PRACTICE OBSERVED

Law and the General Practitioner

Statutory sick pay: it will affect you

NORMAN ELLIS

The new statutory sick pay scheme, which starts on 1 April 1983, will have greater administrative consequences for the employer than any other recent change in employment legislation. Indeed, its impact on the general practitioner's administrative procedures could be greater than any change since the introduction of PAYE (income tax) in 1948.

Biggest change since PAYE

The Social Security and Housing Benefits Act 1982 introduces for the first time a statutory obligation on employers to pay their staff during sickness absences on behalf of the state. Up to the introduction of the statutory sick pay scheme, sick pay as such has not been covered by legislation; the employer has had discretion to decide whether or not to pay staff during absences for sickness. The only constraint on how this discretion was exercised has been any obligations arising from the contract of employment with his employees.

When writing about new legislation it is particularly rewarding to be able to suggest a course of action that can be easily understood and readily applied in general practice. A first impression of the new statutory sick pay scheme may be that it will be complicated and difficult to administer. But if its principles are understood and a few simple preliminary and precautionary steps taken the general practitioner is unlikely to have serious difficulties. If in doubt advice and assistance may be obtained from the BMA regional staff and your local Department of Health and Social Security office.

In common with other employment law the new sick pay legislation pays little regard to the limited resources of a small

employer. Large organisations with personnel departments are anxiously trying to cope with this new legislation, and some are even using additional staff to implement it. The general practitioner has a far greater relative burden of additional administration, and this will have to be borne by his existing practice staff. Thus it is important to prepare the staff in your practice for the new scheme. The DHSS booklet *Employer's Guide to Statutory Sick Pay* is essential reading and should be obtained without delay from your local DHSS office. This is an authoritative guide to the scheme and an essential reference document when you first have to pay sickness benefit. You should also obtain a supply of the two DHSS forms for "transfer" and "exclusion," which may have to be used. Your sickness records should be reviewed, and if necessary amended, to ensure that they conform to the statutory requirements of the Act. Do not try to memorise the details of the scheme. It is through the practical experience of working out actual cases of the sickness scheme that you and your staff will become familiar with it. It should not be long before administering the scheme becomes a routine procedure, almost as familiar as PAYE (income tax).

If you are not an employer and your ancillary staff are employees of a local health authority you should take no action until you receive guidance from the employing authority.

Present position

It is reasonable to assume that most general practitioners do not have a formal sick pay scheme. Many doctors probably rely on a pragmatic approach when determining what pay their staff should receive during absence for sickness. They may even maintain their staff on full wages for short periods of absence, though this may mean that such staff, if they should claim state sickness benefit, would be financially better off during sickness than when working.

But when the period of sickness lengthens a general

British Medical Association, London WC1H 9JP
NORMAN ELLIS, MA, PhD, under secretary

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practitioner's decision to reduce or end sick pay may depend on various subjective considerations, including the value he attaches to the previous service of the sick employee, the length of previous service, and the likelihood of the employee returning to work within the foreseeable future. Only a few practices may have planned ahead for long term sickness, if only because this is regarded as a remote eventuality. Indeed, I would estimate that most general practitioners have not issued written contracts of employment to their staff, and this omission suggests that there is unlikely to be a formal sick pay scheme, although such a contract is not necessary to implement the new sick pay scheme.

Why has the statutory sick pay scheme been introduced?

Since 1948 the government has administered through the DHSS a system of National Insurance sickness benefit. The Department has paid sickness and injury benefit claims made by employees within the National Insurance scheme. When an employee was sick his doctor was asked to complete a medical certificate on the prescribed form, which was submitted to the DHSS to claim state benefits. These benefits were based on whether there were dependants and were tax free. The claim form was often submitted to the DHSS by the employer because it was also used by the employer as evidence that the employee's absence from work was due to ill health. The form may also have been used to trigger payments under schemes for occupational sick pay. When this state scheme was introduced few employees were covered by occupational sick pay schemes; during the past 30 years, however, there has been a substantial growth in the coverage of these schemes. For many employees National Insurance sickness benefit is no longer an important element of their income during short term sickness.

The government is replacing this system by a statutory sick pay scheme for two main reasons. Firstly, it wishes to make sickness payments subject to taxation, thus preventing employees from "overbenefiting" when sick. Secondly, it is seeking to eliminate the duplication of administration undertaken by civil servants and by employers. It intends to reduce the number of civil servants who administer the state sickness scheme by transferring to employers the responsibility for administering the basic state payments during sickness. In addition, the new scheme is intended to increase the employer's awareness of his responsibility for monitoring and controlling the sickness absence of his employees. Self certification was a first important step in this direction.

Basic principles

The statutory sick pay scheme establishes a new minimum entitlement for sick pay for most employees. It replaces state sickness benefit for most periods of short term absence for sickness. The employer is required to pay both the new scheme and any occupational sick pay entitlements. The Act allows the employer to offset his liability to pay statutory sick pay against any contractual liability for sick pay.

