‘Excessive sickness claims’: controlling sickness and incapacity benefits in the early 20th century

Paper presented to the Social Policy Association annual conference, Lincoln 2011

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Abstract

2011 marks the centenary of the first UK national insurance sickness benefit scheme. Recent policy on incapacity benefits has been concerned with increasing controls on claims to ensure that people are ‘really sick’ but policy makers have worried about ‘excessive claims’ for sickness benefits since the very beginnings of the national insurance sickness scheme in 1911. The first investigation into the 1911 scheme was published in 1914 and was asked to ‘inquire into and report upon the alleged excessive claims’ on the national insurance sickness scheme (Schuster 1914). The investigation lasted for six months and took evidence from ninety-four witnesses. It concerned itself with ensuring that all claims were valid.

The sickness insurance scheme, although a state scheme, was administered through ‘approved societies’, friendly societies, and industrial insurance societies, which were free to arrange certain aspects of the scheme in their own ways. After 1914 concern about ‘malingering’ led to increased regulation of the scheme by central government, including a series of guidance issued to approved societies on the control of claims. Particular concern was expressed over the rising numbers of claims by women. Claims for sickness benefits were monitored through the system of ‘sick visitors’ who would visit claimants in their homes to ensure that they were genuinely incapable of work and by increasing numbers of referrals to Regional Medical Officers.

As claims for sickness benefits increased during the depression of the 1930s, particularly claims by women, these concerns grew into constructions of women as ‘malingerers’. Work by Whiteside (1987) has also looked at this period and noted that there was then (as recent research suggests there still is) a grey area between ‘unemployment’ and ‘sickness’, in that claims for sickness benefits increased in times of high unemployment. Work in this field, eg Whiteside (1983, 1987), Heller (2007) has focussed on the role of the state in regulating private agencies in the administration of the scheme. This paper will look at the period from a quite different angle by using an analysis of government documents to investigate the discourse surrounding claims for sickness benefits during the period 1900 to 1926, the mechanisms for monitoring claims and the appeal options available to those refused benefits. While current policies continue to be concerned with assessing genuine incapacity for work, this historical analysis provides important background to the construction of (in)capacity for work over the early twentieth century.

Introduction

This paper is part of a larger research project which seeks to understand the changes in the ways in which capacity for work has been negotiated between claimants for incapacity benefits and decision makers over the course of the 20th century. Set in the context of the present government's welfare to work programme and radical changes to the way that people qualify for incapacity benefits, the paper looks at the development of such benefits since the beginnings of the welfare state in the early 1900s.

Recent government policy on incapacity benefits in the UK has centred around increasing the intensity of mechanisms to establish whether or not people are genuinely incapable of work. The introduction of Employment and Support Allowance in 2008 has narrowed the eligibility rules and introduced new tough tests so that large proportions of claimants are found to be fit for work. This has been accompanied, on the one hand, by government rhetoric that people should be 'saved' from the dependency of claiming incapacity benefits and, on the other, by a flood of media allegations that unsuccessful claimants are workshy scroungers. At the same time critics have argued that the mechanisms for assessing claimants are unfair (Gulland 2011).

However, concerns about whether people are really incapable of work go right back to the very start of the state sickness insurance schemes in 1911, particularly in relation to claims by women. Gilbert argues that 'The problem of 'over-certification' for women illustrated what was perhaps the most important weakness' of the pre-war scheme (Gilbert 1970, p287). Recent work on incapacity benefits has described increases in the proportions of women claiming benefits as 'the feminisation of incapacity benefit' (Kemp and Davidson 2009, p591). While this trend is of particular interest in the early 21st century, policy makers have debated and problematised women's claims for benefits since the first national insurance schemes in the early 20th century. Others have written at length about the politics of the introduction of the 1911 scheme (eg Thane 1996) and about the position of the medical profession and the role of the state in regulating private agencies in the scheme's administration, (eg Digby and Bosanquet 1988, Whiteside 1983, 1987, 1999, Heller 2007) and with the particular issues which arose during the depression of the 1920s and 30s (Tomlinson 1984, Whiteside1983, 1987, 1999).

In this paper I want to go back to the very early days of the 1911 sickness insurance scheme, using official documents as sources, to consider the following research questions:

- What was understood by the term 'incapacity for work'?
- What value was placed on different types of evidence in determining claims?

