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Recent Changes and Reforms to the United Kingdom's Income Support Program for People with Disabilities

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ABSTRACT

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Title

Recent Changes and Reforms to the United Kingdom's Income Support Program for People with Disabilities

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Key Findings and Policy Implications

There is growing interest among policymakers in the United States (U.S.) about income support programs for people with disabilities in other developed countries. Lessons learned by these programs can help inform changes to U.S. programs that provide income support program to this population. Some studies have examined the effects of major program reforms in other countries but there has been limited focus in describing these programs' rules, processes, and reforms in detail.

In this manuscript, we describe the United Kingdom's (U.K.) recent income support programs for people with disabilities in detail. In the mid-2000s, the U.K. developed a new disability income support program—Employment and Support Allowance (ESA). Among ESA's key objectives was to reduce the U.K.'s expenditures on income support for people with disabilities (as a share of gross domestic product) and empower people with disabilities to enter or re-enter the labor force after receiving some assistance.

We found that:

- ESA has a five-step eligibility determination process—Work Capability Assessment (WCA)—that includes an in-person assessment (in most cases) and focuses on general functional abilities rather than the ability to perform past work. Claimants found eligible for ESA benefits are placed into one of two categories, with some beneficiaries receiving time-limited benefits conditional on participating in return-to-work related activities.
- Those found eligible for ESA benefits are placed either in the Support Group (SG) or Work-Related Activity Group (WRAG). Those in the WRAG receive time-limited benefits conditional on their participation in a job program.
- ESA has experienced several reforms since its deployment in October 2008.
- There is no evidence that ESA has achieved its policy goals and critics have raised various issues with the program.

- Although there are a few similarities, ESA and Social Security Disability Insurance (SSDI) differ in several ways. Most notably, ESA program eligibility criteria do not focus on the ability to perform past work.

The policy implications of our findings include:

- There is no evidence suggesting that novel program components of ESA would (or would not) benefit U.S. disability income support programs such as SSDI.
- ESA's development and initial reforms highlight the importance of testing substantive program changes before they are deployed.
- Making modest changes in response to rapid cycle feedback has been a highlight of ESA. A similar approach might benefit U.S. disability income support programs.

Frequent live interactions between claimants and representatives of ESA may help lower initial decision appeal rates and produce more accurate decisions.

ACRONYMS

DDS	Disability Determination Services
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
FfW	Fit for Work
GDP	Gross Domestic Product
GP	General Practitioner
HAP	Health Assessment Provider
HCP	Health Care Professional
IB	Incapacity Benefit
IVB	Invalidity Benefit
JSA	Jobseekers Allowance
OECD	Organisation for Economic Cooperation and Development
PCA	Personal Capability Assessment
SG	Support Group
SOCX	Social Expenditure Database
SSA	Social Security Administration
SSCS	Social Security and Child Support
SSDI	Social Security Disability Insurance
SSI	Supplemental Security Income
U.K.	United Kingdom
WCA	Work Capability Assessment
WFI	Work-Focused Interview
WRA	Work-Related Activity
WRAG	Work-Related Activity Group

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I. INTRODUCTION

Social Security Disability Insurance (SSDI)—the United States' primary income support programs for people with disabilities—is among the various disability insurance programs administered by member countries in the Organisation for Economic Co-operation and Development (OECD). In some respects, disability insurance programs in other OECD countries are dissimilar to SSDI. However, the similarities between SSDI and disability insurance programs in other OECD countries are plentiful. These similarities suggest that policymakers in the U.S. can consider applying lessons learned oversees to the domestic context.

A body of literature assesses recent reforms in disability insurance policies among OECD countries and considers the prospects of using those reforms to inform change in the United States' disability insurance programs (for example, Fultz 2015, Burkhauser et al. 2014, Hawkins and Simola 2018). This literature focuses on the effects of significant program design changes regarding participation and employment. However, this literature pays little attention to documenting and understanding program and program operation details that could help inform domestic disability insurance program policy.

Among the OECD countries with recent disability insurance program reforms, the United Kingdom's (U.K.) Incapacity Benefits (IB) program was arguably the most similar to SSDI, providing income support for inability to work due to a medically diagnosed incapacity (Morris 2016; Burchardt 1999). In 2007, the U.K. replaced IB with Employment and Support Allowance (ESA)—a new sickness and incapacity program that introduced important changes to the eligibility determination process.[1] Some of ESA's program features include a new assessment tool that only measures the ability to conduct daily activities (instead of work specific activities) and the placement of claimants assessed to have limited residual work capacity into a group that provides time-limited benefits conditional on their participation in a job program. All existing IB beneficiaries were re-assessed for benefits under ESA program rules, resulting in 21 percent of beneficiaries—nearly a quarter of a million people—having their benefits terminated (Department for Work and Pensions [DWP] 2014).

In this paper, we use academic articles, program documents, and expert interviews to describe ESA in detail. Our description of ESA addresses three research questions:

- How has the U.K. moved away from using lists of qualifying medical conditions and toward the measurement of residual work capacity in the benefit eligibility determination process?
- How does the U.K. assess capacity to perform substantial work in the current labor market?

[1] The U.K. has programs in addition to ESA that provide benefits to people with disabilities (U.K. Government 2019). For example, Industrial Injuries Disablement Benefit is a supplementary time-unlimited and non-contributory benefit for people who had an accident at work or contracted a disease because of their job. Personal Independence Payment, which replaced the Disability Living Allowance between 2013 and 2015, is a tax-free, non-means-tested and non-contributory benefit that helps offset extra costs associated with having a long term health condition or disability. Disability Living Allowance is still available for children under 16. Attendance Allowance is a pension benefit paid to people over age 65 with an illness or disability. Disability Facilities Grants help people with disabilities pay for essential adaptations. In addition, there are benefits that provide people with disabilities exemptions from and reductions to taxes such as vehicle tax and council (that is, property) tax.

- To what extent, and if so for what reasons, has the U.K. changed requirements, incentives, and technical assistance for employers of claimants or potential claimants?

Our description of the U.K. program pays special attention to operational aspects of the ESA's assessment of work capacity, understanding its limitations and strengths. We also summarize the (limited) information about the effects of ESA on outcomes of interest such as employment, benefit application, and benefit receipt. After describing ESA in depth, we compare and contrast certain ESA program elements to those of SSDI. This comparative analysis highlights key similarities and differences between the two programs, which could help facilitate policy lessons for policymakers.

The remainder of this manuscript is organized as follows: Section 2 describes our data collection and analyzing methods; Section 3 provides an overview of the income replacement programs that preceded ESA in the U.K.; Section 4 describes ESA in detail, focusing on current eligibility determination criteria and processes, existing evidence of effectiveness, program reforms, and critiques of the program; Section 5 compares and contrasts ESA to SSDI; and Section 6 details our conclusions.

II. METHODOLOGY

We used three types of sources to understand the U.K.'s disability insurance program and its recent reforms—peer-reviewed articles, official documents and statistics, and expert interviews. Our first source of information was articles published in peer-reviewed academic journals between 2006 and 2018—from the reform planning period until recently. We began the article search process by creating a set of search terms. We then conducted test searches and refined the search terms based on the results. Our main literature search yielded 70 journal articles. After conducting the main search, we screened the results to identify literature that added value to our knowledge of the U.K. reform. We used expert recommendations and the "snowball method"—searching for additional relevant articles in the citations of already identified relevant articles—to supplement the articles identified in our main search. Overall, we conducted reviews of 23 journal articles.

Our second source of information was official documents and statistics published by various U.K. agencies and international organizations. To find these documents, we conducted a targeted search (using similar search terms) of the websites for the DWP, Department of Justice, and OECD. We searched these websites for reports, legal documents, figures, and statistics. As with the academic article search, we supplemented the website search by snowballing the references of articles we initially identified. We reviewed 33 reports and official documents identified from these searches.

The third source of information was interviews with three U.K.-based experts who could provide us with further information on the U.K. reform from different perspectives and directed us to additional references:

- Dr. Chris Grover, a professor of sociology at Lancaster University, who specializes in the social impact of disability and how the new disability determination process in the U.K. affected people with disabilities.
- Dr. Ben Baumberg Geiger, a professor of sociology and social policy at the University of Kent, who specializes in the impact of work on individuals with disabilities and public attitudes toward benefit receipt. He has also worked with the U.K. DWP on disability policy issues.
- Mr. Mark Swindells, a former DWP employee who had a leadership role during and shortly after key reforms were implemented, is an assistant director at the General Medical Council, a public organization that maintains the official register of medical practitioners in the U.K.

We conducted one-hour semi structured interviews with each expert. Before each interview, we sent the expert a set of questions that focused on his area of expertise. The questions helped to guide each interview but also allowed the experts to identify other important topics that the project team may not have considered. We recorded each interview (with consent from the expert). The manuscript's content does not reflect the experts' opinions and any errors in program descriptions were made by the authors.

Using information from these three sources, we created an overview of the U.K.'s current financial support program for people unable to work due to a disability. The overview addresses

the three research questions described in the introduction, with a special focus on program components that may be of interest to U.S. policymakers, such as recent program reforms and how claims are adjudicated. We then compared and contrasted features of the U.K. system described in the overview with the analogous program features in the U.S. context.

III. PREVIOUS DISABILITY INCOME REPLACEMENT PROGRAMS IN THE U.K.

In this section, we describe previous disability income replacement programs in the U.K. Understanding basic features of the previous programs helps contextualize the ESA program and the reforms that the U.K. pursued. We describe ESA in detail in the next section.

A. Sickness Benefits (1948) and Invalidity Benefit (1971)

The U.K. provided disability-related income replacement benefits for the first time in 1948, as part of the Sickness Benefits program. Claimants who were unable to work due to sickness or disability received modest, means-tested income support for up to 28 weeks. The benefit amount workers with disabilities received was no different than means-tested welfare benefits that non-workers received (Burchardt 1999, Morris 2015).

Introduced in 1971, the Invalidity Benefit (IVB) "invalidated out" workers who were unable to work after developing a disease or illness, providing them longer term income support beyond their 28-week Sickness Benefit. Hence, IVB supplemented rather than replaced the Sickness Benefit. In addition to having a disability that prohibited work for more than 28 weeks (that is, met the Sickness Benefit eligibility criteria), IVB was non-means-tested and eligibility required having sufficient National Insurance contributions to be vested in the program (Burchardt 1999, Banks et al. 2011). IVB had a more generous cash benefit than Sickness Benefits and also included benefits for dependents (Morris 2015). Eligibility for IVB was determined by each claimant's general practitioner (GP)—the medical provider who had the clinical responsibility for the patient at the time—who assessed the claimant's ability to carry out *suitable work*, which was similar to the claimant's own job. In 1975, the government introduced the Non-Contributory Invalidity Pension, which provided benefits to workers with disabilities who were not vested in IVB. The Non-Contributory Invalidity Pension was not means tested and the benefit amount was substantively lower than that of IVB (Burchardt 1999).

