additional pension**

  This is paid under the State Earnings Related Pension Scheme (SERPS). Entitlement is based on earnings between 1978 and 1991. It was cut so that no new rights could accrue from April 1991 as part of a package of changes to benefits for disabled people[17].

  Amounts paid will depend on relevant earnings.

C. How the new benefit will work

There are to be two kinds of incapacity benefit: short-term incapacity benefit and long-term incapacity benefit. The long-term benefit will be paid after a year.

While there are two types of benefit, there are actually three rates. This is because the short-term benefit is paid at two rates - a lower rate for the first 28 weeks (£42.70 - the same as the current sickness benefit) and a higher rate for 29-52 weeks (£52.50 - the same as statutory sick pay). The long-term benefit paid after 52 weeks will be £56.10 - the same rate as current invalidity benefit.

---

[17] See Library Reference Sheet 90/4 pp 12-16 for further details.

D. How the new medical tests will work

For the first 28 weeks of incapacity, the consideration will be incapacity for the claimant's own normal job. The claim will be supported, as now, by statements issued by General Practitioners and hospital doctors.

After 28 weeks, incapacity will be assessed using the new "all work" test. A questionnaire will be sent to claimants to fill in and send or take to their doctor. The precise form of this will be finalised after the current consultation period is over, but it will almost certainly consist of a series of questions to do with the claimant's ability to perform work-related functions such as walking, standing, bending, manual dexterity and reaching and stretching. Other factors such as speech, hearing, comprehension, vision, continence, behaviour and cognition are also likely to be included. The doctor will add a statement of diagnosis and the main disabling conditions to the form, but will not be asked to give an opinion on capacity for work. This will be decided by the Adjudication Officer with help from the Benefits Agency Medical Service.

Full details of the proposals are given in the consultation document[18].

E. The effects on claimants

1. New claimants

Most people would start off on statutory sick pay as now. After 28 weeks they would move on to the higher rate of the short-term benefit. At this point they would have their incapacity for work determined by the new "all work" objective test. After 52 weeks they would move on to the long-term benefit.

People who could not get statutory sick pay but fulfilled the contribution conditions for incapacity benefit (which will be the same as they are now for sickness benefit) would start off on the lower rate of short-term benefit. After 28 weeks they would move onto the higher rate, and after 52 weeks they would move onto the long-term benefit.

---

[18] *A consultation on the medical assessment for incapacity benefit,* DSS, December 1993.

There will be some "structural losses" in benefit for new claimants. This means that some groups will receive less than they would have done under the old rules. Details of these are given in Part III as they occur in the Bill.

2 Existing claimants

People on invalidity benefit or sickness benefit will move on to incapacity benefit in April 1995, but the rate of their benefit will be protected. Most existing claimants will have to undertake the new objective test eventually, but it has not yet been decided how this will be phased in. Details of those exempted from the test are given on page 19.

Part III The Bill's provisions

Clause 1 would insert a new Section 30A into the Social Security Contributions and Benefits Act 1992. This sets out the conditions of entitlement for the two kinds of incapacity benefit and, in particular, the age cut-offs. The short term incapacity benefit (payable for the first year) can be paid for up to five years after pension age (60 for a man and 65 for a woman) but only if incapacity began before this age, and the pension is deferred. This mirrors the existing provision for sickness benefit. Long term incapacity benefit (paid after a year) will cease at pension age. This means that the current rules allowing for invalidity benefit to be paid for up to five years after pensionable age will no longer apply. However, special provisions will be made in regulations for "transitional" cases (those claiming IVB when the changes are introduced in April 1995) - see Clause 4(7). This will mean that those receiving IVB and over pensionable age in April 1995 will be able to remain on invalidity benefit for a further five years if they wish.

Clause 2 sets out the rates of benefit. The short term benefit (the equivalent of sickness benefit) is payable at the lower rate for the first 28 weeks and at the higher rate (equivalent to the new single rate of statutory sick pay) for the remaining 24 weeks. This higher rate is still £3.60 lower than the old rate of invalidity benefit, which people currently receive after 28 weeks. The basic rate of long-term incapacity benefit is equivalent to the current basic rate of invalidity benefit.

There are also provisions for increases to benefit for adult dependants (Clause 2(5)). However, new claimants in some categories who would previously have been able to get these increases under the old rules will no longer be able to do so. The present rules allow claimants to get an increase for a dependent spouse, irrespective of whether or not there are children. They also allow a dependent unmarried partner to receive an increase, but only where that partner is caring for children for whom the claimant is responsible.

