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Understanding Benefits

Benefits for people incapable of work

Simon Ennals

Contributory benefits

Retirement pension
Widow's benefit
Unemployment benefit
Sickness benefit
Invalidity benefit
Maternity allowance

Non-contributory benefits

Child benefit
One parent benefit
Attendance allowance
Invalid care allowance
Mobility allowance
Severe disablement allowance
Industrial injury benefit
Statutory sick pay
Statutory maternity pay

Means tested benefits

Income support
Housing benefit
Community charge benefit
Family credit
Social fund

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Written in association with the
Child Poverty Action Group

This is the fifth of 10 articles

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The social security benefits that doctors come into contact with most frequently are those where a patient requests a "sick note" to show he or she is incapable of work. Some doctors resent this role of gatekeeper to the social security system, arguing that it gets in the way of their relationship with their patients. Doctors may feel pressurised to sign sickness certificates when they think them unjustified, and patients may resent a doctor's refusal to provide one, which then deprives them of benefit for themselves and their family. By developing an understanding of the benefit rules, however, and how the law interprets "incapacity," doctors can be in a powerful position to help patients to obtain their proper benefit rights and to protect them from being forced back into the labour market when their health and fitness may not justify this.

What is incapacity for work?

To qualify for sickness and invalidity benefits, the severe disablement allowance, and, in some cases, the disability premium for income support and housing benefit a patient has to show that he or she is "incapable of work by reason of some specific disease or bodily or mental disablement." Normally there is no problem at the start of a claim. For the first six days patients complete a self certification form SC1. After that the adjudication officer will usually accept the standard Med 3 certificate from a general practitioner. Legally, however, patients have to prove, on the balance of probabilities, that there is no work which they can reasonably be expected to do, taking into account their age, education, experience, state of health, and other personal factors. Work means part time or full time work for which an employer would be prepared to pay or self employed work in some "gainful occupation."

The starting point therefore is that the patient must be suffering from a "specific disease or bodily or mental disablement." It does not matter if the cause of the condition cannot be definitely identified: the importance is the effect on the patient. Genuine anxieties, hysterical states, or depression can all count, however imprecise the cause. Normal pregnancy does not count as a disease or disablement, but conditions arising from the pregnancy, such as high blood pressure, are relevant. Domestic circumstances, such as childcare commitments, are not directly relevant. In some circumstances patients can be deemed incapable, if, for example, a doctor certifies that they should not work

"for precautionary or convalescent reasons" in consequence of a disease or disablement.

Short term incapacity—In the early stages of sickness patients' incapacity is judged by looking at their ability to do their normal job. It would clearly not be reasonable to expect them to change jobs just because of a short term illness. After a time, however—often after four to six months on benefit—the Department of Social Security will begin to consider whether the patient is capable of any other type of work. Whether a job is still being held open for the patient may well be an important factor in determining when the field of possible jobs should be widened, as would be such issues as how close the person is to retirement and the likelihood of recovery within the near future.

Incapacity for work—The test is whether patients are capable of doing any particular job, not whether they can actually get such a job. The fact that a job may be in great demand and that the patient is unlikely to succeed in getting one is not relevant. The test of incapacity is supposed to be a very practical one. The Department of Social Security should look at people's capacities in relation to the demands of real jobs in the competitive world of business. So any job a patient could get only on compassionate grounds, or with an employer making special allowances, is not to be taken into account. In the same way, if a patient could do a job only after extensive retraining, or with special adaptations to buildings or equipment, then it should be disregarded. The test is of the patient's capabilities *now*, rather than what they might be if certain conditions were to be satisfied. The emphasis on the economic realities of the world of work in the test of incapacity is particularly relevant to patients who may have an intermittent disability. A social security commissioner said in 1979, "A person who because of intermittent disablement could perform the duties of paid employment only on an average of, say, three days out of a five day working week . . . could rightly be held to be continuously incapable of work." This is because if patients cannot predict when they will be fit for work most employers would not take the risk of taking them on.

In summary, whether a patient is "incapable of work," and therefore warrants the issue of a sickness certificate, is primarily a medical question. Although initially it is enough to look at a patient's normal job, after a while the test is widened to include any job he or she could reasonably be expected to do. This must,

"Therapeutic work" that earns a patient less than £35 a week will not disqualify her from benefit paid for incapacity to work

however, take into account the real demands and expectations placed on employees doing that sort of work.

Benefits available

STATUTORY SICK PAY

Most employees are covered by the statutory sick pay scheme, which lays down the minimum that an employer must pay for periods of sickness up to 28 weeks. Many employees receive considerably more than this through contractual sick pay arrangements, but an employer may not pay less. Statutory sick pay is paid at two rates, £39.25 a week for people earning less than £125 a week (£175 from April 1991), and £52.50 a week for those earning above. The main groups of people excluded from statutory sick pay are: those earning less than £46 a week; temporary workers with contracts of less than three months; people over pension age; women within 11 weeks of the baby's birth; and people who were receiving one of the other national insurance incapacity benefits—for example, invalidity benefit—within the past eight weeks.