B. Incapacity Benefit (1995)

The working-age population receiving IVB increased steadily between 1971 and 1995, growing most rapidly during the 1980s when the national mining industry rapidly declined and many unemployed individuals in that industry claimed disability benefits (Morris 2015). IVB claims also surged during this time because the government introduced targets of maximum beneficiaries on Jobcentres—the branch of DWP that delivers support services to working-age individuals—in order to reduce the number of unemployment benefit claimants (Campbell 1996), resulting in people shifting from unemployment to disability benefits.

The U.K. introduced IB in 1995 to contain the increasing costs of the nation's disability income support programs. IB was a taxable, non-means-tested, contributory benefit for working age adults with disabilities—age 18 to 65 for men and age 18 to 60 for women. A major difference between IB and IVB was that IB had more stringent eligibility criteria (Banks et. al. 2015). Instead of only assessing whether a claimant could perform work similar to past work, the IB eligibility test also examined the claimant's ability to perform any work, independent of the claimant's skills, experience, and local labor market conditions (Burchardt 1999).

Individuals eligible to claim IB included working-age adults, widows incapable of work for at least a year, and youth who could not work due to a disability (DWP 2005). To be eligible to claim IB, adults needed a certain number of National Insurance contributions paid from their earnings over time (for details, see DWP 2005).

The IB eligibility determination process focused on measuring a claimant's incapacity to work using a two-stage assessment. The initial assessment—called the Own Occupation Test—was conducted by the claimant's GP and determined whether patients could perform the duties of their current job or a similar job. The GP issued a "sick note" to patients not able to perform recent work or similar work. Claimants with a sick note received a cash benefit. In addition to their condition, claimants eligible for a sick note must have worked at their current job for at least 16 hours per week during the previous 8 weeks.

Although GPs ultimately used their own occupation test and discretion to determine whether to issue sick notes, DWP published guidelines to help with the decision making process (DWP 2004). When assessing the patient, GPs were advised to consider:

- The nature of the patient's medical condition following appropriate clinical guidelines
- Whether abstaining from work is the best course of action for the patient given the risks and hazards associated with the patients' work environment
- Appropriate length of time to be abstained from his or her job
- Possible changes or adjustments to working practices
- Gradual and transitional arrangements for return to work

The guidelines also stated that "return to work is one of the key clinical outcomes of successful clinical treatment" and "when used appropriately, certification of a period of time away from work and then a considered return with adjustments if needed, can support a patient's recovery and rehabilitation."

IB claimants who were unable to work 28 weeks after receiving a sick note underwent the second stage assessment—the Personal Capability Assessment (PCA)—to determine their eligibility for indefinite IB. The PCA replaced the IVB's suitable work test with an "all work" test that measured capacity to perform any work regardless of employment history. The PCA was where more stringent eligibility criteria (relative to past programs for disability income replacement) was introduced.

Each PCA was performed by a Health Care Professional (HCP) at a Jobcentre Plus location, which are DWP facilities that provide work-oriented support services. The PCA started with an interview in which an approved HCP commissioned by the DWP—rather than claimant's GP—gathered the information needed to assess the claimant's capacity in various functional areas. The interview also included a "typical day inquiry" in which claimants describe how the condition affects their daily life. If needed, an approved physician conducted a physical examination. Based on the information collected during the interview and examination, the HCP summarized the evidence for a DWP Decision Maker, who then determined whether the claimant met the incapacity threshold (DWP 2005).

The PCA then considered a claimant's capacity to carry out 14 daily activities—such as walking, sitting, and climbing stairs—that were deemed relevant to work ability (DWP 2005, European Commission 2002). For each activity, descriptors—a set of ranking statements—were used to categorize the claimant's abilities. The descriptors were clearly worded statements about the claimant's potential ability level, ranked from most capable to least capable. The HCP chose the statement that best reflected the claimant's ability to perform each activity. Each rank statement had a specific score from 0 to 15 points, with lower scores indicating greater capability (DWP 2005). Those who scored 15 points on a single activity or a total of 15 or more points across different activities were considered incapable and awarded IB indefinitely, whereas claimants with less than 15 points had their claim denied and benefits ceased. Claimants who disagreed with the decision could ask for a decision explanation and if still not satisfied, could file an appeal with the Tribunals Service (DWP 2005).

The two stage IB determination process delineated two benefit payment levels. In 2008—the year before IB was discontinued—claimants under the state pension age received a benefit of £63.75 ($84.50)[2] per week during the 28-week sick note period. If the PCA determined a claimant was eligible for indefinite IB, the claimant received a benefit of £75.40 ($100) per week between weeks 29 and 52. Claimants unable to work for more than a year received £84.50 ($112) per week (DWP 2008a).

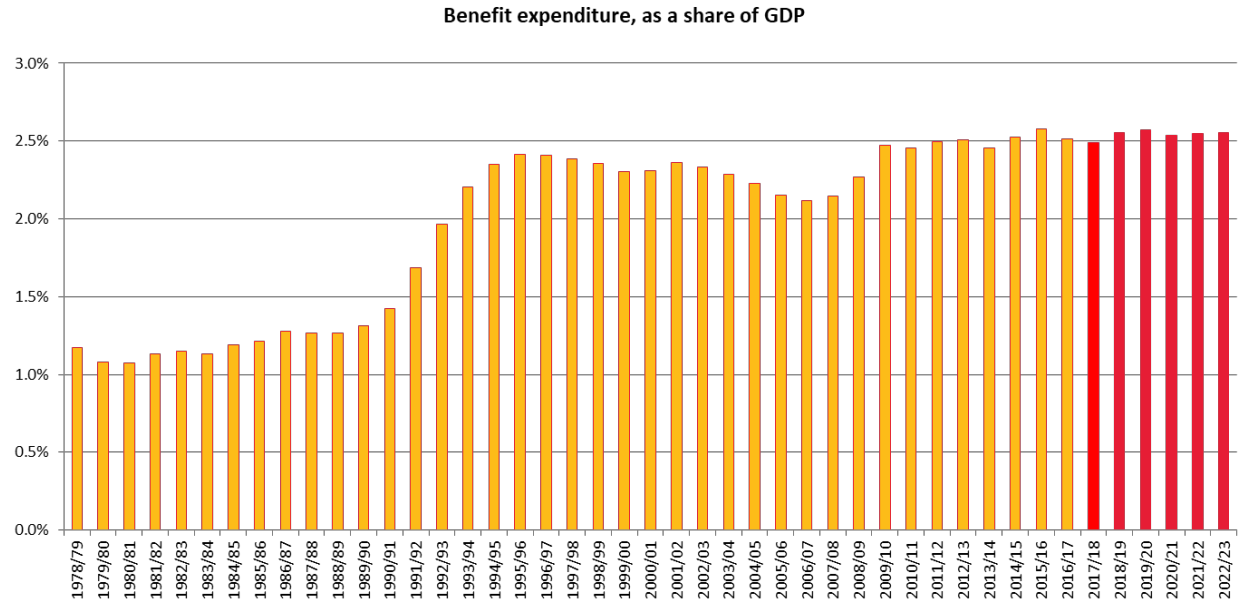
Although IB was meant to substantively reduce the U.K.'s expenditures on disability benefits as a percentage of gross domestic product (GDP), the share of GDP spent on disability benefits remained high after IB's introduction (Figure 1). As a result, during the 2000s there were calls to reform IB or replace it with a new program that could achieve the fiscal objective.

In addition to the unmet fiscal objective, there was another motivation for reform: the belief that helping workers with disabilities return to work (if able to do so) is desirable because work is good for health and well-being (Litchfield 2013). IB and the preceding disability benefit programs ignored the positive correlation between health and work and reinforced the now discredited belief that only those in full health can work. Programmatic reforms designed to promote eventual employment for claimants could improve some claimants' long term wellbeing by assisting them in returning to work. Helping some claimants in this way might also reduce the inflow of long-term benefit recipients, which could help achieve the fiscal objective.

Features of IB made it unable to achieve these fiscal and social objectives. IB's determination process started with an assessment conducted by a claimant's GP, who may have allowed non-medical factors, such as social relationships with their patients and local labor market conditions, to influence the sick note decision. It was argued that GPs in regions with high unemployment rates were more likely to write sick notes relative to regions with better labor markets conditions (Hiscock and Ritchie 2001, Grover and Piggott 2010). Another critique of IB was that it required claimants to wait six months (without returning to work) after the first assessment before receiving the final IB eligibility assessment. Consequently, some claimants may have delayed a return to work attempt (prolonging their labor force detachment) in order to receive the second assessment.

[2] 1 GBB = 1.3 USD. Currency exchange rate on February 28, 2019.

Figure 1. Evolution of benefit expenditure to support disabled people and people with health conditions



Source: DWP 2018, adapted from Table 4. Benefit expenditure to support disabled people and people with health conditions.

Note: Forecast after 2016/2017.

IV. EMPLOYMENT AND SUPPORT ALLOWANCE

In 2006 the U.K. started developing a new income replacement program for people with disabilities—the Employment and Support Allowance (ESA) program—that could address IB's shortcoming and achieve fiscal and social objectives. Since October 2008, all new disability claims in the U.K. have been assessed under ESA program rules. Similar to its predecessors, ESA provides income support to working-age people who cannot work due to a disability. However, ESA differs from IB and earlier disability income replacement programs in that eligibility is determined by measuring an individual's ability to conduct daily activities, rather than work-related activities. Thus, there is no assessment of ability to perform past work. ESA does not make disability a binary construct (that is, a claimant either does or does not have a disability) but instead makes a categorical one, with benefit award type, benefit amount, and duration depending on claimants' assessed work capacity (Table 1). In addition to adjudicating all new claims, the 1.5 million individuals who were still receiving income support due to a successful IB claim were reassessed under ESA rules and (if eligible under the new criteria) started to receive ESA benefits. IB beneficiaries who did not meet the ESA eligibility criteria stopped receiving benefits.

This section details the disability eligibility determination criteria and process under ESA. We start with an overview of the ESA benefit groups and types. Next, we describe the Work Capability Assessment—the process of program's eligibility—in five steps. The section then presents information on program benefits, conditions, and sanctions. We then describe notable reforms and amendments that occurred since the introduction of ESA. It concludes with a discussion of program effectiveness and shortcomings.

A. ESA benefit groups

ESA evaluates a claimant's capability for work and ultimately assigns each claimant into one of the three categories:

1. **Fit for Work (FfW):** Those found to have no limitations for work or work-related activity are assigned to this group. The FfW group is not eligible to receive ESA, but instead, they are instructed to claim Jobseekers' Allowance (JSA)—the primary unemployment benefit in the U.K.
2. **Work-Related Activity Group (WRAG):** This group includes those who have limited capability for work, but do not have limited capability for work-related activity such as learning how to create a résumé or attending meetings with a career counselor. They are considered eligible to the ESA, but are expected to eventually return to work with assistance from support services.
3. **Support Group (SG):** This group includes those deemed to have the most substantial functional limitations. They have limitations to work as well as work-related activities, and therefore are not expected to return to work, although they can voluntarily search for jobs.

