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ADVISING THE STATES OF JERSEY, SOCIAL SECURITY DEPARTMENT ON WORKING-AGE INCAPACITY: A REPORT BY DR. BEN BAUMBERG GEIGER, 1ST SEPTEMBER 2017

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ADVISING THE STATES OF JERSEY, SOCIAL SECURITY DEPARTMENT ON WORKING-AGE INCAPACITY

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Introduction

This short report provides guidance to the Social Security Department of the States of Jersey (hereafter 'SSD') on the assessment of incapacity for the benefits system. It is based on a wider international review of incapacity assessment, and is formed of three main sections:

Disclaimer

The views in this report are the author's own and do not necessarily reflect those of the Social Security Department.

1. Principles of incapacity benefits and their assessment

The rationale for incapacity benefits

'Incapacity benefits' – financial transfers to people whose health/disability reduces their capacity to work – are central to social security systems worldwide. Disabled people are nearly always given more money than non-disabled people while they are out-of-work, and indeed, historically these benefits were largely introduced before unemployment benefits even existed [1]. There are two main reasons for this:

1. The minor reason is that disabled people have higher costs-of-living than non-disabled people [2, 3]. Often other benefits cover some of this additional cost, but they rarely cover the full amount, and higher out-of-work payments to disabled people are therefore usually necessary to avoid poverty.[1]
2. The major reason is that benefits for non-disabled people are not designed to support people for long periods of time – they usually only pay enough to tide people over until they find another job (excluding long-term essential living costs like white goods). However, disabled benefit claimants tend to be out of work for longer periods of time,[2] and they need more than being tided-over: they need enough money to live on for several years, and perhaps for the rest of their lives. They therefore need higher benefits than non-disabled people.

Alongside these, there are other reasons that incapacity benefits have become widespread, some due to political economy (the perceived 'deservingness' of disabled people compared to non-disabled unemployed people), and some due to economic need (employers' desire for industrial injuries to be dealt with by the state rather than compensation claims). But these two reasons are the main explicit justifications given in twenty-first century welfare states. In the final section of this report, we return to considering these principles in the light of the benefits available in the States of Jersey.

The meaning of 'incapacity'

The main rationale for paying incapacity benefits is that disabled people have a reduced capacity for work, and are therefore likely to be out-of-work for much longer than non-disabled people (and possibly indefinitely). Because of this, a simple aim for incapacity assessments is that they should assess people's capacity for work: the question is how to do this.

The earliest assessments of work capacity were those based on ***medical conditions or impairments***, most commonly through 'baremas' that quantify the assumed loss of work capacity associated with e.g. losing a body part [5, 6]. These are still commonly used in Jersey for the assessment of Long-Term Incapacity Allowance (see section 3). However, these are a very poor proxy for whether someone has reduced functioning, let alone a reduced capacity for work, because people's functioning cannot be reduced to their impairments. (Put another way: that someone is missing a thumb tells you almost nothing about their everyday functioning).

In most high-income countries, baremas have been gradually replaced by ***functioning-based assessments***, which look at the functional capacities of the claimant (e.g. their ability to raise their

[1] For example, in the UK, research by the disability charity *Scope* suggests the average extra cost benefit award is £360/month, compared to average extra costs of £550/month [4].

[2] For example, in the UK, about 75% of incapacity benefit claimants have claimed for 2 or more years, compared to only 17% of unemployment benefit claimants. Great Britain official data for August 2016 (the latest available for ESA claimants) taken from Stat-Xplore (ESA) and nomis (JSA), 5/5/2017.

arm, convey a simple message, or cope with any change). However, functioning-based assessments are still poor proxies for people's capacity for work, because they do not explicitly compare claimants' functional abilities to the requirements of work. These assessments may have a 'local notion' of the demands of the modern workplace [7, p18], but a recent World Bank report has argued that "*is that it is difficult to come up with the domains or areas of functional capacity that are highly and consistently correlated with a standardized 'capacity to work', given the enormous variety of work requirements and kinds of employment situations*" [5].

The problems of functioning-based assessments can be seen in the UK's Work Capability Assessment (WCA), which is primarily based on scores against fifteen different functional descriptors. However, not only is there no evidence that the descriptors capture the requirements of the modern British workplace, but the WCA struggles to assess anyone with two or more types of impairments – which probably includes half of all disabled people or more. Despite being carefully created by a technical advisory group, in practice the WCA has failed to control expenditure, has been found to raise the risk of suicide [8], and has consistently generated bad headlines over the best part of a decade. It is hard to disagree with the noted Politics professors Anthony King and Ivor Crewe, who dubbed it as one of the recent 'blunders of our governments' [9].