How does "offsetting" work? If you are committed by contract to pay your employee for a day on which the employee was sick—for example, your practice's scheme for occupational sick pay or holiday pay—this payment will cover your liability for statutory sick pay so long as the amount you are paying is at least the appropriate level for that scheme. You do not have to

pay statutory sick pay as well. More generally, if statutory sick pay is due to be paid on a certain day, any other payment that counts as earnings for the purposes of National Insurance contributions that you are already liable to make on that day will count towards your liability to pay statutory sick pay for that day. There is no need to "offset" statutory sick pay against other payments. It is obligatory or not. It seems possible (though unlikely in most practical circumstances) that an employer may opt to continue to pay full pay as his occupational sick pay and statutory sick pay on top of this as an added "benefit."

The Social Security and Housing Benefits Act 1982 represents a radical new approach to sickness benefits, in that (i) all staff are covered by the Act and will be entitled to statutory sick pay instead of state sickness or injury benefit for most periods of sickness unless for some reason they are excluded, and all employers are legally obliged to pay statutory sick pay; (ii) for those staff not covered by your own sick pay arrangements the new statutory scheme will usually be their only source of income during sickness unless they qualify in addition for supplementary benefits; (iii) staff covered by your own occupational sick pay arrangements may continue to receive a higher level of sick pay than that due under the statutory scheme; (iv) both the statutory scheme and your own sick pay will be paid by the practice; (v) long term sickness will still be covered by the present National Insurance scheme, and staff will normally transfer from the statutory sick pay scheme to state sickness benefit after eight weeks' entitlement in a single tax year.

Summary

The main features of the new scheme are:

- (1) National Insurance sickness benefit will no longer be payable for most sickness absence; instead your staff should receive sick pay directly from you.
- (2) Sick pay will normally be paid in the same way as normal pay and is liable to deductions for income tax and National Insurance contributions.
- (3) Entitlement to sick pay does not depend on previous National Insurance contributions or previous service with the employer.
- (4) Married women paying the reduced "stamp" and part timers are entitled to sick pay provided that their earnings are above £32.50 a week. (And part timers with more than one job may receive the full rates of sick pay simultaneously from several employers.) Sick pay is not paid for sickness lasting less than four days, but for longer absences it will be paid for up to eight weeks. The total sick pay that may be received from one employer for one or more periods of sickness in the same tax year, however, cannot exceed eight weeks' worth. After eight weeks state benefit may be claimed from the DHSS.
- (5) If an employee changes jobs the new employer is also liable to pay up to eight weeks' sick pay, regardless of whether payments have been made by the previous employer.
- (6) You, as the employer, have to decide whether sick pay is payable.
- (7) The employer can deduct the amount paid out in sick pay from subsequent remittances to the Inland Revenue for National Insurance contributions.

This is the first of three articles explaining the new statutory sick pay scheme.

Reference

1 Department of Health and Social Security. *Employer's guide to statutory sick pay*. (Leaflet NI227.) London: DHSS, July 1982.

Overlapping with General Practice

Probation officer

J D R TODD

At a conference recently I heard a general practitioner who practises in the west of Scotland recount the details of one of his recent consultations with a patient of long standing: a small, scrawny man who drank much more than was good for him. During the examination the doctor asked yet again about his patient's current consumption of alcohol. "Och, Ah've gae it up, dooker; it wez just makin' me aggressive." The general practitioner, astounded but gratified that at last long some of his advice was being followed, managed to pull together some platitudes about how splendid a decision this was, how the patient's wife and family must be pleased, and how much better things would be with more money available for other things. "Och, it waznae really that, doctor," said the man, "it's that when yer ma size there's nae point in gettin' aggressive!"

This story made a considerable impression on what training officers in the probation service are pleased to call my "professional development," and it drew together feelings I have had more and more often recently. It seems to me that clients/patients are roughly divisible into two groups. On the one hand there are those whose problems are not in the least susceptible to the "cures" that I have to offer and yet who seem to make more and more demands on me. And on the other hand there are those whom I might be able to help had I but time and energy by the hour.

Since the benefits of the controlled trial are generally not as apparent to practitioners of social work (and a good thing too, many of us who were brought up in the field of medicine do not think) as they are to colleagues in medical science, I have no way of knowing whether I have stumbled across an Objective Truth or whether the years of grass roots grappling (12 of them to date, mostly spent in the probation service) have gradually—and oh so gently—detached me from reality.

Some of my clients would not agree, but fortunately I have detected at least some agreement with this opinion among some general practitioners with whom I have discussed it. Having become acquainted with several doctors, particularly during two years working with a regional council on alcoholism, I have been struck by how often lack of time, inappropriate patient expectations, demands for prescriptions, and the problems of people trying to cope with poverty, squalor, and debt have been repeated. I am sure that this is because these themes almost exactly parallel the views of my own colleagues concerning the pressure of work, demands from clients (often parents) that the probation service should "do" something, and the inappositeness of offering social work help in response to problems that often appear to be the result of social work failure.