The new rules will mean that a dependent spouse will not be able to receive an increase unless he or she is over 60, or if he or she is caring for children. This is not on the face of the Bill, but will be brought in by regulations under Clause 2(5) (new section 86A).[19]

For those claimants who will be able to get increases for their dependants, there will still be some changes to the rates. In some cases the new increases are less generous than the current increases paid with sickness and invalidity benefit. The structural losers will be:

---

[19] Source: DSS.

- New claimants under pension age between 28 and 52 weeks of sickness, who will get £26.40 for an adult dependant, whereas invalidity benefit claimants currently get £33.70

- New claimants over pension age between 28 and 52 weeks of sickness, who will get £32.30 for an adult dependent, whereas invalidity benefit claimants currently get £33.70

The rates of increases for dependent children are broadly the same as at present but here too there is one group of structural losers. Currently people who receive sickness benefit can only get the £10.95 increase if they are over pensionable age. People on invalidity benefit can get this increase irrespective of their age. The restriction is to be carried over to both the higher and lower rates of short-term incapacity benefit. This means that new claimants under pensionable age between 28-52 weeks of sickness will no longer get the increase, whereas they would have done under the old rules.

Subclause 5 of the new section 30(B) (which Clause 2(1) would insert) contains provisions for age allowances to be set by regulations. At present Section 34 of the Social Security Contributions and Benefits Act 1992 sets out the age allowance. It is structured so that the younger a person was at the time they became incapacitated, the higher the allowance. It is £11.95 for people who were under 40, £7.50 for those who were aged 40-49 and £3.75 for men who were aged 50-59 and women who were aged 50-54.

Under the new provisions, which will be contained in regulations, there will only be two rates of age allowance. The higher of the two will be for those whose incapacity began when they were under 35. The lower will apply for those aged 35-44 when incapacity began[20]. This would mean that new claimants between 45 and 54 (in the case of women) and 59 (in the case of men) would no longer receive this allowance, whereas under the existing rules they would. There are no details yet of the rate of the allowances.

There are also structural losses as a result of the fact that there are no longer any provisions for an additional SERPS based pension for new claimants. Over 80% of claimants currently receive these additions. The average award is £13.40[21], and the current maximum is £76.04[22].

---

[20] Source DSS official and DSS Press Release 94/2, 13 January 1993.

[21] HC Deb 17.1.94 c 422w.

[22] Source: DSS.

These structural losses do not apply to existing sickness and invalidity benefit claimants, who have their rates of benefit protected under Clause 4(7) and 4(8).

Clause 3 contains various provisions most of which mirror the provisions for existing benefits. The so-called "linking rules" are retained, so that periods of incapacity which are separated by a period of eight weeks or less, or a spell of entitlement to Disability Working Allowance of less than two years would be linked together when deciding what rate of benefit a person should receive. This would mean that such people would not be disadvantaged. A period of training for work of less than two years would also counted in the linking rules in the same way.

Clause 4 contains the transitional arrangements to protect existing sickness benefit and invalidity benefit claimants.

Sickness and invalidity benefits will become incapacity benefit (Clause 4(3)). However, the powers *"ensure that existing claimants do not suffer a cash loss at the point of change."*[23] Clauses 4(7) and 4(8) provide for incapacity benefit under transitional awards to be paid at the same rate as the sickness or invalidity benefit paid or payable, including the various allowances, additions and increases.

Existing recipients of invalidity benefit will be required to satisfy the new medical test of incapacity for work. There would be exceptions, however. These include:

- People over 58 when the changes come (providing they have been on invalidity benefit since 1 December 1993)
- People on the highest rate of the care component of Disability Living Allowance (DLA)
- People who are terminally ill
- People suffering from one of a number of severe and degenerative illnesses[24]

Clause 5 would introduce two tests for incapacity for work. These would not only apply to incapacity benefit, but also to Severe Disablement Allowance and to certain routes for the disability premia for income support, housing benefit and council tax benefit. They would not apply to statutory sick pay or to industrial injuries benefit.

---

[23] DSS Press Release 94/2, 13 January 1994.

[24] Ibid.

For the first 28 weeks, a person's incapacity would be determined in relation to their ability to do their own job (the occupation in which they have been engaged for more than 8 weeks in the previous 12 weeks). After 28 weeks, or earlier if the person has not recently been employed, the test would be the so-called "all work" test. The details of this are still the subject of a consultation exercise, and will be contained in regulations.

This 28 week watershed has not been contained in legislation before, although it has generally been followed by adjudication officers as a result of case law[25].