Table 1. Summary of key differences between IB and ESA

	Incapacity Benefit	Employment and Support Allowance
Eligibility criteria	Eligibility depends on incapacity/sickness During the first six months after filing a claim, eligibility depends on whether the claimant is able to carry out his or her current job (or a similar one)	Eligibility depends on capability/fitness Eligibility does not depend on whether the claimant is able to carry out his or her current job (or a similar one)
Assessment procedure	Own Occupation Test, carried out by claimants' GP, and Personal Capability Assessment, conducted by a Benefits Agency physician at Jobcentre Plus A physical assessment occurs six months after registering for ESA	Work Capability Assessment, conducted by a private company A physical assessment occurs three months after registering for ESA
Role of GP	Claimant's GP is involved in the eligibility determination process	Claimant's GP is involved with registering for ESA, but not in the other steps. Most of the WCA is conducted by a private Health Assessment Provider.
Benefit rates	There are two benefit amount increases, one after the first stage assessment at week 29 and another after the second stage assessment at week 53	There is only one benefit amount increase after 91 days, which only applies to the SG members age 25 and older.
Categorization of applicants	People are either found FfW and claim JSA, or given unconditional financial support	People are either found FfW, have limitations for work but not for work-related activity, or have limitations for both work and work-related activity. People receive financial and employment supports based on their categorization.

B. Types of ESA

There are two versions of ESA: contribution-based ESA and income-related ESA (DWP 2013a). When a claimant applies for ESA benefits, DWP examines the claimant's National Insurance contributions. Claimants who have enough contributions are entitled to contribution-based ESA, which is time-limited to one year for those in the WRAG. Under contribution-based ESA, SG members receive benefits as long as they meet the SG eligibility criteria. Savings or non-work income do not affect the ESA benefit amount.

If the applicant is not eligible for contribution-based ESA, they may be eligible for benefits from income-related ESA, which is means tested. The exact asset and income calculations for income-related ESA eligibility are complex, but include provisions such as having assets less than £16,000 ($20,800) and a partner who works less than 24 hours per week (DWP 2013a). Income-related ESA benefits are not time-limited for SG or WRAG members (as long as they comply with work activity requirements) (Gjersøe 2016). Recipients of contribution-based ESA can also be concurrently eligible for income-related ESA benefits, but applicants without sufficient National Insurance contributions are only eligible for income-related ESA.

C. The Work Capability Assessment

The Work Capability Assessment (WCA) is ESA's process for determining program eligibility. WCA's development was mandated by the Welfare Reform Act 2007. According to

the Act, WCA was to be designed in consultation with medical and other experts as well as disability groups. To create the WCA, two technical working groups revised and improved the PCA of the IB, with one group focusing on mental health and learning disabilities and the other focused on physical functions (DWP 2008b).

WCA determines benefit eligibility using a five-step process (Figure 2). In this section, we describe each step in detail. As of March 2018, the median WCA took 17 weeks (117 days) to complete (DWP 2018b).

Figure 2. The WCA process

1. Step 1: Registering for ESA

The WCA process starts when an individual contacts Jobcentre Plus to register for ESA benefits. Registration can be made by phone or by submitting—either by mail or in person—an ESA1 form to a local Jobcentre Plus office. After registration, a Jobcentre Plus representative makes an initial assessment, during which the representative collects several pieces of information about the claimant, including type of disability or illness, previous employment, other benefits or statutory support claimed, whether the claimant spent time abroad, pensions or health insurance payouts, educational experience, savings and financial assets, home ownership status, household composition, and any other income (ESA Assessment Support 2018). The claim must also be supported by the individual's GP, who completes a Statement of Fitness for Work form. Using this information, the representative determines eligibility to make a claim and the benefit payment amount the claimant would receive if approved. Some of these basic eligibility criteria include having an illness or disability that affects work, being under state pension age, not getting Statutory Sick Pay or Statutory Maternity Pay (and have not gone back to work after the leave), and not receiving JSA. People receiving disability-related benefit payments from Disability Living Allowance or Personal Independence Payment can apply for ESA benefits regardless of their employment or student status (U.K. Government, 2018).

Once a claim is initially processed, it enters the assessment phase. During this phase, which ends after an initial decision is made, each claimant receives a benefit payment equal to the JSA benefit amount. If a claimant is found FfW, the payments are terminated but do not have to be repaid. For those placed in the SG or WRAG, initial benefit payment amounts are adjusted upward (depending on which group the claimant is placed in as well as the claimant's National Insurance contributions and/or income and assets).

2. Step 2: Referral for assessment

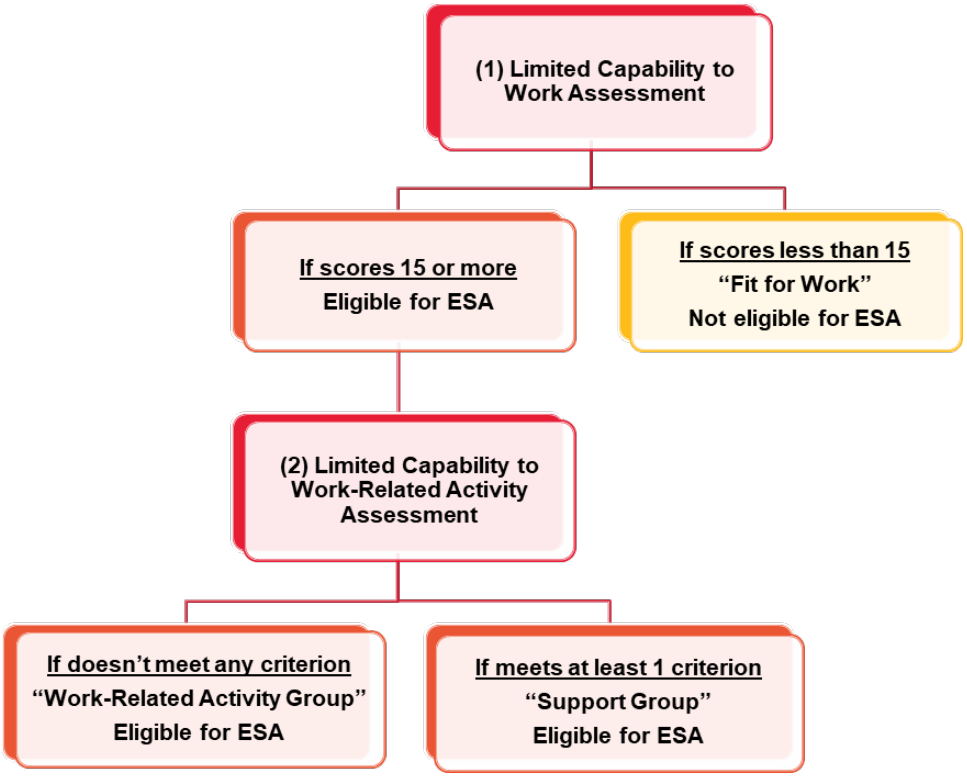
After registration, the Jobcentre Plus representative refers eligible claimants to the Health Assessment Provider (HAP)—a private medical company contracted by DWP—for assessment. The company Atos was the HAP from 2008 until 2015. Since 2015, the company Maximus has been the HAP.

Upon referral, the HAP sends the claimant a Limited Capability for Work Questionnaire (ESA50) or Capability for Work Related Activity Questionnaire (ESA50A), which collect information about the health conditions of claimants and their impacts on various capabilities. Most of the time, the ESA50 is sent to the claimant, but if the initial assessment's findings strongly suggest that the claimant is likely to have a severe limitation, then the ESA50A is sent instead. The claimant (or someone on his or her behalf) completes the form and returns it to the HAP within 28 days. The form invites the claimant to include with the submission any medical evidence that supports the claimant's assertions. Using the form, the HAP decides whether the claimant has a severe limitation or terminal condition and should be placed in an SG (without further review) or must participate in a face-to-face assessment.

3. Step 3: Face-to-face assessment

Claimants invited to a face-to-face assessment go to their local HAP office and meet with a HCP. The HCP—which could be a physician, nurse, or physical therapist—interviews, observes, and (occasionally) performs a limited physical examination of the claimant.[3] The face-to-face assessment normally takes place within the 13-week "assessment phase" that follows registering the ESA. The goal of the assessment is to make a recommendation to DWP about how to assign the claimant into a work capability group (Figure 3).

Figure 3. Face-to-face assessment and recommendation for group placement



[3] DWP requires HCPs to conduct the assessment using a software program called Logic Integrated Medical Assessment. The software allows HCPs to select phrases from a drop-down menu, which helps standardize assessment reporting.

The assessment starts by assigning points for limitations in performing any one of 17 activities needed for daily functioning (Table 2). Claimants scoring less than 15 points are recommended to be FfW.[4] However, if a claimant scores 15 points or more, then he or she has limited capability for work.

Table 2. Functional activities for limited capability for work

Functional activities
Physical disabilities
Activity 1: Mobilizing unaided
Activity 2: Standing and sitting
Activity 3: Reaching
Activity 4: Picking up and moving or transferring by the use of the upper body and arms
Activity 5: Manual dexterity
Activity 6: Making self understood
Activity 7: Understanding communication
Activity 8: Navigation and maintaining safety
Activity 9: Continence
Activity 10: Consciousness during waking moments
Mental, cognitive and intellectual function assessment
Activity 11: Learning tasks
Activity 12: Awareness of everyday hazards
Activity 13: Initiating and completing personal action
Activity 14: Coping with change
Activity 15: Getting about
Activity 16: Coping with social engagement
Activity 17: Appropriateness of behavior with other people

Source: DWP 2016.

Note: See Appendix A for descriptors and scores for each activity.

When assigning points to a claimant for a certain activity, the HCP must choose the descriptor statement (with its associated score) that best describes the claimant's abilities. Most descriptors are associated with either 0, 6, 9, or 15 points (there are no 3 or 12 point descriptors). For example, we provide the descriptors and associated points in Table 4 for the activity of reaching (Table 3). A claimant must score 15 points or more aggregated across all activities in order to be considered having limited capability for work.

[4] Though scoring less than 15 points on the initial assessment typically results in a Fit for Work recommendation, there are two circumstances that can qualify a claimant to have limited capability for work despite such a score: (1) providing medical evidence of a severe life-threatening disease that probably cannot be controlled by a recognized therapeutic procedure and (2) having a condition that could seriously affect mental health—like result in suicide—if found Fit for Work.

