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Incapacity Benefit reform and the politics of ill health.

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Incapacity benefit reform and the politics of ill health

PERSONAL VIEW **Clare I Bambra**

In October 2008 incapacity benefit in the United Kingdom will be replaced, for new but not existing claimants, by the employment support allowance. This radical change has been largely ignored by health professionals, despite the role of general practitioners in the diagnosis and certification of long term sickness absence, the involvement of the NHS (usually via primary care) in interventions for getting incapacity benefit claimants back to work (notably the condition management programme and Pathways to Work), and the importance of income maintenance policies for the health of individuals and the population. But the reform of incapacity benefit signifies a dangerous political shift in how chronically ill and disabled patients are seen as either "deserving" or "undeserving" of state support. Such a shift will have important implications for the health professionals involved.

Incapacity benefit, the main social security cash benefit that isn't means tested, is paid to 2.7 million people in the UK. Recipients, who need to have contributed sufficient national insurance payments, are assessed as being incapable of work because of illness or disability, initially by a GP and after six months by a Benefits Agency doctor. There are two short term rates: a lower rate paid for the first 28 weeks of sickness (currently £63.75 (€80; $120) a week) and a higher rate for weeks 29 to 52 (£75.40 a week). A long term rate (£84.50 a week) applies to people who have been sick for more than a year and accounts for the largest number of claimants. Participation in employability programmes is voluntary for claimants of incapacity benefit.

Healthcare workers will become increasingly involved in regulating the poor

The new employment support allowance will comprise a two tier system of benefits in which all are entitled to a basic benefit (paid at the same rate as job seeker's allowance: £60.50 a week). However, people who are judged (on a medically administered "work capability" test) to be unable to work or with limited capacity for work will receive a higher level of benefit ("support allowance," similar to incapacity benefit) with no conditions. Those who are deemed "sick but able to work" would receive an "employment support" component only if they participated in employability initiatives such as Pathways to Work.

The introduction of the two tiered employment support allowance means that for the first time in the UK conditionality applies to the receipt of sickness related benefits. However, it is in keeping with the reform of other UK benefits (such as unemployment benefit) and changes to sickness absence benefits elsewhere in Europe. Generally such reforms are sold as a way to reintroduce recipients to the labour market or to provide an incentive for people to look for and return to work—although there is no evidence of their effectiveness. However, the reforms also need to be understood in the context of the political debate about the relation between incapacity benefit, health, and employment.

Incapacity benefit has long been criticised as providing a means of avoiding work and as a mechanism whereby levels of unemployment are hidden. Despite evidence that medically certified sickness absence (including incapacity benefit) is actually a good indicator of health and mortality, political and media debates are dominated by the view that incapacity benefit is a disincentive to work and that people with good health choose to fake sickness to receive it. The discourse around "fake" claimants (usually people with a diagnosis of a mental health problem) has popularised the view that some types of illness, and therefore some patients, are less deserving of state support than others. Such concerns are reflected in the employment support allowance's separation of health based claims into two distinct categories: people considered sick but able to work (undeserving poor) will receive lower levels of benefit unless they participate in compulsory employability programmes, whereas those considered to have a more severe illness or disability (deserving poor) will receive a higher rate of unconditional benefit.

Sickness related benefits are among the last in the UK welfare system to be reformed and until recently did not attract as much popular stigma as other benefits. This is also the case in other countries, where people who receive benefits because of ill health or disability have been viewed and treated as more "deserving" than those receiving other types of benefit. The reform of incapacity benefit is a move away from this and may signal a potentially disturbing political discourse about how some patients who are unemployed because of illness or disability are less deserving of unconditional public support than others.

It is unclear how all this will play out, but it seems likely that the deserving/undeserving dichotomy may well reinforce and magnify the existing stigma attached to claims that are based on mental illness and may therefore further increase health inequalities. Either way, it will have important implications for the health professionals involved, as the validity of professional medical certification is being questioned by the government, and healthcare workers will become increasingly involved in regulating the poor.

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