No statutory sick pay is paid for the first three working days, and periods of sickness separated by less than eight weeks are added together to calculate the 28 weeks' maximum sick pay. Statutory sick pay is included as part of the claimant's taxable earnings. The employer is entitled to require a sickness certificate in support of any claim lasting more than seven days.

SICKNESS BENEFIT

Since statutory sick pay was extended to cover the first 28 weeks' sickness in 1987 sickness benefit has become much less important. It is, however, still important for the self employed, the unemployed, and other people excluded from statutory sick pay. Except for incapacity caused by an industrial injury or disease, patients have to have paid enough national insurance contributions to qualify for benefit. Claims are made by sending the form SC1 to the Department of Social Security, followed by sickness certificates.

Employees should ask their employer for form SSP1(E), which states why they do not qualify for statutory sick pay, and send this to the Department of Social Security. The current rates of benefit are £35.70 a week for the claimant plus an additional £22.10 for an adult dependant. The addition for the dependant is paid only for dependants who do not earn more than

£22.10 a week. Although for someone who is unemployed the rate of sickness benefit is virtually identical to unemployment benefit, a claim is still important as the person may go on to qualify for the much higher rates of invalidity benefit after 28 weeks or the disability premium as part of income support or housing benefit.

INVALIDITY BENEFIT

Invalidity benefit is paid for periods of incapacity lasting over 28 weeks. Patients must have received sickness benefit for 28 weeks, or would have received it had they not already been receiving statutory sick pay. Invalidity benefit consists of two elements—the invalidity pension and the invalidity allowance.

Invalidity pension is paid at the rate of £46.90 a week for the claimant, £28.20 a week for the adult dependant, and £9.65 a week for each dependent child. The earnings rule for adult dependants is more generous than for sickness benefit, allowing the dependant to earn up to £37.55 a week before the benefit is affected.

Invalidity allowance is an age related addition, ranging from £10 a week for those first qualifying under the age of 40 to £3.10 for those over 50 when they first qualify.

Invalidity benefit is not taxable and acts as a passport to the disability premium paid with income support and housing benefit.

SEVERE DISABLEMENT ALLOWANCE

The severe disablement allowance was introduced in 1983 to replace the old "non-contributory invalidity pension." Although no national insurance contributions are required, in many ways the severe disablement allowance is much harder to claim than the invalidity benefit. A patient must be under 65 and have been continuously incapable of work for 28 weeks with no breaks at all. He or she must have been present in Great Britain for at least 24 of the past 28 weeks and have lived in Britain for at least 10 out of the past 20 years. This makes it particularly hard for some members of ethnic minority communities and others who have lived abroad to qualify.

In addition to proving incapacity for work most claimants also have to prove that they are 80% disabled. This is a difficult concept to explain to patients and is based on scales of disability used in the industrial injuries scheme. Decisions are taken by Department of Social Security appointed "adjudicating medical practitioners" or "medical boards." This system of determining compensation, based on traumatic losses, has been criticised for being ill equipped to deal with chronic physical or psychiatric conditions: how do you put a numerical value on the disablement arising from chronic asthma? Some conditions—or proxies—are, however, deemed to satisfy the 80% test. They include receipt of attendance allowance, mobility allowance, or war pensioners mobility supplement; a previous assessment of at least 80% for industrial injuries purposes; receipt of a vaccine damage payment; or being registered blind or partially sighted.

Patients do not have to satisfy this 80% test if their incapacity started before their 20th birthday or if they were entitled to the old non-contributory invalidity pension in 1984. For patients under 19 there is an additional rule: they must not be engaged in full time education, meaning at least 21 hours per week. When calculating the 21 hours, however, any periods of special education or tuition because of the disability, such as extra help from a teacher for the deaf, are ignored. The type of course does not matter; the question is simply the number of hours spent in tuition that is not specially designed or adapted for the patient's disability.

Claims for the severe disablement allowance should

be made on the claim form inside Department of Social Security leaflet NI 252. Doctors can play an important part in looking out for people who are incapable of work long term, who may not have made any sort of claim. This is particularly likely to be the case for married women, who may have had no contact with the labour market for many years, and those disabled from childhood, who may never have been to work at all. Since the severe disablement allowance is not means tested it does not matter if there is a partner in employment. If the family is already receiving benefit, then receipt of the severe disablement allowance will ensure that they receive the disability premium as part of their income support.