Data from the early 20th century can be found in a series of investigations into the operation of the sickness benefit scheme: *Report of the Departmental Committee on Sickness Benefit claims under the National Insurance Act 1914* (Schuster 1914) and *Royal Commission on National Health Insurance 1926* (Lawrence 1926). These

investigations collected information from a wide range of sources and their notes of evidence provide a wealth of detail on the views of many stakeholders at the time, although the voice of the sickness benefit claimant is rarely heard. We can get somewhat closer to the claimant's perspective through challenges to refusals of benefit. These can be found in the reports of decisions on appeals relating to claims for sickness benefit. These are reported in *National Health Insurance Commission (England), 'Reports of decisions on appeals and applications under Section 67 of the National Insurance Act 1911 and Section 27 of the National Insurance Act* (NHIC, 1915-1919*).* These sets of documents on the early sickness benefit scheme provide an insight into the concern at the time with the bureaucracy and efficient administration of a new social security scheme. In this paper I want to consider what they can tell us about how those in various positions of power viewed the problem of defining 'incapacity for work'. I would argue that this issue was, and still is in 2011, a hotly disputed social construction and that different views on the matter reveal much about the nature of its construction in social security claims.

Background and sources

The 1911 National Insurance Act

The sickness benefit insurance scheme introduced by the National Insurance Act 1911 was a compulsory scheme, whereby those, aged between 16 and 70, earning less than £160 a year were required to make weekly contributions, supplemented by contributions by their employers and the state. In return they would receive sickness benefit for up to 26 weeks of certified sickness, followed by 'disablement benefit', which was paid at half the rate. A maternity payment was made to insured women and the wives of insured men. The scheme also provided members with the right to treatment by a 'panel' doctor, although not in most cases to hospital treatment. These panel doctors were responsible for providing the initial medical certification for sickness benefits. Although a state scheme, the day to day administration was carried out by 'approved societies': friendly societies, trade unions and industrial societies, which were also able to provide additional benefits if they chose to do so. In 1914 2608 societies had been approved to run the scheme, with memberships ranging from under 100 to hundreds of thousands (Schuster 1914, p5). By 1926, the scheme had 15,000,000 members, administered by 1000 approved societies, varying in size from 50 members to 2 million (Lawrence 1926, para 17).

The 1914 report

The Act received royal assent in 1911 and came into operation in July 1912. The first benefits were paid in January 1913, and by August1913 it had become clear that claims for sickness benefit were far outnumbering those anticipated by actuarial predictions. Concern was raised over these 'excessive claims', particularly in relation to women. A committee was set up to investigate this with the remit of considering:

> 'whether the claims made upon the [insurance] funds …were in excess of the claims, which under a proper system of administration, should have been made upon and allowed by them' (Schuster 1914, p2).

Members of the committee included representatives of approved societies, insurance commissioners, doctors and trade unionists. The committee heard oral evidence from 94 witnesses; over half were from approved societies and trade unions, around a third were representatives of the medical profession (mostly panel doctors) and others included members of insurance committees, women's organisations, employer's organisations. (Schuster 1914, ppiii-iv). Evidence was also provided by Sidney Webb, on behalf of the Fabian Society, which had conducted its own investigation into the scheme. The appendices include 1500 pages of evidence from these witnesses. The committee members examined witnesses in detail about the day-to-day running of the scheme, providing us with a mine of information about attitudes to sickness benefit claims at this early stage of the scheme.

The remit of the committee, to look at 'excessive claims' was related to the original actuarial assumptions underpinning the scheme, which had been made on the basis of claims, mainly by men, to one particular friendly society during the late 1890s (Whiteside 1987). The committee was aware that actuarial estimates could have been wrong, recognising the considerable variation between approved societies, their members and the types of occupations involved. However the committee was also concerned that there was also an element of impropriety in claims and that societies were not making sufficient effort to monitor this. So the focus of the report was with the '*proper administration'* of the scheme. There is a strong focus in the introduction on the problem of variation in membership of different approved societies, partly as a result of different types of occupation but also different cultural norms, including longstanding membership of sickness insurance schemes, religious affiliations and conditional membership for example amongst temperance societies. The report recognised that this variation led to different definitions of 'incapable of work', for example 'in relation to a man engaged in strenuous and exacting work such as coal mining on the one hand and an ordinary member of a society largely composed of sedentary workers on the other' (Schuster 1914, p6). It noted the discretion which societies had to make these decisions, although bound by law and that they should not be 'capriciously' accepting or rejecting claims (p6).

