reform. They believe that the "internal marketplace" of hospital trusts will create more incentive to use junior doctors as cheap labour.⁸

Meanwhile, juniors whom I interviewed are waiting to see what happens. Even those who aspired to general practice said that they were deferring any commitments. "I like general practice," a senior house officer said. "But I'll stay in the hospital until all the politics settle out." Her junior colleague added, "We have to remain here. One cannot come back to the hospital from general practice—at least, not easily." Indeed, the future for young British doctors is difficult to discern amid the storms of political manoeuvre and waves of reform. Junior doctors are disillusioned about the changing face of medicine and seem paralysed to deal with all the external influences.

Essayist Richard Asher wrote that the well trained

doctor is "a jack of all trades and master of one." The apprenticeship of British doctors has heretofore been to the trade of medicine. If junior doctors are to become active students of their profession they may also need to become jacks of other trades: politics, economics, management, labour relations, and more.

- 1 Mihill C. Doctors risk sack on hours. *The Guardian* 1990 September 18:18.
- 2 Anonymous. Hours cut due. *Hospital Doctor* 1990 September 6:8.
- 3 Mihill C. Patient died after wrong injection was given by overtired doctor. *The Guardian* 1990 September 21:13.
- 4 Medical Manpower and Education Division, Department of Health. Medical and dental staffing prospects in the NHS in England and Wales in 1988. *Health Trends* 1989;21:99-106.
- 5 Allen I. *Doctors and their careers*. London: Policy Studies Institute, 1988.
- 6 Department of Health and Social Security. *Hospital medical staffing: achieving a balance*. London: DHSS, 1987.
- 7 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients*. London: HMSO, 1989.
- 8 Harrison S, Hunter DJ, Pollitt C. *The dynamics of British health policy*. London: Unwin Hyman, 1990.

Understanding Benefits

Attendance allowance

Simon Ennals

From the point of view of medical practice and patient care, attendance allowance is perhaps the most important social security benefit. It is one where the detailed knowledge of a patient's needs and condition possessed by the primary health care team is important in helping a patient to qualify. Doctors are ideally placed to spot potential claimants and to help with making a claim. The allowance itself can make an enormous difference to a patient's ability to lead an independent life and it also acts as a passport to the additional premiums to income support and housing benefit described in the third article. With the increasing emphasis on care in the community the attendance allowance, already paid to 713 000 people, will become even more important over the next few years.

The attendance allowance is one of the most misunderstood of social security benefits. It is paid to a person who needs certain kinds of attention because of disability, regardless of whether he or she actually receives that attention. It is often confused with the invalid care allowance, which is paid to the carer of someone receiving attendance allowance. When the attendance allowance was introduced in 1970 it was not designed to meet any particular costs. Clearly the amount paid is inadequate to pay for the kind of attention often required in order to qualify. Most claimants use attendance allowance as a general disablement costs allowance, to help with the additional costs of disability and general housekeeping. It is paid at two rates—£37.55 a week for claimants who satisfy the attendance conditions by day and night, and £25.05 a week for those who satisfy the conditions only by day or night. The government plans to replace attendance allowance for patients under pension age with a new disability living allowance in 1992. The "care" element of this new proposed benefit will work in much the same way as attendance allowance, but with an additional lower rate for less dependent people.

Who can get attendance allowance?

The claimant must satisfy the attendance conditions for night or day attendance, or both (see box).

The claimant must have satisfied one or both of the attendance conditions continuously for six months before making the claim. This has traditionally meant

Qualifying conditions

Day attendance

The person must be so severely disabled that he or she requires from another person *either*:

- (a) frequent attention throughout the day in connection with his or her bodily functions; or
- (b) continual supervision throughout the day in order to avoid substantial danger to himself or herself or others.

Night attendance

The person must be so severely disabled that he or she requires either:

- (a) prolonged or repeated attention in connection with his or her bodily functions from another person; or
- (b) another person to be awake for a prolonged period or at frequent intervals for the purpose of watching over him or her to avoid substantial danger to himself or herself or others.

that many severely ill or disabled claimants have died before qualifying for the allowance. As a result of considerable pressure from organisations working with the terminally ill, the law has now been changed (from October 1990) for terminally ill patients, who will be deemed to have satisfied both day and night conditions for six months. A person will be regarded as terminally ill if he or she is suffering from a progressive disease and can be expected to die within six months.

Until April 1990 the disabled person had to be at least 2 years old, but disabled babies are now eligible. A child under 16 must require substantially more attention or supervision than that normally required by a non-disabled child of the same age and sex.

Attendance allowance is not means tested, and nor does it depend on National Insurance contributions, but the claimant must usually live in Great Britain and have been present there for at least 26 weeks in the past 12 months. A temporary absence of up to 26 weeks, or longer if it is for medical treatment and is approved by the secretary of state, will not affect the right to benefit.