The World Bank report by Bickenbach et al [5] – and an upcoming paper by myself [10] – therefore both argue that we should *directly* assess work capacity, rather than relying on proxies like functioning or impairments. I term these ***direct disability assessments.*** Such assessments have several advantages:

- They are aligned with the rationale of the incapacity benefits system;
- They are also aligned with modern models of disability such as the International Classification of Functioning, Disability and Health (ICF) [11], and legal definitions of disability in anti-discrimination legislation and the UN Convention on the Rights of Persons with Disabilities [12];
- They have the potential to produce more accurate decisions (see below), reducing the number of people with residual work capacity who are awarded benefits, and the number of people who are incapable of work who are denied them;
- They have the potential to have high 'face validity' – that is, for claimants to understand the logic of the decisions that are made.

In the second section of this report, I therefore review international models of how direct disability assessment can be carried out in practice, before making recommendations as to how this could be applied in the case of Jersey.

Other considerations in incapacity assessment

There are several other considerations in incapacity assessment for social security benefits that are worth briefly mentioning here.

There is a temptation to think of work capacity as a binary state: people are either capable of work, or they are not. However, in the words of Sidney Webb back in 1912, 'incapable of any work whatsoever' can only mean 'literally unconscious or asleep' [cited in 13]. For everyone else, the issue is how far their health conditions/disabilities reduce the *chances* of them getting and keeping work. To use the common example of Stephen Hawking: the chances of someone with his impairments working are low, but given his wider abilities, he has been able to have a very successful career. Work capacity is a matter of probabilities, not of sharply defined categories.

SSD specifically asked me to consider whether financial support should vary between *initial claims and longer-term claims* (given the nature of the current Jersey system). There is a rationale for higher payments for long-term claims: more money is needed to cover living costs in the longer-term, as described above, and it is therefore not uncommon for longer-term incapacity benefit rates to be higher (and indeed was the case in the UK until the introduction of ESA in 2008). However, this also has the effect of incentivising claimants to stay on the benefit for longer periods of time, which is why the long-term rate was removed in ESA. The extent to which these incentives have any impact is contested [e.g. 14], but there is no easy answer as to whether financial support should vary by claim duration; I return to this issue below.

The principles of disability assessment for *other financial support* (to cover extra costs, rather than incapacity) are different from those of incapacity assessment: the aim is to assess the costs that individuals face, rather than their chances of getting/keeping work. Direct extra costs assessment is very difficult, and so many states rely on functional capacities as a proxy. However, the Jersey system is a compromise between these two systems, focussed on work capacity for contributory incapacity benefits, but extra costs for means-tested benefits. I return to this issue in the recommendations below. There is also a related question about whether a single assessment is sufficient to govern both financial and *non-financial* support; I discuss this issue when discussing one of the models of incapacity assessment ('demonstrated assessment') in section two.

Finally, there is the question of the *legitimacy* of incapacity assessments: who do the general public think should receive incapacity benefits? This is a large question which is the subject of my ongoing research.[3] Nevertheless, it is worth observing at this stage that there is no simple public desire for incapacity benefits to be cut. Instead, public opinion in most high-income countries is ambivalent: some people are sceptical about the 'deservingness' of vaguely-known others, particularly where they have fluctuating or hidden disabilities. Yet simultaneously, people tend to be overwhelmingly supportive of generous benefits for people they class as 'genuinely disabled'. This ambiguity, combined with the public's lack of understanding of disability *per se*, makes it tricky to respond to public opinion in incapacity assessments. Nevertheless, to the extent possible, I respond to the broad sweeps of public opinion in the recommendations below.

[3] The results will be published in a report by the think-tank *Demos* in December 2017, and an academic paper that will hopefully be published in 2018; while these are outside of the scope of the current report, I will circulate these to SSD in due course.

2. International models of incapacity assessment

In this section, I review models of incapacity assessment from 10 countries: the UK, USA, Canada, New Zealand, Australia, Netherlands, Germany, Sweden, Denmark, and Norway. The case studies are predominantly based on desk research in multiple languages (over 150 documents were reviewed), but I also conducted 40 interviews to clarify key elements of the systems; further details are available in [10].