The report concluded, in relation to men's insurance that any overpayments of benefit were being made as a result of administrative inadequacies, combined with the inappropriate practices by some medical practitioners and that improved administration and clamping down on these medical practitioners would be sufficient to resolve the problems. The report was much more concerned however with the excess payments being made to women and concluded that there were several reasons for this: women's failure to understand the principles of the scheme; large numbers of 'ill paid and ill fed' women (although the argument here was that this was at least in part their own fault for not eating healthily); that sickness benefits were paid in a higher proportion to women's wages than men's thus increasing the incentive to claim; the particular ailments to which women were prone (eg in relation to pregnancy) and the difficulty of supervising women while on sickness benefits. These matters were at the fore-front of the writers' minds but the report concluded that the main reason for the excess claims by women was that women in certain occupations were genuinely ill and that it was only the introduction of

the insurance scheme that had brought the levels of this illness to light. The report provided detailed recommendations, including better definition of the meaning of ‘incapacity for work’, clarity about payments in cases of pregnancy, improved monitoring of sickness certificates, improved procedures for ‘sick visitors’ and the introduction of a system of medical referees to consider uncertain cases of alleged incapacity. A dissenting memorandum was included in the report, added by Mary MacArthur, a socialist feminist, representing the Women’s Trade Union League. Mary MacArthur strongly opposed any aspect of the conclusions which doubted women’s claims or their ability to understand the insurance principle. Her view was that any ‘excess’ claims by women were entirely the result of women’s poor health, poverty and difficult employment conditions. This perspective was one which recognised the structural mechanisms behind women’s claims for sickness benefits.

The 1926 Report

By 1924, having survived the social upheavals of the First World War and its aftermath, and after several revisions to the original legislation, the principle of national health insurance was well established. However there were continuing concerns about the administration of the scheme, in particular in relation to its cost and complexity, the adequacy of its provisions and its detailed administration through the approved societies. A Royal Commission was set up with a general remit to consider the national health insurance scheme. Membership of the Commission included 12 men and 2 women. Their qualifications for membership are not clear but they included representatives of government, trade unions, an academic political economist and medical experts. The Commission considered 143 pieces of written evidence and heard oral evidence from 107 witnesses, including government bodies, approved societies and medical professionals. In its introduction the Report regretted the difficulty of gaining the view of insured persons, although accepts as second-hand evidence, evidence from the ministry of health and that of GPs who were considered to have close contact with insured persons.

The Commission was unable to come to a unanimous conclusion and its findings were reported in two reports: a majority report and a minority report. The majority report was concerned primarily with the provision of medical services, the ways in which these were organised and the possibilities of extension to further areas (eg maternity, dental and hospital provision), the introduction of dependants’ allowances for claimants and with the financial security of the approved societies. The minority report, signed by three trade union representatives, diverged from the majority report in several respects but mainly in relation to the minority authors’ belief that the system should be taken out of the hands of the approved societies and run instead by local authorities. No substantive changes were made as a result of either report (Thane 1996, p179) but the published reports and volumes of appendices serve as valuable sources of evidence on attitudes to sickness benefit at the time.

Reports of Appeals to the Insurance Commissioners

The original national insurance legislation stated that any dispute between members and approved societies should be dealt with internally according to the rules of the society but that appeals could be made (by either party) to the Insurance Commissioners (NI Act

1911, s67 as amended by NI Act 1913 s27). Between 1915 and 1919 the commissioners published five reports of appeals, covering 142 cases. These appeals considered disputes about such matters as:

- Membership of the society – for example if a society claimed that a membership was invalid because the member had failed to disclose an existing health problem
- Refusal of sickness benefit
- 'misdemeanour' while claiming sickness benefit
- Breach of society's rules eg by breaking a curfew

Hearings were sometimes oral and could include witnesses and further statements of evidence from both sides. Parties could be represented by solicitors. Other appeals were based on paper submissions only. Anonymised details of cases are published in the reports. Unfortunately, for researchers, the names of approved societies are not included, so we are unable to see which particular societies were subject to (or initiators of) appeals or whether there were any patterns relating to types of society. Information about appellants is patchy – it is usually possible to determine the gender of the appellant but not always possible to know what their age, occupation or marital status was, This depends on the level of detail provided in the case and whether the writer of the report deemed it relevant to mention. The commissioners were of the view that the cases should be published in order that

> 'societies will welcome a series of Reports which may serve as precedents for their guidance in the future, and may at the same time illustrate the principles and procedure which should govern the decision of disputes between societies and their members' (NHIC 1915, piii)

After 1920, responsibility for appeals was passed to the newly formed Ministry of Health in England and Wales and the Board of Health in Scotland. Under the new rules, dissatisfied members, who had exhausted internal dispute mechanisms, could apply to the relevant body for leave to appeal. Their case would then be passed to a 'referee' who would hear the case and make a decision[1].