Under Section 171A, regulations could provide for a person to be disqualified from invalidity benefit, for example if they fail to turn up for a medical examination without good cause. Similar provisions exist under Section 59 of the Social Security Contributions and Benefits Act 1992 and under Regulation 17 of the Social Security (Unemployment Sickness and Invalidity Benefit) Regulations 1983 SI 1598. The maximum period of disqualification under the present rules is 6 weeks. This would be the same under incapacity benefit[26]

Clause 6 would allow some people to receive incapacity benefit irrespective of the new tests. Regulations will set out the details, but they will include people who have a terminal illness. Also under new section 171D(2) (introduced by Clause 6(1)) claimants will be allowed to do voluntary or therapeutic work subject to hours and an earnings limit. Currently there is a so-called "therapeutic earnings" rule which allows people to do some therapeutic work providing they earn less than £42 per week. However, the specific provisions for up to 16 hours per week voluntary work will be new. Under the new Section 171E, existing provisions allowing work undertaken by councillors to be disregarded in assessing incapacity for work will be continued.

Clause 6(2) would require Social Security Appeal Tribunals to sit with an advisory medical assessor when determining the assessment of incapacity if there is a dispute about the claimant's degree of incapacity.

Clause 7 would abolish the lower rate of statutory sick pay. This would mean that all claimants, including those now on the lower rate, would receive the higher rate - £52.50.

Clause 8 would make minor consequential changes to severe disablement allowance to do with training for work.

---

[25] e.g. Commissioners' Decisions, R(S) 7/60, R(S) 2/78.

[26] Source: DSS.

Clause 9 would allow people to qualify for disability working allowance after a period of Employment Training which was itself preceded by entitlement to incapacity benefit or severe disablement allowance.

Clauses 10 to 15 contain general provisions.

Schedule 1 contains the consequential amendments.

Part IV Responses to the Bill

The National Association of Citizens Advice Bureaux in their briefing[27] highlight the problems reported by their bureaux of people having benefit withdrawn inappropriately under the current medical procedures. They go on to stress the loss of income which they argue will result for many disabled people under the Bill's provisions:

The withdrawal of invalidity benefit now and the tightening of the rules for claiming under the Bill will leave many disabled people with a severely reduced income. In a time of recession and high unemployment many people find it difficult to find employment and indeed we understand that the DSS's own research states that the changes are likely to create an increase in the unemployment register estimated at 60,000.

A CAB in Somerset reports a client who has been in receipt of invalidity benefit due to an accident sustained at work whilst working as a care assistant. Her invalidity benefit has now been withdrawn, for reasons her GP describes as "political". She is left with vastly reduced income as she and her husband have to live on state pension plus a small occupational pension. The CAB comments "given the depressed nature of the job market in this area, it is unlikely that she will find suitable work".

A CAB in Merseyside writes "We have had four clients in September who have had their invalidity benefit stopped and are appealing. In each case, the client's own doctor considered them unfit for work. The DSS ruled they were fit for light work. Clients were told that they must sign on in order to receive benefit when this is not the case. The problems for one family were exacerbated by the fact that their partner worked for 24 hours so they faced a drastic loss of income while they applied for family credit."

The tightening up of invalidity benefit claims happening now and the additional tightening up proposed under this Bill raises the question about what other benefits claimants are left to claim. In theory subject to them meeting the entitlement conditions, a claimant should be able to claim unemployment benefit. However in practice many clients have been adjudged in the DSS's view to be not disabled enough to get invalidity benefit but not fit enough for work and therefore unable to claim unemployment benefit as the case below demonstrates. CABx also report that clients are being told by job centres that they need not sign on and can get income support pending an appeal. However this means that if they lose their appeal they will have a gap in their contribution record. The CAB Service is extremely concerned about the severe drop in income that these people will face, and that they may be left without an income if they are regarded as not fit enough to sign on.

They are also concerned about the new medical test:

The CAB Service is concerned about any proposals to move towards a more functional test and to assess purely medical factors.

---

[27] *Briefing for Second Reading*, NACAB, January 1994.

The aim of the new test would be to produce a "tighter and more objective assessment of medical condition and incapacity." This would involve dropping factors other than the medical condition and considering functional ability to do any work, moving away from consideration of ability to undertake specific jobs to an assessment of ability to undertake work-related activities, and defining a clear threshold above which a claimant would be considered incapable of work and below which they would be considered fully capable of work. CAB evidence indicates the problems of moving to a functional test. A functional test assessing purely medical factors in particular will cause problems for people whose disabilities are intermittent and who have mental health disabilities.

The Disablement Income Group argues that DSS research does not justify the image of IVB claimants as "lead swingers"[28]:

1. Growth in IVB claims: what research really shows

Source: two DSS-Commissioned research publications:

"Why are there so many long-term sick in Britain?", Disney and Webb, (1991) and "An analysis Of the growth in invalidity benefit claims",Holmes, Lynch and Molho) (1991).