Rather than cataloguing each case in turn (from which it is difficult to draw lessons for the States of Jersey), I instead present a typology of three ways in which disability assessments can be done in practice: 'structured assessments'; 'demonstrated assessments'; and 'expert assessments'. In the course of discussing each type, I consider how limitations can be dealt with, and which limitations remain, as well several other issues that SSD mentioned were of interest (including the organization and professional role allocation of the assessments).

Model #1: Structured assessments of incapacity

The Dutch system exemplifies the 'structured assessment' of work capacity. Claimants' functional capacities are assessed, then compared to the functional requirements of 7,000 actually-existing jobs in the Netherlands [15] in a database called CBBS [16, 17]. It covers 28 different functional domains against which claimants are assessed, allowing variation between regular demands and peak demands, as well as covering the required work pattern, education, experience and skills of the job [18, 19]. This provides an empirically-based assessment of jobs that the individual can do, and the percentage earnings reduction that their disability causes compared to their previous occupation, which then underpins their eligibility for disability benefits.

The other main example of structured assessments comes from the US. Here the Social Security Administration (SSA) establishes if a medical impairment exists, and then compares this to a listing of impairments [20]. If claimants do not have an impairment that meets the listing, then a Residual Functional Capacity Assessment is conducted, which is then compared to the demands of work. Claimants ineligible for incapacity benefits are typically told of three occupations that the SSA believes are commensurate with their abilities [21]. However, the structured assessment is much cruder than that in the Netherlands, and simply classifies jobs as based primarily on 'exertional' (physical) limitations: very heavy work, heavy work, medium work, light work, or sedentary work [20].

There are several issues that need to be considered in structured assessments. Firstly, it may imply that relatively unqualified staff can be responsible for assessing work capacity (once functional impairments have been assessed) – the functional profile can simply be fed into a database. However, this is not the case. In the Netherlands, the result is not itself fully automated, with a labour expert providing the final definitive judgement based on their own professional expertise [19]. While the degree of discretion is relatively constrained [22], this ensures that obvious errors or data limitations do not lead to unfair decisions. Moreover, the Netherlands have been experimenting with personalised expert judgements as to possible job *adjustments* that would enable the person to work. (This is now done for the assessment for the youth disability benefit, SMBA, which requires labour market experts to explain their decisions within a structured report). While the database is a valuable aid to decision-making, it does not fully substitute for expertise.

Secondly, while structured assessments can provide valid judgements of whether people should receive financial support, they are not necessarily helpful for the non-financial purposes of incapacity

benefits (i.e. helping people get back to work). They ignore psychosocial factors, do not start from the priorities of the individual in question, and do not consider what would help the individual to work [23]. They also tend to consider the way that the workplace presently is, rather than how it might be changed, although the Netherlands are experimenting with ways of overcoming this (see above). Still, such issues explain why the Dutch assessment is often described as capturing 'theoretical' work capacity rather than a basis for rehabilitation [24 and expert interview].

Finally, perhaps the greatest challenge for adopting this approach in small jurisdictions such as the States of Jersey is the resources required to create an up-to-date picture of the demands of work. Given the prohibitive cost of covering all jobs nationally, CBBS covers about 20% of all of the possible occupational codes in the Netherlands, weighted towards 'lower level jobs' that are potentially available to all claimants [17, 19]. Nevertheless, it still requires a team of about 35 full-time specialists in the social insurance agency to make on-site observations of Dutch jobs [17, 19 and expert interview]. The situation is worse in the US, where the main information source ('DOT') has not been substantially revised since 1977 [20, 21, 25], but where its replacement ('O*NET') is considered inadequate for social security assessment [25, 26]. One alternative is to focus on the functional requirements of a much smaller number of jobs. The Dutch SMBA assessment for youth disability benefit provides functional profiles for 15 relatively light minimum wage jobs (e.g. 'parking lot attendant', 'receptionist'), which are each meant to be representative of the requirements of wider groups of jobs nationally.

Overall, the Dutch structured assessments seem to produce decisions that are widely accepted as fair, and are consistently cited by international experts as best practice [5, 7, see also 27]. However, given the resources required, it may not be possible to adopt such a system in small jurisdictions such as the States of Jersey.