Findings – understanding incapacity for work in the early 20th century

This set of documents provides us with invaluable, if incomplete, evidence about the ways in which claims for sickness benefit were constructed in this early stage of its development. I would now like to turn to the research questions outlined at the beginning of this paper and themes arising from the documentary sources. Themes which I want to

[1] There is some evidence from the Ministry of Health and the Scottish Board of Health relating to numbers of types of appeals in the Royal Commission evidence. Similarly there are references to appeals in Ministry of Health and the Scottish Board of Health annual reports but I have not yet been able to find out whether reports are available in the same level of detail as that provided by the National Insurance Commissioners.

consider, across these three sets of documents, are: definitions of incapacity for work; the role of moral judgement in assessing capacity for work; and the value placed on different types of evidence in assessing capacity for work. These themes are evident in the early 20th century but they are equally important today.

Definitions of incapacity for work

The 1914 report concluded that one of the main problems with the operation of the scheme concerned the definition of 'incapacity for work'. Part of the problem related to whether people should be assessed only against their usual occupation or whether they should be assessed more widely. The report recommended that a distinction should be made and that people should be assessed against their usual occupation in the first instance, but that the definition should become narrower if it became clear that they would never be able to return to their original occupation but could retrain for another job (Schuster 1914, p69). The report implied that, if the problems of inadequate certification by doctors and lack of adequate oversight of decisions could be resolved, then the assessment of capacity for work would be straight forward. However there is further evidence in the documents that defining incapacity for work involved social factors beyond the notion of usual occupation. Sidney Webb's view was that the law was wrong since the only way that he could interpret it was that 'incapable of any work whatsoever means literally unconscious or asleep' (Schuster 1914, Appendix, para 27,125). Sidney Webb was not advocating this interpretation but bringing to the attention of the committee the difficulty of attempting to follow the legislation to the letter.

There were particular concerns about certain groups of sickness benefit claimants: women, people who were unemployed or insecure employment and those whose behaviour was considered to be morally suspect.

Women and housework

A major concern was how to deal with women whose doctors had certified them as incapable of work but who were suspected of continuing to carry out housework, or as the quotation below shows, extraordinary housework:

> 'in the case of men, enforced idleness often becomes irksome and leads to a return to work, whereas the possibility of doing ordinary housework, or, at appropriate seasons, extraordinary housework, may induce women to stay on the funds for longer' (Schuster 1914, p48)

Mary MacArthur's evidence to the investigation was much more sympathetic to women. Noting that many low waged women had not been voluntary members of sickness schemes before 1911, she explained:

> 'What was the use of a doctor telling a woman that she was incapable of work, and ought to stay at home, when he knew that she was uninsured and had to earn her children's bread from day to day? Now the doctor feels free to certify that the

> woman must in the public interest, as well as in the interest of her own recovery, regard herself as incapable of work' (Schuster 1914, Appendix para 11407)

Here she was arguing that there had been no difference in the prevalence or severity of women's illnesses or an increase in malingering but that for the first time these women were able to afford to be ill. However, concern about the problem appears to have been widespread, at least in the view of the approved societies. Many examples are scattered through the pages of the appendices to the 1914 report. Mr Sanderson of the Amalgamated Association of Card, Blowing and Ring Room Operatives, described how he saw the problem:

> There is an impression among women that if they are incapable of work in the mill they are entitled to benefit. They seem to have the opinion that although they can do work in the home – say where there are four or five children and there is considerable work to be done – they are still entitled to benefit (Schuster 1914, Appendix, para18)

He went on to explain that he believed that such women were using the sickness benefit payment as a supplement to their husband's wages: they could make more money by staying at home and claiming sickness benefit than they would if they went to work and paid someone else to look after the children and do the housework. When questioned later about his view of the meaning of incapacity for work, Mr Sanderson argued that the definition ought to be 'incapable of doing usual occupation' and that this would apply to men as well as women. However he believed that there should be a special form for women which should also state that she is incapable of doing housework (Schuster 1914, Appendix, para 438).