Both these papers indicate that the Increase in invalidity benefit (1VB) claimants is multi-factorial. There appear to be several common elements, including longer duration of claims (especially in 55-65 year-olds, in those in receipt of attendance allowance and in those with a history of sickness-related benefit claims), and a probability of claiming IVB in areas of poor housing and high unemployment.

DIG's view is that the evidence shows that demographic and other changes have had a significant impact on the growth in numbers of IVB recipients, and that the problem of increasing numbers is largely a consequence of a lack of realistic work opportunities. This prevents people rehabilitating themselves to become fit for work. It does not imply that it has become easier to claim in the first instance, (if any case claimants receive IVB initially because they are incapacitated).

The attempts by politicians to build a new image of IVB claimants as lead-swingers and idlers kept in comfort by society thus find no justification here.

They go on to criticise the test of capacity for work, arguing that functional impairment does not necessarily equate with incapacity for work:

---

[28] *Briefing for Second Reading debate,* Disablement Income Group, 19 January 1994.

2. Establishing incapacity for work: why a flexible approach is needed

Functional impairment does not necessarily equate with incapacity for work. Research evidence shows clearly that there are many reasons why someone may not be able to work -their functional impairment being only one. The situation is not black or white - incapacity is part of a continuum from fully capable to fully incapable and we find it hard to believe that a rigid demarcation line will not lead to some very harsh consequences for certain disabled people.

Furthermore, a purely medical test of incapacity for work, based on adding up scores relating to ability to carry out functions of daily living, fails to take account of the reality of there ever being the kind of employment opportunities for which a person with those, disabilities is suited. We would therefore be very concerned if the way in which the new test worked resulted in an arbitrary threshold score which would determine absolutely whether a person was entitled to incapacity benefit or not. We hope that the panel of experts and disabled people's representatives, which the Secretary of state has established to define what constitutes incapacity and how it should be measured, will come up with a formula which provides a reasonable degree of flexibility.

Whilst it may be appropriate to revise the GP's role, not even the Government can take away the GP's responsibility as guardian of his patient's health. DIG believes that the GP should have a role in commenting on whether undertaking work would be likely to worsen his patient's condition in the case of people who just fail to qualify for incapacity benefit. Here. clarification from the GP, taken note of by the adjudication officer, would provide an important safeguard.

3. "Incapacity for work": towards a better definition

It is a mistake to view incapacity for work in stark, all-or-nothing terms. There is a very wide gap between "own" work (ie previous type of employment) and "all work" and for this grey area it is important to identify an appropriate means of assessing reduced capacity.

We prefer a definition in between "own" and "all" which we suggest should be "work for which the person is suited by education. training or experience". It is a definition less severe than "all" and avoids the absurd situation of, for example, an executive recovering from a nervous breakdown being considered fit for work as a storekeeper.

4. The "all work" test - a misnomer

The Bill does not actually define the "all work" test in a way which makes it clear it is relevant to incapacity for work. We find this unacceptable. A test which is called an "all work" test cannot simply be about physical and mental functions. A disabled person's inability to work depends on other factors such as education or experience.

And there should be a proper definition in the Bill itself, rather than relying on Regulations which themselves will not be liable to sufficient Parliamentary scrutiny.

The Disability Alliance[29] is also opposed to the new test:

Comment :

Disability Alliance is fundamentally opposed to a test of incapacity based on a scale of functional ability alone.

Non-medical factors are relevant and should be taken into account. Other factors which interact with disability have an impact on work capacity. This is recognised in the test currently used for IVB, where age, work history, educational ability, personal skills, are taken into account when assessing incapacity.

The assessment of incapacity by reference to ALL work is unrealistic as the ability of any individual to undertake work depends on the type of work under consideration. The job requirements, and therefore functional ability, needed for clerical and manual work are vastly different.

A threshold cannot adequately be defined. Disability is not homogenous and can take various forms and degrees of severity. The same disability may also have a different impact on individuals. Incapacity for work, like disability, is a continuum and an absolute cut-off point is an arbitrary concept which will produce arbitrary results.

As the new test has been presented "tighter" than at present, excluding 20% of people currently eligible for IVB, many more claimants could be found capable of work even if they have a disability or illness which restricts their capacity for work. The document leaked to the press last June indicated that average weekly losses for people failing the new test could amount to £87, with some losses as high as £160. Half of such claimants would

---

[29] *Initial response to the incapactiy benefit Bill*, Disability Alliance, 13 January 1994.

qualify for means-tested benefits, but half would not because of other income such as occupational pensions and partner's earnings.