Table 3. Scoring limitation against an activity using descriptors: example based on activity "Reaching"

Descriptor	Score
(a) Cannot raise either arm as if to put something in the top pocket of a coat or jacket	15
(b) Cannot raise either arm to top of head as if to put on a hat	9
(c) Cannot raise either arm above head height as if to reach for something	6
(d) None of the above	0

Source: DWP 2016.

Note: See Appendix A for the full list of descriptors and scores.

If a claimant has limited capability for work, the HCP then assigns points across 16 additional activities to determine whether the claimant also has limited capability for work-related activity (Table 4). Claimants who satisfy at least one of the 16 additional activities are recommended for the SG whereas all others are recommended for the WRAG. After the face-to-face assessment, the HCP sends a report—including the assessment score(s), the HCP's claim decision recommendation, and any medical evidence supplied by the claimant—to a Decision Maker at Jobcentre Plus.

Table 4. Additional functional activities to determine limited capability for work-related activity

Functional criteria
Activity 1: Mobilizing unaided
Activity 2: Transferring from one seated position to another
Activity 3: Reaching
Activity 4: Picking up and moving things
Activity 5: Manual dexterity
Activity 6: Making self understood
Activity 7: Understanding communication
Activity 8: Continence
Activity 9: Learning tasks
Activity 10: Awareness of hazard
Activity 11: Initiating and completing personal action
Activity 12: Coping with change
Activity 13: Coping with social engagement
Activity 14: Appropriateness of behavior with other people
Activity 15: Conveying food or drink to the mouth
Activity 16: Chewing or swallowing food or drink
Example descriptor for Activity 2: Transferring from one seated position to another
Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person.

Source: DWP 2016.

Note: See Appendix B for descriptors and scores for each activity.

Independent reviews have suggested that the assessment's 15-point threshold works well for distinguishing between people who are FfW and people who have a work limitation (Litchfield 2013). When the WCA was developed in 2006 and 2007, a group of experts tested the discriminating power of the 15-point threshold by reviewing 300 cases. The group tested whether the group placements based on this threshold matched their expert opinion, and the descriptors and activities were amended as needed. However, the point system should not be interpreted as a continuum. In other words, comparing point values both above or both below the 15-point cutoff has limited value because having a higher score does not necessarily imply a higher functional impairment.

4. Step 4: DWP initial decision

Decision Makers represent DWP in the eligibility determination process and (after reviewing medial evidence, assessment scores, and HCP recommendations) make claim decisions. After the HCP makes a recommendation based on the evidence, DWP classifies claims into two groups based on their complexity, and assigns them to Decision Makers, taking into account their individual level of experience. Specifically, claims for which the HCP recommends placement in the SG are classified as non-complex and assigned to relatively less experienced Decision Makers, whereas all other cases are considered complex and are assigned to more experienced staff. With this division of labor, less experienced staff focus mostly on checking the completeness and accuracy of the information gathered about their assigned claims, whereas more experienced staff scrutinize the evidence gathered to date from the WCA. This staff allocation may affect the decision-making process in favor of claimants with FfW recommendations because Decision Makers go against considerably more instances of FfW recommendations (Litchfield, 2013). For example, in 2013 Decision Makers accepted almost all SG (99.7 percent) and WRAG (96.8 percent) recommendations, but moved about 15 percent of FfW recommended claimants to an initial DWP decision of WRAG (DWP 2013b).

Before finalizing the decision for complex cases, the Decision Maker conducts a Decision Assurance Call with the claimant to discuss the proposed decision, describe the next step in the process, and give the claimant one more opportunity to provide medical evidence. Introduced in 2011, the calls are intended to reduce the number of appeals and overturned decisions (Harrington 2012). DWP uses text messaging to remind claimants about attending Decision Assurance Calls and the call success rate is about 85 percent (Work and Pensions Committee 2014). After the Decision Assurance Call, the Decision Maker then makes a determination and notifies the claimant by mail. Claimants found program eligible receive benefits for the period starting just after applying for ESA at a Jobcentre Plus.

Though Decision Makers are supposed to make the final decision on behalf of DWP based on all the evidence, in ESA's initial years the Decision Makers rarely made decisions that disagreed with the HCPs' recommendations (Harrington, 2010). By June 2010, among claimants receiving an FfW HCP recommendation, Decision Makers had placed just 1.9 percent in the WRAG and 0.4 percent in SG (Harrington 2010). Harrington argued that this was due to a lack of confidence among Decision Makers, many of whom initially perceived themselves as simply "rubber stamps" for the HCPs' recommendations and were unhappy with that role (Adams et al. 2012). Harrington recommended that Decision Makers receive additional training to enhance their discretion and confidence.

In response to this suggestion, DWP provided Decision Makers with additional training regarding how to weight evidence and use discretion. In 2011, DWP introduced the Quality Assurance Framework and the monthly Every Decision Counts session—which were later replaced by Ask the Expert sessions—to check Decision Makers compliance with regulations and ensure consistent quality standards (Litchfield 2013). Independent reviews conducted soon after these changes found that more Decision Makers were willing to overrule HCP recommendations (DWP 2012).

5. Step 5: Appealing DWP initial decision

Claimants who are not happy with DWP's initial decision have two levels of appeal. If a claimant does not agree with the Decision Maker's finding, the claimant has one month to request that DWP conduct a Mandatory Reconsideration. When such a request is made, DWP must conduct a review and provide a clear explanation of its decision. After requesting the Mandatory Reconsideration, the claimant has one month to submit supplementary evidence. If DWP denies the claim again at the end of Mandatory Reconsideration, the claimant has one month to appeal the decision to an independent court—Her Majesty's Courts and Tribunals Service. Prior to October 28, 2013, initially denied claimants could appeal to the Tribunals Service without first requesting a DWP Mandatory Reconsideration (Parkin 2015). ESA benefits are not paid to the claimant during the appeals process. However, if the initial decision is revised, then the claimant receives backdated benefits that include the appeal period.

The ESA decision appeal clearance time is the time between DWP's initial decision and when the appellant is notified of the final decision. The average appeal clearance time among those that go to the Tribunals Service was 26.5 weeks in 2014, 19 weeks in 2015, 17 weeks in 2016, 21 weeks in 2017, and 27 weeks throughout the first three quarters of 2018 (Ministry of Justice 2010).[5]

Mandatory Reconsideration in Numbers*
About 15 percent (~330,000 cases) of initial decisions had a Mandatory Reconsideration, of which 13 percent (~43,000 cases) were revised. The remaining 87 percent (~280,000 cases) were not revised. About 21 percent of claimants who requested a Mandatory Reconsideration (~68,000 cases) and did not receive a revision then appeal to the Tribunals Service (DWP 2018b: p3).

*October 2013–December 2018, for initial and repeat ESA WCAs.

Within the first few years of the ESA, Tribunals Service experienced a steady increase in appeals [6]—from 10,000 cases in 2009 to 45,000 cases in 2010—that resulted in lengthy decision times (Ministry of Justice 2010). Appeals to the Tribunals Service dropped substantively after the DWP introduced the Mandatory Reconsideration. For example, the

[5] ESA appeals are made to the Social Security and Child Support (SSCS) Tribunal, which does not release statistics on case clearance times by benefit type. However, ESA constitutes the majority of appeals sent to the SSCS Tribunal—about 70 percent from April to June 2013—and therefore average SSCS clearance times are a good proxy for ESA appeal clearance times.

[6] This increase was partially caused by initial confusion about the purpose of ESA. IB's first stage assessed incapacity to work, whereas ESA's assessment focuses on remaining functional capacity to perform daily activities. Initial independent reviews of ESA suggested that when ESA was introduced, this key difference in approaches to assessment was not clearly communicated to ESA claimants, and many of them were puzzled by the decision they received (Harrington 2011).

number of FfW decision appeals went from 20,000 in 2012 to 6,600 in 2013 to 4,700 in 2014 (DWP 2018b).

The introduction of Mandatory Reconsideration also influenced the decision of an appeal. Claimants initially deemed FfW constitute the majority of appeals. After the introduction of Mandatory Reconsideration, the majority of FfW initial decision appeals have been resolved at this level. Consequently, those who appeal to the Tribunals Service are more likely than in the past to be dissatisfied with DWP's decision because the claimant's condition is often not severe enough to be granted ESA benefits. As a result, among the appeals that reached the Tribunals Service level, the proportion whose decisions were overturned increased after the Mandatory Reconsideration reform. Between 2008 and 2013, the Tribunals Service overturned 35 to 40 percent of the initial decisions they reviewed, whereas after Mandatory Reconsideration, the proportion of decisions overturned by the Tribunals Service climbed to 55 to 65 percent (DWP 2018b).

D. ESA benefits, conditions, and sanctions

ESA benefits, requirements, and sanctions reflect the hierarchical sorting of claimants into groups based on their work capability, with more generous benefits and less strict requirements and sanctions going to those with more severe functional limitations (Table 5). In this section, we summarize the benefits for each group.

Table 5. Benefits, requirements, and sanctions for the three WCA groups

	Level of limitation	Benefit amount, per week	Activity requirements	Sanctions
Support Group	Limited capability for work and work-related activity	Contribution-based ESA: £110.75 ($146.90) Income-related ESA: Up to £110.75 ($146.90) (benefit amounts depend on claimants' income and other circumstances)	None	None
Work-related Activity Group	Limited capability for work, but no limitation for work-related activity	Contribution-based ESA: £73.10 ($97.00) Income-related ESA: Up to £73.10 ($97.00) (Benefit amounts depend on claimants' circumstances)	Attending Work Focus Interviews Taking part in compulsory work-related activity that the claimant has been assigned to	When non-compliant, benefit payment is completely suspended until the beneficiary starts complying again
Fit for Work Group	No limitation to work or work-related activity	Not eligible for ESA benefits; eligible only for JSA JSA benefit amount: Up to £73.10 ($97.00) (benefit amounts depend on claimants' circumstances)	Not eligible for ESA benefits; eligible only for JSA JSA requirements: Sign on as available and seek work Be prepared to accept any reasonable offer of work	Not eligible for ESA benefits, instead eligible for JSA JSA sanctions: When non-compliant, benefit payment is completely suspended until the beneficiary starts complying again

Between 2013 and 2018, 3.7 million initial and repeat ESA WCAs were started and 60 percent of these (2.2 million cases) received an initial DWP decision (DWP 2018b). The initial decision distribution during this period was 38 percent FfW, 10 percent WRAG, and 52 percent SG. Benefit assessments of 1.5 million former IB beneficiaries under ESA program rules resulted in 78 percent in SG, 9 percent in WRAG, and just 13 percent in the FfW group (DWP 2018b). The large proportion of former IB beneficiaries entering the SG was likely because many long-term IB beneficiaries have substantive, chronic health conditions and disabilities (Litchfield 2014).