The cases which reached the appeal stage were clearly in the minority compared to all the decisions made on claims for sickness benefit, but the detail provided in them give us an insight to thinking at the time. A couple of examples of women and housework appear in the appeals papers: in these cases the women had claimed sickness benefit and then had been refused or had their membership suspended for breaching the society's rules on 'behaviour during sickness'. Case II describes a woman who was observed 'carrying coals', an activity which the society considered evidence of inappropriate behaviour during sickness. In this case the commissioners disagreed and upheld the claimant's appeal on the grounds that the society's rules were not sufficiently detailed to make this a clear misdemeanour (NHIC 1915 p9). In case V a woman, employed as a baker, was refused benefit after a sick visitor had observed her performing household duties. The commissioners found in favour of the woman mainly because the society had not produced any evidence to support its case. (NHIC 1915, p14). In a later case, Case CXXXVIII, a woman housekeeper aged 62, who was blind and had been receiving long term sickness benefit (known as disablement benefit) for some months but continued to live with her former employer, was refused benefit on the grounds that she continued to do some light housework for her employer, which the society considered to be evidence of her capacity for work. The commissioners disagreed arguing that 'we are unable to find the acts performed by the Appellant, performed in pursuance of a natural and

praiseworthy desire to make herself of some use to her benefactors, constitute remunerative work' (NHIC 1919, p325).

The question of women and housework continued throughout this period, leading Braithwaite to conclude in his memoirs that 'women are not an insurable proposition' (Braithwaite 1957, p232). Whiteside (1983) argues that the issue became even more dominant during the 1930s, citing the popular press describing married women as the worst 'benefit spongers' (p175), while later variations of sickness benefits include the notorious 'household duties test' in the short-lived Non-contributory Invalidity Pension (1975-84).

The relationship between sickness and unemployment

Other writers have shown that there is a grey area between incapacity for work and unemployment. Tomlinson's and Whiteside's work on the relationship between sickness benefit and unemployment benefit during the depression of the 1930s makes this very clear (Tomlinson 1984, Whiteside 1987), as does more recent work on Incapacity Benefit (Houston and Lindsay 2010, Webster et al 2010). Some cases in the appeals papers show that approved societies would sometimes assume that a member claiming sickness benefit was malingering if she or he was clearly unemployed or finding it difficult to find work. (cases XVII, XXXV, XXXVII). The commissioners were unwilling to accept this as evidence of malingering and berated the societies in these cases for making assumptions not based on clear evidence. For example in case XVII the approved society had refused sickness benefit to a member who they presumed 'it is a clear case of out-of-work, not sickness benefit' (NHIC 1915, p48). The commissioners in this case disagreed and found that there was clear medical evidence that the member was incapable of work and noted;

> 'We may remark for the future guidance of the society that where they have any reason for supposing that the claim of a member for sickness benefit is not well founded it is their first duty to enquire into the true facts of the case' (p49)

However in case LVI, which concerned nine women herring workers, the report noted in its introduction 'work at this occupation had been very scanty and irregular, a fact not perhaps without significance' (NHIC 1916 p150) and later that the cases related to 'a class of persons whose work was of so casual and irregular a nature and likely to involve claims ..not always justified by the facts or easy to supervise' (p151). In other words the commissioners were concerned that people with irregular patterns of employment might be more likely to make unreasonable claims for sickness benefits.

Moral judgement

The 1914 report and its appendices are littered with moral judgements regarding members of the insurance scheme and about claimants of sickness benefits. The report considered a number of instances where doctors deliberately provided misleading information on a medical certificate (to protect the patients' interests), dwelling at some length on the issues raised by alleged moral failings such as venereal diseases, diseases 'peculiar to women', for example pregnant unmarried women or health problems as a

result of abortion. The report's concern with these types of health problems was not just about the moral queasiness of the time but a genuine concern, based on the legislation, that payments should not be made for health problems caused by 'misconduct'. In the appeal decisions the commissioners usually avoided making negative moral judgements about appellants but did sometimes indulge in positive judgments that appellants appeared to be moral and upstanding members of the community, for example in their supportive comments in case CXXXVIII, discussed above, regarding a blind woman's 'praiseworthy attempts' pay back her benefactors. There are however several cases where the argument was based around the moral judgements made by the societies. The commissioners were critical of this, arguing that societies must rely on valid evidence. In an early case (VIII) they described their reaction to the society's behaviour in relation to a woman whom the society had accused of participating in improper conduct (drinking) but where no acceptable evidence was produced to support the allegation: 'the circumstances of the case are not wholly free from suspicion' but 'it is not easy to describe in temperate language the subsequent course of events'. (NHIC 1915, p22).