The claimant must not have been living in certain kinds of accommodation provided for out of public funds, such as local authority homes and hospitals, for

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 and maternity pay

Means tested benefits

Income support
Housing benefit
Community charge benefit
Family credit
Social fund

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This is the sixth of 10 articles

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Attendance allowance is paid whether or not the claimant receives the necessary attention

28 days or more. Two or more periods of less than 28 days which are separated by less than 28 days will be linked together. So if a patient spends two weeks in hospital, comes out for three weeks, and then returns to hospital again, it will all be treated as the same period in hospital. The attendance allowance would stop two weeks after the second admission to hospital. Recipients who regularly enter such accommodation for "respite care" may be able to plan a pattern of care which does not affect their benefit by ensuring that they spend a clear 29 days at home whenever their connected periods in care reach the threshold of 28 days. Even if this sort of timetabling is not possible, recipients remain entitled to attendance allowance for any days in the week when they return home. Claimants should always inform the attendance allowance unit if they enter hospital or other scheduled accommodation to avoid the risk of being overpaid.

What the attendance conditions mean

THE DAY CONDITION

Claimants need satisfy only one of the tests either for attention or for supervision. "Attention" means some services of an active nature, while "supervision" is passive and may be precautionary and anticipatory. "Frequent attention" implies more than twice, at least, but need not be required to the same extent every day. "Throughout the day" is a crucial part of the test. Many people with disabilities require considerable attention at certain times of the day and little at other times. Some attention must be needed in the middle of the day—just morning and evening would not be enough.

"Bodily functions" have been defined as including "breathing, hearing, seeing, eating, drinking, walking, sitting, sleeping, getting in and out of bed, dressing, undressing, eliminating waste products and the like, all of which an ordinary person who is not suffering from any disability does for himself." To this list could also be added washing, bathing, and communicating.

This is a long list covering different kinds of functions and which therefore embraces people with many different disabilities. The definition does not, however, always seem logical in terms of what is necessary for people to live independently. While help with cutting up food, turning on taps, washing,

shaving, and brushing hair are all taken to involve bodily functions, cooking, shopping, and housework are not. This distinction excludes many severely disabled people from qualifying for attendance allowance.

"Continual supervision in order to avoid substantial danger" has four parts to it.

- There must be substantial danger arising from the claimant's medical condition, which has to be considered on an individual basis.
- The danger must not be too unlikely to occur, but the fact that it has never happened does not mean that it is unlikely to do so.
- The claimant must need supervision, and the need is not necessarily lessened simply because he or she can call for help.
- The need must be "continual," which can be tested by asking: Could the claimant be alone for a considerable period of time without substantial danger? A claimant liable to epileptic fits without warning may well need continual supervision.

THE NIGHT CONDITION

"Prolonged or repeated attention in connection with bodily functions" is an easier test than the daytime test of frequent attention. If someone requires one prolonged period of attention (20 minutes or more) he or she would qualify. "Repeated" means simply more than once a night. Sleep is a bodily function, so a child who needs soothing back to sleep after a fit or after bed wetting would qualify. "Watching over" is a recent night time test, which specifically requires someone to be awake for a prolonged period, or at frequent intervals, for the purpose of supervision.

Whenever the day or night conditions say "requires," it is worth noting that this means reasonably required rather than strictly medically required. If it is reasonable for the claimant to undertake an activity, such as going up or down stairs, for which he or she needs attention or supervision, that need should be taken into account, regardless of whether it would be possible to avoid the activity. Claimants are not expected to stay bed bound to avoid the risk of falling over.

RENAL DIALYSIS

Some patients undergoing renal dialysis qualify for attendance allowance. Someone who undergoes dialysis for at least two sessions a week, whether at home or as a hospital outpatient, and during it needs attention or supervision from someone other than hospital staff satisfies the day or night condition and qualifies for attendance allowance at the lower rate.

Claims, examinations, and reviews

Claimants must complete the claim form contained in the Department of Social Security leaflet DS 2 and send it in to the local Department of Social Security office. For children under 16 the mother should normally claim, unless she is not living with the child. When the patient may be terminally ill the claim can be made on his or her behalf by a friend or relative. The doctor should complete a report on form DS 1500, which the Department of Social Security has distributed to surgeries, health centres, and hospitals. This should be given to the patient in a sealed envelope if necessary. Claims are forwarded to the attendance allowance board, responsible for all claims. The board usually appoints a doctor known as the delegated medical practitioner to decide the claim on its behalf. The doctor in turn arranges for another doctor, known as the examining medical practitioner, to examine the claimant and write a report. With claims from terminally ill patients no medical examination is required, and claims should be processed very quickly.