SG. This group includes those determined to have the most substantial functional limitations and as such are eligible for ESA's largest cash benefit. In 2018, SG members received a weekly cash benefit of at least £110.75 ($146.90) per week, but the actual amount varied across beneficiaries, depending on the type of ESA eligibility (and related factors like contribution history, income, and assets), receipt of other benefits, and couple status.[7] SG members have no job search requirements because they have been determined to have limited capability for work and work-related activity.

Eligibility for SG is periodically reassessed for some beneficiaries. Since October 2017, SG members with "severe conditions" are exempt from eligibility reassessment. DWP's Severe Conditions Guidance (2017a) for HCPs states that a claimant must meet four criteria to be exempt from future reassessment:

1. The claimant's level of function will always meet limited capability for work-related activity criteria
2. The condition will always be present
3. There is no realistic prospect of recovery of function (based on currently available treatment)
4. The condition is unambiguous

WRAG. Members of this group are entitled to receive ESA benefits because they have limitations for work but not for work-related activity. However, relative to the SG, the benefit for this group is less generous. The current ESA benefit rate for this group is equivalent to the current JSA benefit rate—up to £73.10 ($97.00) per week. When ESA began in 2008, WRAG received a benefit amount greater than the JSA benefit amount (but still less than that for the SG). The benefit amount was initially reduced in the 2012 Welfare Reform Bill and then further reduced in 2017 to about the JSA amount. The U.K. government introduced these changes to encourage WRAG members to return to work. The resources freed up by having fewer WRAG members could be used to provide them with additional employment supports or provide extra cash support to SG members (Kennedy et al. 2017). The benefit reductions did not affect existing beneficiaries, just newly allowed claims.

[7] DWP counts two people as being in a couple if they live in the same household and are: married to each other, civil partners of each other, or living together as if they were married.

WRAG members are not expected to work in the short-term, but are required to engage in activities intended to eventually get them into paid employment. There are two broad activities for WRAG members: Work-Focused Interviews (WFIs) and Work-Related Activities (WRA) (DWP 2017b). A WFI is a meeting between a WRAG member and a Jobcentre Plus work coach or a personal advisor. The meeting usually takes place at a local Jobcentre Plus.[8] The purpose of WFIs is to discuss prospects for employment and identify any activity, education, or training that might help with this. The first WFI takes place after the WCA. Subsequent meetings occur based on individual circumstances, but beneficiaries are expected to attend and participate in scheduled meetings and interviews unless there is good cause.[9]

DWP sometimes requires WRAG members to participate in WRA, which can involve looking for work, undertaking training, or taking part in Work Programme.[10] WRA can include activities such as developing basic skills for math or writing, learning how to create a résumé, or attending confidence-building sessions. Those required to engage in WRA must be given a written action plan by their work coach or personal advisor that specifies what activities they must participate in. WRA activities must be reasonable given a beneficiary's circumstances. WRAG members are exempt from WRAs if they receive Carer's Allowance,[11] are a single parent of a child under age 3, or have reached pension age.

WRAG members who do not actively participate in required activities are subject to loss of benefits. ESA imposes sanctions on non-compliant beneficiaries by completely suspending their benefit payments until they start complying again. The sanction amount has become more severe over time: until December 2012, the non-compliance sanction was 50 percent of the benefit amount for the first four weeks of non-compliance, rising to 100 percent after that (Kennedy et al. 2017).

FfW Group. As its name suggests, members of this group are considered fit for work and consequently do not receive any ESA benefits. Instead, they are instructed to claim Jobseekers' Allowance (JSA), though being placed in the FfW group does not guarantee JSA receipt. If their JSA application is successful, these individuals receive an unemployment benefit as large as £73.10 per week, which is conditional on fulfilling requirements that are stricter than those required of the WRAG. These requirements include having to sign on as available for and

[8] The meeting can take place by phone or at the WRAG member's home in exceptional circumstances.

[9] Good cause may include bereavement, illness, hospital/health care admissions or appointments, and emergency or caring responsibilities.

[10] Work Programme is a pay-for-success initiative in which service providers are paid by the U.K. government based on their success at helping WRAG members find work. Specifically, "providers receive a job outcome payment after a participant has spent a minimum length of time in employment (either 13 or 26 weeks, depending on one's group placements), and sustainment payments for every 4 weeks the participant remains in employment up to a maximum of 20 pay periods. The harder it is to help an individual into work, the higher the payment the provider receives" (Dar 2016). For example, in Work Programme ESA, claimants are considered "harder to help" compared to young JSA beneficiaries. Service providers have the freedom to introduce and implement their own ideas and schemes regarding how to help WRAG members find work.

[11] Carer's Allowance is a non-contributory benefit payable to people who spend at least 35 hours a week providing regular care to someone who has a disability. The person cared for must receive Disability Living, Attendance Allowance or Personal Independence Payment.

seeking work and be prepared to accept any reasonable work offer. JSA recipients are unable to refuse work due to its type or compensation level. If a JSA recipient does not comply with the requirements, he or she can be sanctioned and stop collecting allowance payments for a period of time.

E. Reviewing and reforming WCA

The Welfare Reform Act of 2007 mandated WCA's creation and also required that WCA be assessed annually during the first five years after its deployment. An independent reviewer conducted each assessment: Dr. Malcolm Harrington—Emeritus Professor of Occupational Medicine—conducted the first three independent reviews and Dr. Paul Litchfield—an occupational physician—conducted the other two. The U.K. Secretary of State assigned a Scrutiny Group for each review cycle to ensure that the review was robust, comprehensive, fair, and presented in a clear and appropriate format. For each review, the independent reviewer produced a report that evaluated:

- Operation of the assessments for limited capability for work and limited capability for work-related activity
- ESA claimants' WCA experience
- The perceptions of health care professionals and other staff administering the WCA
- The effectiveness of WCA in correctly identifying claimants who are unfit for work due to ill-health or a disability (Harrington 2010)

The reviewer's reports were prepared using information from various sources. Each reporting period announced a Call for Evidence, which allowed any individual or stakeholder group to provide input. The independent reviewer held stakeholder meetings and seminars, conducted visits to Jobcentre Plus sites (where the application process begins and decisions are made), medical examination centers (where face-to-face WCA interviews takes place), first-tier Tribunals Service (where appeals were considered), and employment provider centers (where some of the work-related support activities were delivered). In addition, the independent reviewer sat with assessors at various stages of the process and had access to internal data collected by the Jobcentres and medical examination centers (Harrington 2010).

Advocacy groups also played a role in shaping the recommendations made in the annual independent reviews. For example, for the first year review Macmillan—a cancer support organization—conducted a consultation exercise in which 14 senior cancer specialists provided guidance on how WCA should treat cancer patients receiving oral chemotherapy instead of radiotherapy. Similarly, in September 2010, mental health advocacy groups provided recommendations about how to refine the mental, intellectual, and cognitive descriptors used in the WCA (Harrington 2011).

Each independent review report provided a set of recommendations for improving the program. The DWP then considered the recommendations and wrote a response that explained why each recommendation would or would not be implemented. The independent review process (together with the government's assessment of whether or not policy objectives were being met) provided a catalyst for improving the WCA over time.

The most noteworthy reforms and improvements regarding the eligibility determination criteria and process that took place since the implementation of the ESA in 2008 are listed in Table 6. Some of these reforms reflect policy changes, whereas others are improvements made to address recommendations from the independent reviews.

During the period we conducted this study, the U.K. was developing another major reform that could affect disability benefits. Specifically, the U.K. is considering whether to merge a number of separate benefits (including ESA) into a single in-and-out of work payment called a Universal Credit. We do not describe that reform in this paper because it has not yet been enacted and because the proposed process to quality for the disability component of the Universal Credit is similar to ESA's eligibility determination process.

Table 6. Notable changes to WCA since implementation

Change	Description	Origin
Addition of decision reassurance call (2010)	DWP introduced this step to improve communication with the applicant. The Decision Maker now calls applicants who were initially assessed as FfW, advises them of the next steps, and asks whether they can provide further evidence that may inform the decision.	DWP response to independent reviewer recommendation
Amendment to descriptors (2011)	Ten of the 17 descriptors were altered and the number of descriptors was reduced from 20 to 17 in total.	DWP response to independent reviewer recommendation
Reassessment of IB recipients (2011)	DWP started reassessing the IB beneficiaries using the WCA. The implementation of this program substantially increased the number of claims processed.	Policy change
Introduction of time-limit to benefits (2012)	DWP introduced a 365-day time-limit to benefits for claimants in WRAG. After one year, if their condition deteriorated they may be moved to SG. Otherwise they will no longer receive ESA.	Policy change
Introduction of changes to sanctions (2012)	DWP increased the reduced benefit amount for WRAG members subject to sanction.	Policy change
Amendment to assessment of people with cancer (2013)	DWA expanded the categories of cancer treatments under which a person may be treated as having limited capability to work or work-related activity.	DWP response to independent reviewer recommendation
Introduction of Mandatory Reassessment (2013)	If a claimant does not agree with the Decision Maker's decision, the claimant can request a review that DWP is obliged to conduct.	DWP response to independent reviewer recommendation
Adjustment to WRAG benefit rate (2015)	DWP removed the benefit component of WRAG and aligned its benefit level with JSA to generate savings to be used for better employment support.	Policy change
Amendment to reassessment of individuals in SG (2017)	ESA SG with 'severe conditions' no longer need to be reassessed.	Policy change

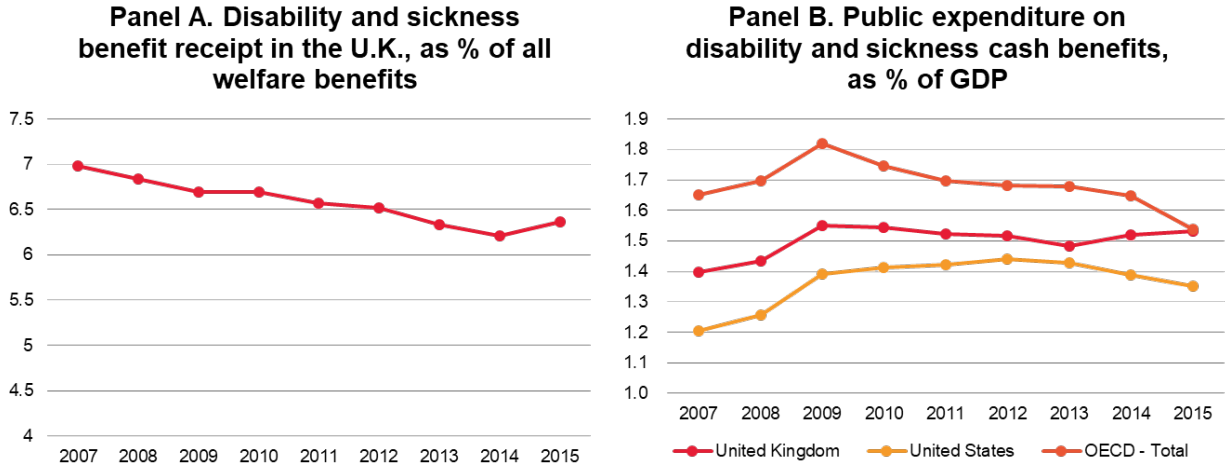
F. Evidence of effectiveness

At its creation, the ESA had three broad and interrelated goals: (1) reduce the cost of disability benefits as a share of GDP, (2) increase employment among people with disabilities,

and (3) improve the overall well-being of people with disabilities. Unfortunately, there is very little causal evidence about ESA's impacts. However, descriptive evidence suggests that ESA made no progress toward decreasing benefit expenditures as a share of GDP and increasing employment rates among people with disabilities.