It is useful to remember that there were certain types of behaviour which the societies could legitimately take into account. The rules of many of the societies prohibited immoral activities of various kinds such as drinking or fighting and the appeals decisions were clear that it was within societies' right to refuse benefit where these rules had been breached. What they insisted upon however was that societies had evidence to support these decisions.

By 1926 the moral status of claimants seemed to have a lower profile, perhaps as a result of increased guidance from the centre on the use of evidence in deciding claims. There is a more moderate approach to dealing with people with sexually transmitted diseases for example. In 1914 there was much debate about whether or not it was possible to allege that having a sexually transmitted disease was evidence of 'misconduct'. By 1926 the committee had accepted that there were good public health reasons for not doing so, that is that people should be encouraged to seek medical help as soon as possible and should not be put off by the fear of accusations of misconduct (Lawrence 1926, appendices, para 295). However it is equally possible that the lack of discussion of moral issues in this report reflects the wider concern with administration of the 1926 Commission, compared to the focus on excessive claims in 1914.

The role of moral judgement is not entirely clear. It seems that approved societies did use moral judgement in assessing claims on a day-to-day basis, at least in the early years, although this was disapproved of by the commissioners hearing appeals. Evidence for the later period is less clear.

Weight of evidence

A concern of the 1914 report was that 'panel' doctors would sign sick certificates in order keep patients on their books – a belief that was later picked up and run with by Beveridge in relation to separating out benefits and health care (Whiteside 1999, p35). The 1914 report noted that doctors' duty was to their patients and not to society at large or to the approved societies in particular and that while this was an admirable professional

position, doctors must recognise their responsibility to the sickness insurance scheme as a whole:

> 'A regard for the interest of the patient, therefore involves a duty to see that the undeserving do not receive benefit to the detriment of the deserving'. (Schuster 1914, p37).

As a result of this concern the report argued that approved societies must have mechanisms for challenging doctor's certificates. The report recognised that challenges by the approved societies to doctors' decision making was a challenge to doctors' professional standing, quoting a case of a doctor who was alleged to have said 'my certificate as a Bachelor of Medicine of the University of London stating that the girl is unable to work is correct' (Schuster 1914, p38) or on signing a sickness certificate the doctor 'pledges his personal honour and professional reputation' on it (p39). The view of the report however was that the sickness certificate constituted only evidence and that the decision rested with the approved society. Therefore the society had the right and duty to consider the quality of the evidence and to consider whether further evidence, for example through the use of sick visitors, might be necessary in order to make a decision.

The appeals reports include many examples of how the commissioners valued different types of evidence. They were critical of 'hearsay' evidence or evidence from societies which could not be supported by documents. They appeared to value their own judgement of the veracity of appellants, for example, in the very first case they described the appellant as 'a witness of truth' (NCIH1915, p8) and there are several examples of them favouring the evidence of appellants' family doctors over the second opinions sometimes obtained by societies, where the second doctor had not examined the patient or where the examination appeared to have been cursory. In case LIII the commissioners made this quite explicit: 'the facts disclosed show how very important it is in cases where the Society's doctor disagrees with the panel doctor … the panel doctor should be communicated with and his views ascertained' (NCIH 1916, p144). In case XI both sides were represented by solicitors and both gave evidence from two doctors. The evidence was conflicting but the commissioners preferred the evidence provided by the claimant 'we were more impressed by the evidence of the panel doctor, who had been in constant attendance on the Appellant for a considerable period and had periodically examined him' (NCIH 1915, p16).