Depending on the final form of the questionnaire, those most likely to lose out are people with fluctuating or less visible disabilities, particularly those with chronic pain. The consultation document states that people with mental health problems and "back pain" are likely to be automatically referred to BAMS.

The test will also be applied to Severe Disablement Allowance and the disability premiums for means-tested benefits like Income Support, Housing Benefit and Council Tax Benefit. The loss of a disability premium could amount to £18.45 per week for a single person under 60, and could affect the right to claim the higher pensioner premium payable to the over-60s. The leaked document suggested that the new test could exclude 15,000 people from access to the disability premium altogether.

Conclusion

The proposed changes to IVB will amount to a cost cutting exercise, saving an estimated £1.5 billion within three years.

Reference has been made to the increase in numbers of claims and the relative "generosity" of IVB, suggesting that many claimants are not genuinely incapable of work.

Research from the independent Policy Studies Institute has shown that increases in claims stems from social and demographic factors (such as an increase in people over pension age retaining benefit, more women in the labour force, an increase in the disabled population). The Department of Social Security's own research further indicates that other factors are relevant such as longer waiting times for hospital treatment, community care. This research also finds no evidence that the level of IVB acted as a disincentive to work.

Reducing the role of GPs has been a measure designed to assist in restricting access to benefit. However this fails to address the main cause of increasing numbers of claims identified by independent and Department of Social Security research, namely longer durations of claims.

Speculation about claimants "swinging the lead" has not been substantiated. Research undertaken by Disability Alliance and RADAR ("Worried Sick") and other local groups suggest that claimants are often inappropriately

refused benefit. The success rate of appeals against IVB cutoffs in 1992 was 53%; evidence from local studies suggest that the number of appeals has increased since the introduction of new medical control procedures introduced earlier this year.

The Disability Benefits Consortium (an umbrella organisation) is opposed to the exclusion of non-medical factors from the new incapacity for work test[30]:

Summary of key points:

The Government proposes to change the test of "incapacity for work for Invalidity Benefit. This currently involves assessment of both medical and non-medical factors (such as age, education, work skills) and ability to undertake specific jobs through consideration of job descriptions.

The new test is thought to involve

- consideration of functional ability alone;
- assessing ability to undertake work-related activities rather than specific jobs;
- defining a clear threshold between capacity and incapacity.

It has been estimated that as rnany as half of Invalidity Benefit claimants could be affected during the course of a year, with weekly losses averaging at £87 - £160.

The Disability Benefits Consortium rejects the exclusion of non-medical factors :

* "functional impairment" does not equate with work capacity, although there is a link between 'incapacity for work and severity of disability. Age and skills are relevant factors, and are taken into account in the present incapacity test, which has been in use since 1911.

* the ability to undertake some voluntary or therapeutic work is likely to result in the loss of Invalidity Benefit if non-medical considerations are removed, resulting in discentives to rehabilitation and work.

---

[30] *Briefing on the proposed "functional test" for long term incapacity benefits*, Disability Benefits Consortium, November 1993.

* isolating the ability to perform work-related tasks cannot take into account the realities of actual workplaces and the demands of employers for a flexible and reliable workforce.

* people who are most likely to lose out under a new test include those whose disabilities or symptoms are not readily observable (such as pain); people with fluctuating disabilities; users of mental health services, particularly those with depression, panic attacks or anxiety.

* as incapacity for work is a continuum between full capacity and total, incapacity, the notion of an absolute cut-off point or threshold is an impossible one to assess.

The Disability Benefits Consortium is concerned that the move towards a new test is a cost-cutting exercise, creating an arbitrary cut-off point rather than a realistic assessment of work capacity.

It believes that the test would be both unworkable and unfair and calls on the Government to think again.

Appendix 1

Reports resulting from the Government's research programme into invalidity benefit

Invalidity Benefit: A Preliminary Qualitative Study of the Factors Affecting its Growth, Ritchie and Snape, Social and Community Planning Research, 3 September 1993

GPs and IVB A qualitative study of the role of GPs in the award of Invalidity Benefit, Jane Ritchie with Kit Ward and Wendy Duldig, Department of Social Security Research Report No 18, 3 September 1993

Invalidity Benefit A survey of recipients, Lonsdale, Lessof and Ferris, Department of Social Security Research Report No 19, 29 September 1993

Invalidity benefit An international comparison; Susan Lonsdale, Social Research Branch, DSS, 29 September 1993

Invalidity benefit A longitudinal survey of new recipients, Bob Erens and Deborah Ghate, DSS research report No 20, 15 October 1993