Despite showing progress, the government's benefit receipt reduction goals for ESA have not been realized. To reduce the cost of disability benefits as a share of GDP, in 2005 the government set a target of have 1 million fewer beneficiaries by 2015 and started planning for ESA, which began in 2008. However, the number of beneficiaries declined by less than 300,000 over that decade (Emmerson et al. 2017). Among the working-age population, this corresponds to a decrease in the rate of disability benefit receipt as a proportion of receipt of any types of benefit from 7.0 percent to 6.4 percent since the introduction of ESA (see Figure 4, Panel a). In addition, when ESA began the government estimated that 90 percent of claimants would be placed in the WRAG and only 10 percent in the SG (Kemp and Davidson 2010). In reality, more than half of the new claimants (and about 80 percent of IB beneficiaries) were placed in the SG. Falling short of key projections, the cost of disability benefits as a percentage of GDP after ESA remained around 1.5 percent, with a 0.1 percent increase between 2007 and 2015 (Figure 4, Panel b).

Figure 4. Trends in receipt of and public expenditures on incapacity benefits



Source: Panel A: ONS and LFS; Panel B: OECD Social Expenditure Database (SOCX), accessed on February 26, 2019, at https://stats.oecd.org/

Notes: U.K. public expenditures on disability and sickness cash benefits include Disability Living Allowance and Personal Independence Payment, and therefore slightly overestimates public expenditures on ESA.

The available evidence suggests that ESA had no success helping people with disabilities stay in or re-enter the labor force. A 2011 report found that a quarter of all ESA claimants were in employment 12 to 18 months after their initial claim but only 9 percent of those placed in WRAG group—the group whose members are eventually supposed to return to the labor force—were employed during the same period. Using longitudinal data from the Labour Force Surveys, Barr et al. (2015) found that reassessment of ESA beneficiaries was not associated with increased transitions into employment. Another survey-based study by Sissons and Barnes (2013) showed that new ESA beneficiaries who started receiving benefits after working for some

time are relatively more likely to move from ESA to employment than those without such backgrounds. These studies suggest that health status and labor force attachment are key determinants of future employment and that ESA may not have been effective in overcoming these determinants to improve employment outcomes.

There is no evidence regarding whether ESA improved the well-being of people with disabilities by providing financial support and helping some individuals to find employment. The only evidence partially addressing this issue focused on the impact of IB reassessments on beneficiary health outcomes. The study used local authority-level data and found that each additional 10,000 IB beneficiaries reassessed for ESA benefits was associated with 6 additional suicides, 2,700 cases of mental health problems, and 7,020 antidepressant items prescribed (Barr et al. 2016).

In addition to failing to fully deliver policy objectives, WCA has been subject to criticism from advocacy groups, independent experts, and scholars. The issues underlying these criticisms have adversely affected public perceptions about ESA (Geiger 2018). The most prevalent criticism of WCA is that it does not adequately assess functional capability. There are three aspects to this criticism.

1. Because the assessment scoring is additive, it does not often mark for SG benefits people with various low-scoring impairments that, in combination, severely reduce functional capability (Geiger 2018). This criticism has risen in prominence after the 2015 reform that lowered the WRAG benefit amounts to JSA levels.
2. The WCA's automated processes—particularly the face-to-face interviews carried out by HAPs using a standardized software program—do not capture well mental health conditions and their associated functional limitations (Litchfield 2014).
3. Although the descriptors were designed to capture daily-life activities that are thought to be relevant for modern day workplaces, in reality some people assigned to WRAG and FfW groups cannot transition easily to employment. Critics suggest that things could improve if the WCA was modified using employer input or if there were legal requirements for employers to accommodate workers with disabilities (Geiger 2018; Grover and Piggott 2013).

In addition to these assessment design shortcomings, critics also note problems with WCA operations. For example, the ESA caseload increased substantively after 2011, when the reassessment of 1.5 million IB beneficiaries started. Assessing that many additional people was costly and put pressure on both the HAP and the Tribunals Service. These factors eventually created the perception that the quality of WCA had deteriorated. Some believe that this perception led to Atos withdrawing as the HAP, the introduction of Mandatory Reconsideration, and the end of benefit reassessments for some SG members.

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V. COMPARING ESA AND SSDI

In this section we compare and contrast certain elements of ESA and SSDI. We first assess the application and assessment processes and then discuss other program features. This analysis could help U.S. policymakers understand how the U.K.'s ESA relates to current U.S. law and practice. Because Supplemental Security Income (SSI) and SSDI use the same criteria to determine medical eligibility for benefits, our ESA and SSDI analysis also makes indirect comparisons between ESA and SSI eligibility criteria.

A. Application and assessment

In some ways, the initial steps in the ESA and SSDI application processes are similar. The programs use sequential application processes that require potential claimants to initiate the process by providing basic information. Using this information, a program representative (at Jobcentre Plus for ESA or the Social Security Administration [SAA] for SSI or SSDI) assesses whether the applicant meets the most basic criteria needed to file a claim and is either vested in the program or (in the case of SSI and Income-Related ESA) has sufficiently limited income and assets. Applicants who do not meet these most basic criteria receive a technical denial and no further medical or functional determination is made.

If the application moves forward, the next step is to collect the medical information required to adjudicate the claim. In the U.S., the collection of medical information (as well as the rest of the adjudication process) is overseen by an examiner at a state-run Disability Determination Services (DDS) office. SSDI applicants provide their medical information and records to a claim examiner. For about half of SSDI applications, the DDS examiner (after conferring with a medical consultant) will order a consultative evaluation, which is a medical assessment conducted by a qualified medical source, to gather any additional medical information needed to adjudicate the claim (Wittenburg et al. 2012). If a consultative examination is not ordered, then the DDS examiner determines whether the claim is based solely on the medical information supplied by the applicant. In the U.K., the HAP collects medical information from the applicant. Similar to about half of SSDI applicants, almost all ESA applicants have an in-person assessment with a physician paid by the program. After collecting the applicant's medical information and performing an in-person assessment (that may include a physical examination), the HAP gives the data to a DWP Decision Maker who makes the initial eligibility determination.

Despite these similarities, there are several differences between the ESA and SSDI application and eligibility determination processes. Most critically, though both programs collect medical information to help adjudicate each claim, the programs use different criteria to determine whether the claimant is eligible for support. SSDI determines eligibility based on whether an applicant is unable to perform substantial gainful activity[12] due to a "medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months" (Section 223(d) of the Social Security Act, 42 U.S.C. § 423(d)(1)(A)). In contrast, ESA assesses whether an applicant's medical conditions have created enough functional limitations to substantively

[12] In 2019, the substantial gainful activity amount is $1,220 a month for non-blind beneficiaries and $2,040 a month for blind beneficiaries.

diminish capacity for work or work-related activity. The difference in focus is subtle, but critical. Instead of trying to determine (with limited direct evidence) whether an applicant's medical conditions prohibit work above a certain earnings threshold like SSDI does, ESA focuses on assessing functional limitations and their severity. Between the medical evidence supplied by the claimant and the face-to-face assessment, ESA's eligibility determination process provides evidence that directly relates to the program's eligibility criteria. Hence, unlike SSDI, ESA avoids creating (and justifying) a Listing of Impairments that medically qualify someone for benefits. ESA also avoids SSDI's use of vocational factors—such as age, education, and work experience—along with residual functional capacity to determine whether an applicant can perform any work that exists in the national economy (including work the applicant has performed in the past).

B. Decisions and appeals

In addition to the different eligibility criteria, there are key differences between how SSDI and ESA communicate and adjudicate decisions and appeals. The time needed to make an initial claim decision varies for both programs, with ESA taking 117 days on average as of March 2018, whereas SSDI typically took 83 days in federal fiscal year 2014 (DWP 2018b; SSA 2015). However, unlike initial SSDI eligibility determinations, ESA Decision Makers contact applicants before an initial decision is made, inform each applicant of what the decision will likely be, and allow each applicant a final opportunity to provide additional medical evidence that could influence the decision. This step may help maximize the amount of information used to make the initial claim decision, which could improve the initial decision's accuracy.

There are also substantive differences between how SSDI and ESA receive and adjudicate appeals. About 15 percent of ESA initial decisions are appealed whereas 27 percent of the SSDI claims filed in federal fiscal year 2010 that received a medical decision were appealed to the administrative law judge level or higher (DWP 2018b; SSA 2018). Including appeals, ESA adjudicates applications faster than SSDI: the average ESA application receives a final decision after 127 days whereas the average SSDI application takes 235 days for a final decision (Social Security Advisory Board 2017). As of March 2018, about 35 percent of ESA appeals result in an overturned decision (DWP 2018b). For SSDI, between 1999 and 2009, 10 to 15 percent of reconsideration level decisions and 64 to 74 percent of Administrative Law Judge hearing level (or higher) decisions were overturned (SSA 2018). In addition to dissimilar appeal rates, differences in the number or appeals may help explain the contrast in days to final decision. ESA has two levels of appeal whereas SSDI has as many as four—reconsideration (in most states), administrative law judge hearing, appeals council, and federal court review. The amount of resources devoted to appeals may also help explain the substantive difference in days to decision across programs. For example, a recent report suggests that decreased staffing ratios have adversely affected the productivity of administrative law judges (SSA 2017).

Another distinction between the ESA and SSDI claim adjudication processes is the role of medical providers and private sector corporations. Both programs accept medical evidence from applicants that is generated from a qualified medical source. However, there are substantive differences across programs in how and from whom other medical evidence is obtained. Consultative examinations, which are SSDI's mechanism for obtaining direct medical evidence, can be administered by the applicant's medical provider or a state-contracted medical provider.

Consultative examinations are ordered and paid for by DDS and SSA, but the medical provider does not work directly for the government or a single company. The quality of consultative examinations are overseen by the state and evidence suggests that quality can vary. A 2012 review of a sample of consultative examination reports found that some reports had enough deficiencies that making a claim decision based on the report was difficult (Wittenburg et al. 2012). In contrast to SSDI, ESA relies on the HAP—a private corporation under contract with DWP—to collect medical information from the applicant and perform an in person assessment.