INCOME SUPPORT AND HOUSING BENEFIT

Invalidity benefit and the severe disablement allowance are important not merely for themselves but also because of the way they act as passports to the disability premium in the income support and housing benefit calculations. The importance of sickness certificates, even for people who are unemployed or who may not have paid any national insurance, cannot be over-emphasised, since they enable income support to be paid without the patient having to look for work and, after 28 weeks, will lead to the award of the disability premium, thereby increasing the person's benefit by up to £22.10 a week for a couple. It is also important to remember that evidence of incapacity can be backdated where appropriate, using the form Med 5, which can lead to an immediate increase in the patient's benefit.

Disputes about incapacity

The adjudication officer will normally accept a sickness certificate without question, particularly for the first few months of the illness or injury. At some stage, however, the patient may be referred to a doctor from the regional medical service. The regional medical officer will assess whether, taking account of the patient's degree of incapacity in specific functions—for example, climbing ladders, bending—the patient is fit to do any sort of work. This assessment is then notified to the general practitioner. At this point it is important to realise that the regional medical officer's assessment is merely the view of another medical practitioner and is not binding on the general practitioner, who should continue to issue sickness certificates if he or she considers it appropriate. The

general practitioner has probably known the patient for some time and may have a considerably more detailed knowledge of the patient's condition. If the general practitioner continues to issue certificates the Department of Social Security will probably refer the patient to a second regional medical officer. If the second regional medical officer also considers the patient to be capable of some work benefit will usually be stopped. If the general practitioner still considers the patient to be incapable of work he or she can help to convince the adjudication officer, or a social security appeal tribunal, by writing a fuller statement describing the incapacity, as well as issuing sickness certificates. In some cases it may be appropriate to refer the patient to a consultant, especially if the patient has been referred before. The actual decisions on benefit entitlement are taken by lay adjudication officers or appeal tribunal members, and reports from general practitioners, even fairly brief ones, or written answers to questions put by the claimant's adviser, are given considerable weight.

Therapeutic work

Although doing any paid work usually disqualifies the patient from benefit, there is a provision that allows "therapeutic work." This can apply when someone meets the basic test of incapacity described above, but nevertheless does some work which is either done under medical supervision as part of hospital treatment as an inpatient or outpatient or some other work which they have "good cause to do." This could be light work that is in some way therapeutic, by exercising damaged limbs, or by helping in recovery from a psychiatric illness, for example. It is very important that this is agreed with the Department of Social Security in advance, to avoid accusations of working on the side, and that earnings are less than £35 a week. Nevertheless, if a patient has been working without prior approval it is still possible for a doctor retrospectively to approve the work as therapeutic if appropriate.

Doctors have a central role in the administration of all three types of benefits—contributory, non-contributory, and means tested—through providing evidence on incapacity. Although it may at times seem an onerous task, it is vital to ensuring that patients receive, and retain, their full benefit entitlements. More detail on all these issues can be found in Child Poverty Action Group's *Rights Guide to Non-Means Tested Benefits*.

ANY QUESTIONS

A 60 year old man had a transurethral prostatectomy recently. Around 6% of the 70 sections of the prostate examined microscopically showed adenocarcinomatous cells (acinar pattern). What is the prognosis and what treatment is advised?

The prognosis in a patient with carcinoma of the prostate depends on the histological grade of the tumour and the clinical stage of the disease. Further investigation is required to determine whether the disease is confined to the prostate or is locally invasive—that is, has spread through the capsule or into the seminal vesicles. This cannot be judged by the number of prostatic chips affected as prostatic cancer usually arises in the periphery of the gland and only a small amount of the malignancy may have been resected. The most accurate assessment of local invasion is by transrectal ultrasonography with a multiplanar probe and guided biopsy of any suspicious area. An isotope bone scan must be obtained to exclude bony metastases, and if it is equivocal magnetic resonance imaging of the spine must be arranged.¹ The extent of the rise in the concentration of prostate specific antigen will give a good indication of the bulk of residual tumour.² Several treatment options are available. If further investigation has shown metastatic disease orchidectomy or antiandrogen treatment may be started immediately or deferred until the patient develops

symptoms. The same choice may be taken for local invasive disease, although external beam radiotherapy to the prostate or inserting iodine-125 seeds may be preferred as this reserves hormone manipulation for a later date if this proves unsuccessful.

If the carcinoma is confined to the prostate and is histologically well differentiated it may take 10 to 15 years to become clinically evident.³ So active treatment may reasonably be deferred, particularly in someone whose general health is poor and who may succumb to a condition other than his prostatic cancer. If, however, the patient is young and fit and the tumour is histologically more aggressive we would offer radical prostatectomy as the only chance of cure. Advances in surgical technique have resulted in a considerable reduction in the complications of such surgery,⁴ and more urological units in the United Kingdom are following the American lead in undertaking radical prostatectomy. —J C GINGELL, consultant urologist, and D A GILLATT, senior registrar, Bristol

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