Model 2: Demonstrated assessments of incapacity

The second model of directly assessing work capacity is based on the actual experiences of the individual in the labour market, which I term the 'demonstrated assessment of work capacity'. Many people's functional capacities and ability to cope in different workplaces are inherently uncertain. Leading models of supported employment such as Individual Placement & Support [28] therefore use an iterative learning process to assess an individual's work capacity: they try the most suitable work environment first, and see how the person manages.

A similar principle can be applied to incapacity benefits assessment. Perhaps its clearest statement can be seen in an Australian high-level strategy document, which argued the current assessment was flawed because it was tasked with assessing claimants' work capacity over the next two years, and for many claimants *"there is little or no practical evidence on which to base this judgment"* [29]. It therefore recommended that most claimants should only be eligible for the disability pension "*when their 'Continuing Inability to Work' has been demonstrated"* in practice.

Since the ensuing reforms, Australian claimants need to actively participate in a (usually government-funded) 'program of support' for 18 months before being eligible for the disability pension [30], at which point they are referred to an expert assessment (below). Further evidence was also expected to come from looking at individuals' prior work history – whether they had *"'fallen out of employment' rather than had to cease work because of their disability"* [29], which is also explicitly considered in Canada.

Similar reasoning can be seen in Denmark [31]. Claimants are now only awarded a disability pension if an assessing multidisciplinary team is confident – and can demonstrate – that the individual has no

capacity for work [32, 33 and expert interviews]. In practice the majority of claimants are required to go through a scheme called Resource Activation for one to five years. Another crucial aspect of the Danish system is that individuals are often sent on a work trial/work test for several months in order to clarify their work. These take place in either a private company or an activation service, and are not meant to replace existing jobs, but instead to test which tasks individual are capable of within a work setting.

Again, there are several issues that need to be considered in this approach. Firstly, because rehabilitation benefits are generally lower than disability pensions, critics have argued that this is simply a benefit cut for people who have no realistic chance of work. For example, in Denmark, there has been considerable media and political attention on those placed in work trials or Resource Activation who have very low levels of assessed work capacity [e.g. 30mins of work capacity at low speed, twice per week; see 34]. Second, while real-life labour market experiences provide some evidence of work capacity, there is still a need for considerable expertise in interpreting people's past experiences and in deciding what future rehabilitation steps are still feasible (if any). The Danish system exemplifies this: it combines investment in a rehabilitation process with investment in a multidisciplinary team assessment (see also below).

Third, this only provides an accurate picture of work capacity if the rehabilitation maximises work capacity. In practice, however, older models of rehabilitation are not necessarily focused on employment in the open labour market, and even where rehabilitation is focussed on supported employment, there are examples from almost every country where this does not maximise work capacity. For example, in Denmark, there are anecdotal reports of work trials that are poorly matched to the individual in question [expert interviews and 34, 35], and despite a series of reforms in Australia, a recent Government consultation found that *"providers and people with disability expressed widespread, almost universal, concern about [the assessments], including consistent feedback that they often refer people with disability to inappropriate services"* [36]. It is therefore an open question whether small jurisdictions such as the States of Jersey would be able to ensure sufficient rehabilitation to demonstrate an individual's true work capacity.

Finally, even though demonstrated assessments seem to overlap most strongly with assessments for non-financial support, this overlap is only partial. This is partly because the claimants' relationship with the assessor may be one of distrust when being evaluated for financial support, but more trusting when their rehabilitation needs are being evaluated. It is also because there are pressures for benefit eligibility to be standardised, but for rehabilitation assessment to be personalised [37]. Yet even if these tensions can be overcome, modern ability-based rehabilitation needs to be based on a holistic assessment of an individual, including *inter alia* their motivation [38], but motivation is not usually considered a legitimate influence on benefit eligibility. Conversely, benefit eligibility assessments examine people's capacity to do jobs that they have no desire to do, which is unhelpful for the purposes of rehabilitation. It is therefore possible to combine these assessments in an inefficient way that *increases* the resources required for assessment, which was a key reason why Australian dual-purpose assessments were later abandoned. Even if the latest Danish reforms ultimately overcome this tension, the possibility of inefficiencies remains for other states.

Overall, not only does the demonstrated assessment of incapacity have the potential for greater accuracy, but it also has a strong link to rehabilitation. Again, however, it requires substantial expertise and investment in order to be implemented successfully, and the required rehabilitation system may not be feasible to introduce in small jurisdictions such as the States of Jersey in the short-term.