A major difference between the programs that spans both eligibility determination and benefit receipt is the number of application outcome/benefit types. SSDI's application process has a binary outcome—the claimant either does or does not meet the program eligibility criteria. Those who meet the eligibility criteria receive full benefits whereas those who do not meet the criteria receiving nothing. Unless a SSDI beneficiary's medical condition improves to the extent that they can engage in substantial gainful activity, SSDI benefit duration is indefinite. The only mechanism SSDI has for reassessing program eligibility is continuing disability reviews, which are either triggered by certain beneficiary events such as substantive earnings or occur in regular intervals based on the likelihood of the beneficiary's medical improvement. In contrast, the ESA eligibility determination process places applicants into three groups: the SG, the WRAG, or the FfW group. The SG and FfW groups have the greatest parallels to SSDI applicant outcomes. With an indefinite full benefit, the Support Group most resembles receiving SSDI benefits, though not all Support Group members have their benefits routinely reassessed. Similarly, the FfW group, which receives no disability based benefit, is analogous to being denied SSDI benefits. However, ESA's WRAG has no similar SSDI application outcome category. WRAG members receive time limited income support that is less than what SG members receive and must participate in certain work-related activities. In other words, the benefits afforded to the WRAG are unique (relative to SSDI benefits) in that they seek to assist workers who experience disability onset but may be able to eventually return to work with help from limited services and supports.

C. Reform

Apart from eligibility criteria and benefit details, one noteworthy difference between ESA and SSDI is their history of developing and implementing reforms. With the 2008 reforms that created ESA, U.K. policymakers mandated an independent review process that annually assessed ESA and identified potential reforms for DWP's consideration. Based on these reviews and other feedback, DWP has made several improvements to the WCA. Policymakers have also been willing to enact reforms that would seem to help ESA achieve its fiscal goal of reducing government expenditures on benefits for workers with disabilities. Consequently, reforms to ESA are not uncommon and several have been implemented since ESA's creation. For example, ESA has made multiple downward adjustments in the benefit levels of WRAG members, which may have discouraged ESA benefit application among those unlikely to qualify for the SG. Though making changes to ESA quickly may at first seem unambiguously beneficial because of the ability to rapidly address things that are not working as intended, implementing reforms without rigorous piloting or evaluation may result in unintended consequences. Unfortunately, we found no evidence that assesses the effectiveness of the post 2008 ESA reforms, so we cannot definitively say whether they worked as intended (although some reforms were strongly correlated with their intended policy goals) or had unintended effects.

Relative to ESA, SSDI makes substantive reforms less frequently but focuses more on generating rigorous evidence to inform changes. SSDI has very limited ability to make substantive permanent program changes without legislative action, although SSDI has been allowed (by legislative action) to temporarily waive program rules to test promising program ideas (Wittenburg et al. 2013). These SSDI tests have generated substantive rigorous evidence but few have identified promising interventions or resulted in adopted reforms. As a result, many aspects of the SSDI program have not changed for decades, even when circumstances seemed opportune for reform. For example, when the Disability Insurance Trust Fund—the fund from which all SSDI benefit are paid—was nearing exhaustion in 2015, instead of reforming program features to lower expenditures as in the U.K., U.S. policymakers temporarily increased the portion of Federal Insurance Contributions Act tax allocated with the Disability Insurance Trust Fund relative to the Old Age and Survivors Insurance Trust Fund. This reallocation allowed policymakers to address SSDI's solvency issues for years without changing the program itself. Among the few reforms to SSDI made by policymakers in recent decades, the Ticket to Work program—which was meant to improve return-to-work outcomes among SSDI beneficiaries—was not developed or rigorously tested before its deployment. Evaluations of the program's effectiveness have not found substantive positive impacts (Stapleton et al. 2008).

D. Employer engagement

Both ESA and SSDI do not engage employers on behalf of applicants or beneficiaries. Unlike its predecessor program, ESA's assessment does not focus on one's ability to do work, but instead focuses on one's functional limitations. This change in focus implies that employer engagement (or any other past employment considerations) are not directly relevant to the application process. However, by making assignment to the WRAG an application outcome, ESA is identifying the applicants it believes should eventually be able to work. ESA provides WRAG members with work-related training, but it does not work directly with employers to help obtain employment for this group. Unlike ESA, SSDI examines applicants' ability to perform work and does not have an application outcome identifying those who should eventually be able to return to work. Through its work incentives and the Ticket to Work program, SSDI does provide access to return-to-work incentives and resources to beneficiaries who voluntarily wish to use them. However, like ESA, SSDI does not engage employers directly to help some beneficiaries return to work.

VI. CONCLUSION

In this manuscript, we describe ESA—the U.K.'s primary disability benefit program—in detail, with a special focus on operational details such as changes in program eligibility criteria and eligibility determination processes. Using information collected from expert interviews, peer reviewed manuscripts, and program documents, we briefly describe ESA's predecessor programs for context, then describe ESA, and then compare and contrast ESA to SSDI.

The ESA program, which was created to decrease U.K. expenditures on disability benefits and increase employment among people with disabilities, has a five-step eligibility determination process that places applicants into three groups. This process collects evidence through documents and a face-to-face assessment to measure each claimant's functional limitations. Those found eligible for ESA benefits are either placed in the SG and receive an unconditional cash benefit or in the WRAG and receive benefit payments only if they actively participate in return to work activities. ESA's development seemingly relied primarily on lessons learned from IB instead of external rigorous evidence regarding whether ESA's structure would achieve the intended policy goals. Since its initial deployment, ESA's eligibility determination and benefit rules have been reformed to better meet fiscal objectives and respond to feedback from independent reviews. Even with these reforms, ESA still has its critics, who argue that ESA does not adequately assess functional capability and has operational problems.

ESA and SSDI have a number of important differences and similarities. Both programs collect evidence using documents, but SSDI does not rely on face-to-face assessments to help determine eligibility as much as ESA does. ESA program eligibility assesses functional limitations whereas SSDI focuses whether a claimant can engage in substantial gainful activity. With its focus on helping beneficiaries eventually return to work, ESA's WRAG is different than SSDI's single beneficiary type, which requires no return to work efforts in order to receive benefits. Although SSDI has rigorously tested several benefit reform ideas, it has not implemented the volume of changes ESA has made in its relatively shorter existence.

Because there is no evidence establishing ESA's causal effects (and limited descriptive evidence suggests that ESA has not achieved its policy objectives), it is difficult to recommend incorporating novel components from ESA into U.S. disability policy. Nevertheless, ESA's creation, structure, and changes contain policy lessons for the U.S. context. Most importantly, the U.K.'s experience with ESA highlights the need to rigorously test new programs and reforms prior to full implementation. ESA was developed primarily from IB, replicating seemingly successful processes while abandoning those deemed less helpful. However, there was no effort to determine through testing whether the changes incorporated into ESA would achieve the desired policy objectives. Furthermore, during ESA's initial years, program rules and processes were changed several times in response to feedback from the public, experts, and independent reviews. A pilot test of ESA might have avoided the need for some of these post-rollout changes. Through its testing of some proposed program changes (usually by randomized controlled trial), SSA has already pursued a rigorous approach to reform. The U.K.'s experience with ESA underscores the benefits of SSA's use of testing.

Although ESA's development and rollout have shown the importance of rigorously testing significant program changes before they are enacted, it also demonstrates the role that rapid

cycle evaluation can play in making modest program improvements. The U.K. built into ESA's rollout five annual independent reviews as well as the authority for ESA to make modest program changes without legislative action. Focused on producing feedback that could lead to helpful program changes, the independent reviews implicitly acknowledged that any new program (regardless of how rigorously it was developed or tested) can be improved using the lessons learned during the program's initial years. ESA's independent review approach differs from SSA's policy change procedures. SSA has examined program changes using independent evaluators, but the evaluations have not involved providing rapid cycle feedback or making modest changes. In addition, SSA has not typically been given the authority to make modest program changes without legislative approval. When considering future reforms to programs like SSDI, U.S. policymakers might consider providing the federal agencies that oversee program reforms with the authority to make modest changes in response to rapid cycle feedback.

Finally, ESA offers suggestions to improve the accuracy of initial benefit decisions and lower decision appeal rates. Just before an initial decision is made, the ESA Decision Maker conducts a Decision Assurance Call to explain to the claimant the proposed decision and provide another opportunity to submit medical evidence. In addition to the various purposes it serves, the Decision Assurance Call is the last in a series of mandatory live interactions—whether face-to-face or by phone—between DWP representatives and the claimant. These interactions likely provide the claimant (relative to not having these interactions) with more opportunities to ask questions and obtain a better understanding of the decision process. Although there are opportunities for SSI and SSDI applicants to meet with or speak to an SSA representative, these interactions are not mandatory. ESA's initial decision appeal rates are substantively less than those for SSDI. Although we cannot definitively say whether ESA's multiple mandatory live interactions with claimants are responsible for the relatively lower appeal rates, ESA's decision process could provide SSA with ideas to test for more accurate initial decisions that are less frequently appealed.

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APPENDIX A

ESA – DESCRIPTORS TO DETERMINE WHETHER YOU HAVE 'LIMITED CAPABILITY FOR WORK'

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Part 1: Physical disabilities	
Activity 1: Mobilising unaided by another person with or without a walking stick, manual wheelchair or other aid if such aid can reasonably be used.	
Descriptor:	**Points**
(a) Cannot either: i) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion; or ii) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion.	**15**
(b) Cannot mount or descend two steps unaided by another person even with the support of a handrail.	**9**
(c) Cannot either: i) mobilise more than 100 metres on level ground without stopping in order to avoid significant discomfort or exhaustion; or ii) repeatedly mobilise 100 metres within a reasonable timescale because of significant discomfort or exhaustion.	**9**
(d) Cannot either: i) mobilise more than 200 metres on level ground without stopping in order to avoid significant discomfort or exhaustion; or ii) repeatedly mobilise 200 metres within a reasonable timescale because of significant discomfort or exhaustion.	**6**
(e) None of the above apply.	**0**
Activity 2: Standing and sitting	
Descriptor:	**Points**
(a) Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person.	**15**
(b) Cannot, for the majority of the time, remain at a work station, either: i) standing unassisted by another person (even if free to move around); or ii) sitting (even in an adjustable chair) for more than 30 minutes, before needing to move away in order to avoid significant discomfort or exhaustion.	**9**
(c) Cannot, for the majority of the time, remain at a work station, either: i) standing unassisted by another person (even if free to move around); or ii) sitting (even in an adjustable chair) for more than an hour before needing to move away in order to avoid significant discomfort or exhaustion.	**6**
(d) None of the above apply	**0**
Activity 3: Reaching	
Descriptor:	**Points**
(a) Cannot raise either arm as if to put something in the top pocket of a coat or jacket.	**15**
(b) Cannot raise either arm to top of head as if to put on a hat.	**9**
(c) Cannot raise either arm above head height as if to reach for something.	**6**
(d) None of the above apply.	**0**