Doctors have long been aware that the best prophylaxis available to people is comparatively prosaic—good food, decent housing and sanitation, improved working conditions, and

freedom from stress. They know that, for instance, some of those factors were far more important in eradicating tuberculosis as a major disease than was the introduction of streptomycin. Similarly, probation officers are coming to believe that "treating" delinquents through social work has not been particularly effective in either rehabilitating them or in reducing the number of offences that they commit, and that the incidence of crime may be built into our society in the same way that, for instance, cardiovascular disease seems to be.

But because the impact of probation officers and doctors on the structure of society as a whole is strictly circumscribed, what they can actually do is use their understanding of the structure to deliver their particular services more effectively. It is in this area that the ways in which our work overlaps are of particular interest to me. For example, one general practitioner said to me that what he would most welcome was more access to a range of facilities that would give patients time. It was really as simple as that. Trapped in the five minute consultation syndrome, he thought that though he might be able to identify a patient's non-medical problems and how they might be causing or contributing to the patient's medical problems, there was no time available to deal with those problems other than superficially. This is clearly most frustrating in the cases of the waiting room "ghosts"—those patients/clients who always seem to be haunting the surgery or office, eager to present another variation of what is essentially the same physical or psychological problem. A more efficient way of dealing with these people—a total solution to their difficulties—would be to have the capabilities of doctor or probation officer—would have the double benefit of freeing time for other purposes and for specialists to decide whether they had a part to play in a particular case.

Fishing together

There is nothing new in the notion that doctors and probation officers fish in the same pool (though ostensibly for different catches): note the growth of "team care" and the development of health centres, which house groups of primary health care workers of general practitioners, health visitors, midwives, community psychiatric nurses, psychologists, social workers, marriage guidance counsellors, and so on. There seems to be a feeling among those who work in these settings that patients are indeed given more time simply because the opportunities are maximised for seeing workers with different types of training, who do what they are best at with the people who might benefit most from what they have to offer. It might be relevant that probation officers are conspicuous by their absence from health care teams such as these, since the probation service as a whole has generally thought of itself as somehow apart from the mainstream of social work. This argument held sway in the Seebohm era and led to the reorganisation of the personal social services so that social workers became responsible for providing services ranging from dealing with mental health problems with elderly mentally infirm people, and excluded the group specifically labelled "offenders." Curiously enough, the Scottish

Sheffield S8 9HU

J D R TODD, probation officer

Correspondence to: 51 Meersbrook Road, Sheffield S8 9HU.

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Probation Service was merged with general social work at that time, and I have never heard it suggested that people who were thought capable of handling delinquents as well as dealing with anything from a "telephone application" to counselling parents who abused their children have since proved more unsuccessful than the rest of us in dealing with offenders.

It seems to me to be the sedulous fostering of the notion that what we do is remarkable and incapable of imitation or reproduction that has interfered with probation officers cooperating more closely with workers in related disciplines, of which community medicine is certainly one. Yet the broad similarities of what general practitioners and probation officers try to do seem to be much more important than the differences, and this is nowhere more apparent to me than in the way in which we relate to the larger structure where our work is located. For example, general practitioners use their consultant colleagues, who are often in university departments of large teaching hospitals, and are aware that these colleagues become interested in progressively smaller and smaller parts of a patient, which are investigated with singular thoroughness and high technology, while the general practitioner is more concerned with the whole. Similarly, a probation officer reporting to a court about a client who has been sentenced to prison will want to know what the client relates to the rest of his family and whether he has ever

experienced the benefits of regular employment and so on, whereas the court's principal concern is sentencing the offender in respect of the behaviour that led to his conviction. Obviously, consultants are interested in socioeconomic factors in the same way and for the same purposes that magistrates and judges are, but the point is that such factors are rarely their overriding concern.

There are several ways in which doctors and probation officers might work towards achieving a greater appreciation of what the other's task involves. At the risk of being accused of wanting the doctors to make all the running, may I say that one way is to get general practitioners concerned in the work of the probation service by co-opting them on to case committees. There are small groups of the magistrates who are members of area probation committees (appointed by the Home Secretary and acting as the employers of the probation service in each area) and who are attached to individual teams of officers in order to discuss professional matters at regular meetings. In this way general practitioners might learn more about the work of the service (you really did not know that we have a statutory responsibility to try to re-educate offenders, did you?). And those probation officers who still subscribe to Voltaire's well-known assertion that doctors treat diseases about which they know little by prescribing drugs about which they know less for patients about whom they know nothing, might discover that the grounds as ever existed for it have almost completely disappeared.

Diary of Urban Marks: 1880-1949

It was rather late in the morning when Leapingwell walked into my bedroom and woke me from a fitful doze. His first remark was "Come on, Wake up. Do you realise we have to earn our own living?" A remark like this was calculated to awake one with a shock. To realise that I could now put MRCS LKCP did not make me so proud, but the knowledge that I was now an independent being and could live on my own bread and butter filled me with ecstasy. I was now 25 years and three months old and had the world before me. What could anyone desire more? I hastened to Covent Garden where I knew I should find my father, who at that time visited the Garden daily in the course of his business as a wholesale fruiterer. I broke the news to him but to my dismay he did not seem overweighed with joy. I sensed that something was wrong. We went to lunch at the Tavistock and he then told me that he was practically a bankrupt. 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