The examining medical practitioner will visit the claimant at home, conduct a medical examination, and complete a form which summarises the claimant's needs for attention or supervision, as described by the claimant or a carer. It also includes a checklist of activities which the claimant can and cannot do. The evidence of the claimant and the carer is crucial to the report, and they are well advised to make a list of all the attention and supervision needed before the doctor's visit, to ensure nothing is forgotten. Equally important is evidence from the family doctor, health visitor, or nurse, confirming the patient's need for help.

The delegated medical practitioner makes a decision based on the examining doctor's report and any other evidence the claimant submits. In borderline cases it may be worth the claimant writing out a statement of needs, which can then be confirmed as accurate by a general practitioner or consultant. Attendance allowance can be awarded for life or for a shorter period. For a child the award will always end on the 16th birthday, after which a new claim must be made.

If the delegated medical practitioner refuses attendance allowance, or awards only the lower rate, the claimant can ask for a review of the decision by writing to the attendance allowance unit within three months. Reviews can also be requested at any time if there is a change in circumstances, such as a deterioration in the patient's condition, or if the original decision was taken in ignorance of, or based on a mistake about, a material fact. The claimant will then be examined again by a different doctor, and additional evidence can be sent in, including, for example, a diary kept over a few weeks detailing all the attention or supervision required.

The review procedure can be long and complex and can place a tremendous strain on the claimant and the carer. Doctors can help by being aware of the possibility of reviews, being able to direct patients to competent advisers (such as advice centres or law centres) for help, and being prepared to give their opinion about their patient's needs for attention. In 1988, 72% of people who sought a review after an initial

refusal were subsequently awarded attendance allowance.

Patients to look out for

Attendance allowance is currently paid to people with a wide range of medical conditions. What is important is not the condition but the loss of function that it causes. Mentally ill claimants often have a more difficult time qualifying than physically ill claimants, but many do, and it is often worth a claim. Deaf children who need an interpreter also often get attendance allowance. Children suffering from diabetes or metabolic diseases which require closely supervised diets have been awarded attendance allowance, as have people suffering from asthma, heart disease, arthritis, and multiple sclerosis. Among elderly people, senile dementia and arthritis commonly give rise to the attendance needs which qualify them for attendance allowance. As a general rule, anyone who appears to satisfy the attendance conditions, whatever the medical diagnosis, should be encouraged to claim.

Attendance allowance and other benefits

Attendance allowance can be received along with any other benefit and is tax free.

- Someone receiving attendance allowance is treated as 80% disabled for the purposes of severe disablement allowance (see article on incapacity benefits).
- In calculating income support and housing or community charge benefit attendance allowance acts as a "passport" to the disabled child premium and to the disability, severe disability, and higher pensioner premiums.
- If the disabled person has a carer he or she can claim invalid care allowance at £28.20 a week providing that he or she:
 - cares for at least 35 hours per week
 - does not earn more than £20 a week
 - is not in full time education
 - is under 65 when first claiming.

For Debate

Compensation for medical accidents

Brian Capstick, Peter Edwards, David Mason

Recent publicity has continued to bring the question of compensation for victims of medical accidents into the public eye. The perceived problems are, firstly, that the expense of awards is an intolerable strain on health service resources; secondly, that there is an inequity between those who get nothing under a tort system and the fortunes—sometimes in excess of £1m¹—awarded to the winners; and, thirdly, that there is an incipient public health problem of litigation deterring doctors from entering obstetrics, once a popular specialty.

Although the debate is often conducted in terms that refer to medical malpractice litigation generally, the present concern has arisen largely out of the single issue of those obstetric claims in which cerebral palsy is said to have been caused as the result of birth asphyxia. In 1988 we began a study of 100 such claims, which comprised a statistical survey of origins and outcomes,² an analysis of the medical and legal issues (*Obstetric Malpractice Claims*, forthcoming), and the present outline³ of the options that exist to control the cost of these and, to some extent, other claims.

The no fault option

No fault compensation is increasingly mooted as a means of compensating the victims of medical accidents, and a private member's bill introduced by Mrs Rosemary Barnes proposing such a scheme is due to receive its second reading in the House of Commons on 1 February. We therefore considered the extent to which a no fault scheme would be likely to overcome the three problems of cost, equity, and the threat to public health to which we have referred above, both generally and in the context of the cases of brain damaged babies that we studied.

FAIRNESS FOR ALL?

The class of beneficiaries is the first matter that any no fault scheme has to define, and it goes straight to the issue of fairness.

The most cautious type of no fault scheme is that which permits claims only by a narrowly selected group of patients, such as the Vaccine Damage Payments Act 1979 or the scheme operating in the state

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