Model #3: Expert assessment of incapacity

The final form of directly assessing work capacity is the most common, and also closest to the current Jersey model: to ask a professional to use their expertise to judge whether an individual is capable of work. Sometimes this is done by people's own treating doctor (e.g. the first stage of the New Zealand assessment), although in some countries these have been replaced by government-appointed experts on the assumption that an independent assessor will be less swayed by their existing relationship with the claimant [39], as discussed in the Stafford Report (5.27). However, there are longstanding concerns about the consistency and validity of such discretionary assessments.

One issue is around correctly understanding the demands of work. Commonly assessments are done by independent doctors (Germany) or allied health professionals (Australia, Canada), but the training of these professionals is around diagnosing/treating ill-health rather than occupational health. Nor do we have a clear idea of what assessors consider to be the general demands of the workplace – insurance physicians tend not to mention job requirements explicitly when making individual decisions about work capacity [40, 41]. One solution is to adopt a new professional category with more relevant expertise and more explicit reporting requirements, such as the Dutch professional category of 'labour market experts'. Alternatively [42], *"the solution is hardly to find the ultimate expert but rather to allow groups of 'experts' with different types of expertise to give arguments for and against disability pension"*, a view that can be seen in practice in the Danish and Swedish multidisciplinary team assessments.

A further key issue is in ensuring consistency in a discretionary assessment. A recent systematic review found that expert assessments of work ability *"show high variability and often low reliability"* [43]. They suggest that this can be partly combated through standardisation, which can be seen in, for example,[4] the standardised inputs that are prepared for rehabilitation assessment meetings in Denmark, via a standard rehabilitation plan that is completed by the claimant in partnership with their caseworker. The expert-based elements of assessment in the Netherlands are perhaps the most structured, in which insurance physicians follow both interview protocols [45] and disease-specific guidelines for assessing work-related functioning [46]. Yet even with such standardisation, getting consistent work capacity judgements from expert assessment is difficult.[5]

There can therefore be a considerable gap between the formal definition of work capacity being assessed, vs. the actual criteria used by assessors. For example, while the German criterion is formally based on the number of hours/day that an individual could work, in practice assessors divide between more- and less-disabled individuals based on a rule of thumb [50]. Similarly, in Australia the assessments were formally made more stringent (from 30 to 15 hours/wk of work capacity), but the long-term claim rate was almost unchanged [29], which suggests that assessors' rule-of-thumb was unchanged. Even today, experts in Australia variously described the benchmark hours criterion as 'arbitrary' and 'almost a fictitious construct'.

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[4] This should not be confused with vaguer and more generic guidance about assessing work capacity [such as in Canada or Australia; see 30, 44].

[5] The evidence on standardisation in Barth et al's review is not compelling (the link they find between standardisation and reliability is confounded by whether the study is conducted in a 'manufactured' research or more naturalistic insurance setting). In contrast, direct evaluations of standardisation have found mixed results [e.g. 47]. And even in the Netherlands, where specific guidelines exist for assessing work hour capacity, expert insurance physicians failed to reach high levels of agreement when assessing the hours of work capacity that a social security applicant was capable of, whether they received a written assessment from a nurse [48] or interviewed the applicant themselves [49] – in contrast to their relatively reliable assessments of functioning.

Overall, experts can assess work capacity with some degree of legitimacy, and are used in many systems around the world. Nevertheless, there are some concerns over the validity and reliability of their judgements. These may be partially mitigated through appropriating training/expertise, and standardisation of inputs, decision protocols and reporting requirements.

Further issues: The dividing line between disability and unemployment

A final question that often arises for all these models is how to maintain the distinction between disability and unemployment, given that claimants' capacity to work is likely to be affected by non-medical issues (such as personal or labour market factors). The solution in nearly all countries is twofold: to require that claimants have a medically-diagnosed health condition [41]; and to make clear that social security assessments only consider if a person is capable of doing work that they are qualified to do, not whether they could actually get a job in their area. There are numerous examples of this [15, 20, 30, 44], even if some countries do choose to take labour market factors into account in certain situations (e.g. Germany and Sweden).