Part 1: Physical disabilities	
Activity 4: Picking up and moving or transferring by the use of the upper body and arms	
Descriptor:	**Points**
(a) Cannot pick up and move a 0.5 litre carton full of liquid.	**15**
(b) Cannot pick up and move a one litre carton full of liquid	**9**
(c) Cannot transfer a light but bulky object such as an empty cardboard box.	**6**
(d) None of the above apply	**0**
Activity 5: Manual dexterity	
Descriptor:	**Points**
(a) Cannot either: i) press a button, such as a telephone keypad; or ii) turn the pages of a book with either hand.	**15**
(b) Cannot pick up a £1 coin or equivalent with either hand.	**15**
(c) Cannot use a pen or pencil to make a meaningful mark.	**9**
(d) Cannot use a suitable keyboard or mouse.	**9**
(e) None of the above apply.	**0**
Activity 6: Making self understood through speaking, writing, typing, or other means normally used, unaided by another person	
Descriptor:	**Points**
(a) Cannot convey a simple message, such as the presence of a hazard.	**15**
(b) Has significant difficulty conveying a simple message to strangers.	**15**
(c) Has some difficulty conveying a simple message to strangers.	**6**
(d) None of the above apply.	**0**
Activity 7: Understanding communication by both verbal means (such as hearing or lip reading) and non-verbal means (such as reading 16 point print) using any aid it is reasonable to expect them to use, unaided by another person	
Descriptor:	**Points**
(a) Cannot understand a simple message due to sensory impairment, such as the location of a fire escape.	**15**
(b) Has significant difficulty understanding a simple message from a stranger due to sensory impairment.	**15**
(c) Has some difficulty understanding a simple message from a stranger due to sensory impairment.	**6**
(d) None of the above apply.	**0**
Activity 8: Navigation and maintaining safety, using a guide dog or other aid if normally used	
Descriptor:	**Points**
(a) Unable to navigate around familiar surroundings, without being accompanied by another person, due to sensory impairment.	**15**
(b) Cannot safely complete a potentially hazardous task such as crossing the road, without being accompanied by another person, due to sensory impairment.	**15**
(c) Unable to navigate around unfamiliar surroundings, without being accompanied by another person, due to sensory impairment.	**9**
(d) None of the above apply.	**0**

Part 1: Physical disabilities	
Activity 9: Absence or loss of control leading to extensive evacuation of the bowel and/or bladder, other than enuresis (bed-wetting) despite the presence of any aids or adaptations normally used	
Descriptor:	**Points**
(a) At least once a month experiences: i) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder; or ii) substantial leakage of the contents of a collecting device sufficient to require cleaning and a change in clothing.	**15**
(b) At risk of loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder, sufficient to require cleaning and a change in clothing, if not able to reach a toilet quickly.	**6**
(c) None of the above apply.	**0**
Activity 10: Consciousness during waking moments	
Descriptor:	**Points**
(a) At least once a week, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration.	**15**
(b) At least once a month, has an involuntary episode of lost or altered consciousness resulting in significantly disrupted awareness or concentration.	**6**
(c) None of the above apply.	**0**

Part 2: Mental, cognitive and intellectual function assessment	
Activity 11: Learning tasks	
Descriptor:	**Points**
(a) Cannot learn how to complete a simple task, such as setting an alarm clock.	**15**
(b) Cannot learn anything beyond a simple task, such as setting an alarm clock.	**9**
(c) Cannot learn anything beyond a moderately complex task, such as the steps involved in operating a washing machine to clean clothes.	**6**
(d) None of the above apply.	**0**
Activity 12: Awareness of everyday hazards (such as boiling water or sharp objects)	
Descriptor:	**Points**
(a) Reduced awareness of everyday hazards leads to a significant risk of: i) injury to self or others; or ii) (ii) damage to property or possessions such that they require supervision for the majority of the time to maintain safety.	**15**
(b) Reduced awareness of everyday hazards leads to a significant risk of i) injury to self or others; or ii) damage to property or possessions such that they frequently require supervision to maintain safety.	**9**

Part 2: Mental, cognitive and intellectual function assessment	
(c) Reduced awareness of everyday hazards leads to a significant risk of: i) injury to self or others; or ii) damage to property or possessions such that they occasionally require supervision to maintain safety.	**6**
(d) None of the above apply.	**0**
Activity 13: Initiating and completing personal action (which means planning, organisation, problem solving, prioritising or switching tasks)	
Descriptor:	**Points**
(a) Cannot, due to impaired mental function, reliably initiate or complete at least 2 sequential personal actions.	**15**
(b) Cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions for the majority of the time.	**9**
(c) Frequently cannot, due to impaired mental function, reliably initiate or complete at least 2 personal actions.	**6**
(d) None of the above apply.	**0**
Activity 14: Coping with change	
Descriptor:	**Points**
(a) Cannot cope with any change to the extent that day to day life cannot be managed.	**15**
(b) Cannot cope with minor planned change (such as a pre-arranged change to the routine time scheduled for a lunch break), to the extent that overall day to day life is made significantly more difficult.	**9**
(c) Cannot cope with minor unplanned change (such as the timing of an appointment on the day it is due to occur), to the extent that overall, day to day life is made significantly more difficult.	**6**
(d) None of the above apply.	**0**
Activity 15: Getting about	
Descriptor:	**Points**
(a) Cannot get to any specified place with which the claimant is familiar.	**15**
(b) Is unable to get to a specified place with which the claimant is familiar, without being accompanied by another person.	**9**
(c) Is unable to get to a specified place with which the claimant is unfamiliar without being accompanied by another person.	**6**
(d) None of the above apply.	**0**
Activity 16: Coping with social engagement due to cognitive impairment or mental disorder	
Descriptor:	**Points**
(a) Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual.	**15**
(b) Engagement in social contact with someone unfamiliar to the claimant is always precluded due to difficulty relating to others or significant distress experienced by the individual.	**9**
(c) Engagement in social contact with someone unfamiliar to the claimant is not possible for the majority of the time due to difficulty relating to others or significant distress experienced by the individual.	**6**
(d) None of the above apply.	**0**

Part 2: Mental, cognitive and intellectual function assessment	
Activity 17: Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder	
Descriptor:	**Points**
(a) Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.	**15**
(b) Frequently has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.	**15**
(c) Occasionally has uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.	**9**
(d) None of the above apply.	**0**

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APPENDIX B

ESA – DESCRIPTORS TO DETERMINE WHETHER YOU HAVE 'LIMITED CAPABILITY FOR WORK-RELATED ACTIVITY'

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Activity 1:

Descriptors:

Cannot either:

(a) mobilise more than 50 metres on level ground without stopping in order to avoid significant discomfort or exhaustion;
or

(b) repeatedly mobilise 50 metres within a reasonable timescale because of significant discomfort or exhaustion.

Activity 2: Transferring from one seated position to another

Descriptors:

Cannot move between one seated position and another seated position located next to one another without receiving physical assistance from another person.

Activity 3: Reaching

Descriptors:

Cannot raise either arm as if to put something in the top pocket of a coat or jacket.

Activity 4: Picking up and moving or transferring by the use of the upper body and arms (excluding standing, sitting, bending or kneeling and all other activities specified in this Schedule)

Descriptors:

Cannot pick up and move a 0.5 litre carton full of liquid.

Activity 5: Manual dexterity

Descriptors:

Cannot either:

(a) press a button, such as a telephone keypad; or

(b) turn the pages of a book with either hand.

Activity 6: Making self understood through speaking, writing, typing, or other means normally used

Descriptors:

Cannot convey a simple message, such as the presence of a hazard.

Activity 7: Understanding communication by hearing, lip reading, reading 16 point print or using any aid if reasonably used

Descriptors:

Cannot understand a simple message due to sensory impairment, such as the location of a fire escape.

Activity 8: Absence or loss of control over extensive evacuation of the bowel and/or voiding of the bladder, other than enuresis (bed-wetting), despite the presence of any aids or adaptations normally used

Descriptors:

At least once a week experiences:

(a) loss of control leading to extensive evacuation of the bowel and/or voiding of the bladder;
or

(b) substantial leakage of the contents of a collecting device sufficient to require the individual to clean themselves and change clothing.

Activity 9: Learning tasks

Descriptors:

Cannot learn how to complete a simple task, such as setting an alarm clock, due to cognitive impairment or mental disorder.

Activity 10: Awareness of hazard

Descriptors:

Reduced awareness of everyday hazards, due to cognitive impairment or mental disorder, leads to a significant risk of:

(a) injury to self or others;
or

(b) damage to property or possessions such that they require supervision for the majority of the time to maintain safety.

Activity 11: Initiating and completing personal action (which means planning, organisation, problem-solving, prioritising or switching tasks)

Descriptors:

Cannot, due to impaired mental function, reliably initiate or complete at least two sequential personal actions.

Activity 12: Coping with change

Descriptors:

Cannot cope with any change, due to cognitive impairment or mental disorder, to the extent that day to day life cannot be managed.

Activity 13: Coping with social engagement, due to cognitive impairment or mental disorder

Descriptors:

Engagement in social contact is always precluded due to difficulty relating to others or significant distress experienced by the individual.

Activity 14: Appropriateness of behaviour with other people, due to cognitive impairment or mental disorder

Descriptors:

Has, on a daily basis, uncontrollable episodes of aggressive or disinhibited behaviour that would be unreasonable in any workplace.

Activity 15: Conveying food or drink to the mouth

Descriptors:

(a) Cannot convey food or drink to the claimant's own mouth without receiving physical assistance from someone else;

(b) Cannot convey food or drink to the claimant's own mouth without repeatedly stopping, experiencing breathlessness or severe discomfort;

(c) Cannot convey food or drink to the claimant's own mouth without receiving regular prompting given by someone else in the claimant's physical presence;
or

(d) Owing to a severe disorder of mood or behaviour, fails to convey food or drink to the claimant's own mouth without receiving:

   i) physical assistance from someone else;
   or

   ii) regular prompting given by someone else in the claimant's presence.

Activity 16: Chewing or swallowing food or drink

Descriptors:

(a) Cannot chew or swallow food or drink;

(b) Cannot chew or swallow food or drink without repeatedly stopping, experiencing breathlessness or severe discomfort;

(c) Cannot chew or swallow food or drink without repeatedly receiving regular prompting given by someone else in the claimant's presence;
or

(d) Owing to a severe disorder of mood or behaviour fails to:

i) chew or swallow food or drink;
or

ii) chew or swallow food or drink without regular prompting given by someone else in the claimant's presence.

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