Over the first ten years or so of the Act, 142 appeal cases reached the commissioners. As with appeals today, these represent the tip of the iceberg. Although Digby and Bosanquet (1988, p108) claim that there were few disputes about sickness benefit in this period, evidence from the witnesses to the 1914 report suggests that there may have been many dissatisfied claimants, most of whom probably did not challenge decisions of approved societies. For example, Mr S Sanderson, of the Amalgamated Association of Card, Blowing and Ring Room Operatives, claimed that 400 people (mostly women) had been refused benefit on the grounds that they were found fit for work because they had been observed to be carrying out household duties. Ten of these appealed through the internal appeals mechanism (Schuster 1914, Appendix, para 300). Another 720 people were

referred to the medical referee, of whom 294 stopped claiming benefit and a further 63 were found fit for work (para 168-169). It appears that none of these challenged the decision.

By the time of the 1926 report, the system of sick visitors and medical referees was more strongly embedded in the scheme but there was still some debate as to how the decision making process used evidence from different sources. Evidence from Sir Walter Kinnear of the Ministry of Health noted that the numbers of appeals had fallen in recent years because of the increasing use of regional medical officers.

> 'When an insured person is examined by a regional medical officer and a consequence his benefit has ceased, the insured person as a rule is satisfied and does not prosecute his appeal further.' (Lawrence 1926, Minutes of Evidence, para 400).

He conceded that one reason why people did not proceed with their claims may have been because they were 'too tired', suggesting that there might well have been a considerable number of unhappy claimants who were failing to have their cases considered in full. Although there is some evidence that appeals mechanisms had become more standardised by 1926, the number of appeals was still very low, suggesting that people were not exercising their right to challenge refusals of benefit.

Conclusion

What this tells us is that the definition of incapacity for work in these early years of the sickness benefit scheme was contested. In making decisions about claims, approved societies used a range of social assumptions, including the appropriateness of women continuing to carry out household tasks, the probability that those in insecure work would be more likely to claim sickness benefits and judgements about the moral probity of claimants.

By 1926, the view of the Ministry of Health, at least, was that the problem of defining incapacity for work had been resolved. In his evidence to the Royal Commission, Sir Walter Kinnear, from the Ministry described what he thought the position was:

> In the early years of the Act we had considerable difficulty in interpretation of the phrase, but now, as a result of decisions on appeals to the Department, broad general considerations have been laid down by which both doctors and societies are able to arrive pretty accurately at a proper interpretation of the phrase. Lawrence, 1926, Minutes of Evidence, para 281).

In his use of the term 'accurately', Sir Walter Kinnear implied that it was possible to come to a technically correct assessment of a claimant's incapacity for work. However, when questioned further by the committee, Kinnear began to stand back from this position and admit that wider social factors came into play:

> The rule now generally recognised is that in the earlier stages of the illness they should be totally incapable of following their ordinary occupation….. then of course if after a certain time it appears to the society that a member will never be able to resume his own occupation, the society must apply its mind afresh to the question…… Our suggestion to societies is that if [any other kind of work] is not available, they ought to give the individual some time to equip himself or to prepare himself for some other form of work…. But in the earlier stages of the illness, the test is inability to resume one's ordinary occupation. That of course is a considerable modification of the hard and fast test: 'totally incapable of all kinds of work'. (Lawrence, 1926, Minutes of Evidence, para 295).

A member of the committee continued to probe this definition:

> [Sir John Anderson] could it be put like this then: that in practice as things work out ' incapable of work' means physically incapable of doing work which in the circumstances of the moment could be regarded as reasonably open to the insured person? – [Kinnear] that is a fair definition (Lawrence, 1926, Minutes of Evidence, para 296).

This definition has moved away from the technically 'accurate' incapable of work to taking account of a range of social factors, including the availability of suitable work. The questioning went on to discuss whether a different test should be applied to those moving onto disablement benefit (that is after 26 weeks of sickness). Kinnear argued that in practice a tougher test was used by many societies but acknowledged that this should not necessarily be the case and that each claim should be looked at individually. What we see here is an attempt by central government to standardise definitions and their interpretation but an awareness that individual approved societies were using their own interpretations. The commissioners, with a more legalistic approach to administrative justice generally did not approve of these assumptions, instead requiring approved societies to provide evidence to support allegations against members. However, in their own weighing up of conflicting evidence the commissioners appear to have a preference for their own observations of appellants' trustworthiness (sometimes bringing in their own ideas about moral probity), a strong preference for the evidence of medical men [sic] and a preference for the evidence of appellants' panel doctors over those who did not know them well. However this approach to decision making took place at the appeal level and it looks fairly likely that few unsuccessful claimants used this mechanism to challenge refusals of benefit. The rest would have been susceptible to the more morally charged decision making mechanisms of the approved societies.

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