This does not mean that non-medical factors were ignored in work capacity assessment, but rather that they were only considered if they influenced the jobs that people were *capable* of doing. So for example, in the Netherlands, you are not considered as capable of doing a job that you are completely unqualified for. And in the Canadian expert-based assessment, age, education and work experience are all taken into account in determining whether someone had limited work capacity, explicitly because these genuinely affect what people are capable of doing [44]. Direct disability assessment does not necessarily mean that non-medical factors are taken into account (they were ignored in other cases), but where they are considered, steps are taken to ensure that a sharp administrative boundary between unemployment and disability remains.

3. Implications for Jersey

The challenge for small jurisdictions such as the States of Jersey is in meeting the following, sometimes mutually contradictory requirements for incapacity assessments:

- *Validity* – incapacity benefits should go to people with reduced work capacity. Ideally two types of failure should be avoided: giving benefits to those who have high work capacity, and providing no support to those who have substantially reduced chances of work.
- *Reliability/Predictability* – people in the same situation should receive the same decision, irrespective of exactly who assesses them. From SSD's perspective, it is also strongly desirable for the population-level outcomes of the assessment (and therefore financial costs) to be reasonably predictable, rather than becoming more/less lenient over time.
- *Legitimacy* – ideally the assessment should match the public's idea of 'fairness'. However, this is difficult to achieve when the public's attitudes are ambiguous and their understanding is limited. Nevertheless, from the perspective of claimants, the decisions should seem reasonable, and the process justified and empathetic.
- *Deliverable* – the assessment should be deliverable given the practical constraints faced by small jurisdictions such as the States of Jersey, including the professional staff available, the fit with wider systems (including benefits and rehabilitation), and the resources available.

Bearing these goals in mind, along with the international evidence above, the nature of the existing system, and the recommendations of the Stafford Report (R.42_2007), I recommend:

Recommendation area	***Jersey Considerations***
1. Definition of incapacity	Few disabled people are 'completely incapable of any work', but relatively large numbers struggle to meet the requirements of the modern workplace, and are therefore unlikely to find/keep work. Jersey should consider defining 'incapacity' as a reduced capacity to get/keep work due to a health condition or disability.
2. Design of incapacity benefits	There are currently two principles for financial support for disabled people in Jersey – benefits that cover incapacity to work (*Short-Term Incapacity Allowance (STIA)*, *Incapacity Pension*), and disability benefits with other criteria (*Personal Care/Mobility components to Income Support, Long-Term Incapacity Allowance (LTIA)*). The next two recommendations focus on the design of each of these and their inter-relationship. Incapacity benefits are currently confusing, and do not offer sufficient protection against incapacity to work. STIA is a conventional sickness benefit, but is then usually followed by LTIA, which – despite its similar name – is entirely unrelated to incapacity. Respondents to the Stafford Report nevertheless attempted to interpret the LTIA awards in terms of capacity for work (3.10), as this is what they assumed the assessment was assessing. In fact, long-term incapacity is covered by Incapacity Pension, which is a residual benefit that cannot even be directly applied for, and which is claimed by less than 1% of the working-age population, far fewer than LTIA.

	Jersey should consider introducing adequate protection against incapacity to work. This could include (i) replacing Incapacity Pension with a Reduced Work Capacity Allowance, given to people with a substantially reduced capacity for work (aligned with the definition of 'incapacity' above); (ii) adding an incapacity component to Income Support for those with insufficient contributions. The cost of these could be offset by changes to non-incapacity disability benefits, as covered below.
3. Design of other working-age disability benefits	There are three problems with the non-incapacity working-age disability benefits in Jersey. Firstly, while STIA criteria are based on incapacity, LTIA is not, which is confusing. Secondly, there are two non-incapacity benefits (LTIA and Income Support) with entirely different criteria. Third, the assessment for LTIA is an old-fashioned barema, which is inadequate for both assessing the extra costs of disability, or for assessing incapacity. The Stafford Report found that this is the most controversial element of the current system (2.24, 8, 9.21), and summarised extensive criticisms of this approach by experts (2.21, and 8.43 on the challenges of summing percentage limitations). It is likely that there are people claiming LTIA who have neither extra costs nor incapacity; and simultaneously people not eligible for any benefits who have both extra costs and incapacity. Jersey should consider (i) changing the criteria of LTIA to be focussed on the extra costs of disability, following the same design as the Personal Care/Mobility components to Income Support, but with a contributory basis; (ii) changing the name of LTIA to 'Disability Extra Costs Allowance' to avoid confusion. Similar recommendations were made in the Stafford Report. Combined with Recommendation 2, this would lead to a reduction in the number of people on LTIA/Disability Extra Costs Allowance, and an increase in the number on incapacity benefits – together with improved validity & legitimacy of both sets of benefits. The remainder of the recommendations focus primarily on incapacity (rather than extra cost) benefits, as these have been the focus of this report.
4. Process of incapacity assessment	As per Recommendations 2 and 3, Jersey should consider expanding the role of incapacity benefits (via a Reduced Work Capacity Allowance). As for Incapacity Pension, it may well be that given practical constraints, this will continue to be assessed via an expert-based direct assessment of incapacity. However, Jersey should consider maximising the validity and reliability of these assessments by (i) ensuring that medical assessors have substantial occupational health expertise (see also Stafford Report 8.90), perhaps replacing doctors with allied health professionals with greater understanding of incapacity (potentially also helping to resolve some of the issues identified in the Stafford Report 9.24); (ii) using information on people's past labour market experiences, to the extent this provides further evidence

	of work capacity (as in Canada); (ii) providing guidelines that help assessors understand the threshold at which people should be regarded as having reduced capacity for work (which provide useful guidance for decisions, rather than arbitrary thresholds that are ignored in favour of rules-of-thumb), perhaps via research on the requirements of work in Jersey; (iv) having due consideration for fluctuating conditions; (v) providing structured inputs into medical assessments that provide the information required, potentially with the help of a social security administrator, and with due consideration of the best way of obtaining supporting medical evidence; and (vi) requiring structured frameworks through which medical assessors have to report their decisions to SSD.
5. Post-assessment reporting and appeals	It is important for claimants to trust the system, even if they disagree with the outcome, but currently the guidelines for the Medical Boards are unpublished (Stafford Report 8.53), and Stafford ultimately concludes that *"Claimants' understanding of, and level of support for, the incapacity benefit system would undoubtedly improve if the system was more transparent."* Jersey should consider adopting a structured framework for post-assessment reports, which clearly communicate the reasons for the decision to claimants. This could be connected to the structured frameworks for medical assessors to report their decisions to SSD (although these may need to be adapted to be of most benefit to claimants). The 14-day deadline for submitting appeals for LTIA assessments is very short by international standards, and may be unreasonable for those with disabilities and other acute life events. Jersey should consider setting a longer deadline for requesting redeterminations and appeals for the revised medical assessments.
6. Work incentives	Claimants on any benefit with substantially reduced (but not zero) work capacity should have incentives to experiment with work. Jersey should consider ensuring that claimants can leave benefits but return to the same claim if they try to work but ultimately are not capable of it or if their fluctuating condition deteriorates once more; and consider ensuring that claimants are incentivised to work part-time alongside their benefits to the extent they are capable of this, and do not jeopardise their entitlement to incapacity benefits *per se* (considering *inter alia* permitted work, partial benefit awards, and gradual rather than abrupt withdrawal rates). However, the best form for this may not be the Return to Work Bonus proposed in the Stafford Report. At the same time, there is no rationale for giving higher benefits to those in-work. Jersey should consider raising the level of the mobility component of Income Support for non-earners to match that of earners.
7. Link to non-financial support	The relationship of financial to non-financial support was discussed at length in the Stafford Report 2007. In the process of

	reforming the incapacity assessment, Jersey should again consider how best to provide early intervention to those with reduced work capacity, and whether further investment in current best practice models of vocational rehabilitation / supported employment is necessary. However, Jersey should *not* consider making this mandatory – the evidence suggests that this may lead to worse (rather than better) work outcomes [51].
8. Short-term incapacity	For the first 12 months of incapacity, claimants currently receive Short-Term Incapacity Allowance, which is assessed by their GP. However, GPs are not necessarily the right professional to be undertaking such assessments. Jersey should consider whether (i) the current system should be maintained; (ii) this period should be shortened and the incapacity assessment moved forward (e.g. to 6mths), as suggested in the Stafford Report; (iii) GPs should continue to perform the assessment, but should be provided with additional guidance/training/reporting frameworks.
9. Follow-up work	These recommendations are at a broad level. After reflecting on these recommendations, Jersey should conduct further, more detailed work to ensure that any changes to the existing system are deliverable and achieve the intended outcomes.

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