Terminal Cancers and Industrial Injuries Disablement Benefit

Report by the Industrial Injuries Advisory Council in accordance with Section 171 of the Social Security Administration Act 1992 considering terminal cancers and Industrial Injuries Disablement Benefit

Presented to Parliament by the Secretary of State for Work and Pensions
by Command of Her Majesty
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This publication is available at **http://iiac.independent.gov.uk/reports/reptable.shtml**

Any enquiries regarding this publication should be sent to us at **iiac@dwp.gov.uk**

Print ISBN 9781474101776
Web ISBN 9781474101783

Printed in the UK by the Williams Lea Group on behalf of the Controller of Her Majesty's Stationery Office

ID 2634715 04/14

Printed on paper containing 75% recycled fibre content minimum

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Dear Secretary of State,

REVIEW OF TERMINAL CANCERS AND INDUSTRIAL INJURIES DISABLEMENT BENEFIT

We present our review of entitlement conditions for Industrial Injuries claimants with terminal prescribed malignant diseases. Currently, claims for certain prescribed diseases with short life expectancies are accorded priority during processing by the Department for Work and Pensions. Some asbestos-related malignant diseases also attract beneficial exceptions to the usual entitlement rules, such that the 90 day waiting period from the onset of a disease to when payment can start is waived and that 100% assessments of disablement are automatically awarded.

It has been brought to our attention that these beneficial entitlement conditions and priority processing arrangements are not the same for prescribed malignant diseases with very similar prognoses. This could lead to a potential inequity of treatment between claimants with different terminal prescribed malignant diseases.

During the course of our review we have considered evidence on life expectancy in relation to all of the prescribed malignant diseases and consulted with Departmental officials. We conclude that the list of 'priority' prescribed diseases for which claims are expedited should be amended to include the prescribed lung cancers prescribed disease (PD) C4 (lung cancer due to arsenic fumes) and PD C22b (lung cancer due to nickel refining), as well as angiosarcoma of the liver (PD C24); but that it should exclude asbestos-related diffuse pleural thickening (PD D9).

We also recommend that the prescribed lung cancers PD C4, PD C22b, PD D10 (lung cancer due to tin mining and other chemical exposures) and PD D11 (lung cancer with silicosis) and angiosarcoma of the liver (PD C24) should benefit from the advantageous entitlement rules (waiving of the 90 day waiting period and the automatic right to a 100% assessment) currently applicable to the asbestos-related cancers PD D3 (mesothelioma) and PD D8/8A (asbestos-related lung cancer with/without asbestosis).

Our recommendations are likely to apply to fewer than ten claims for Industrial Injuries annually. Thus, the costs of implementing these changes, which are aimed at redressing a potential inequity between claimants with similar shortening of life-expectancy, are likely to be small.

Finally, we recommend that the Department reviews all Industrial Injuries awards made with an automatic 100% payment after three years to ensure they remain appropriate. Although the vast majority of claimants with the diseases of interest will unfortunately die as a consequence, there will be a few cases where a mistaken diagnosis has been made or where there has been an unanticipated recovery, and there should be a mechanism for reviewing such cases.

Yours sincerely,

Professor Keith Palmer, IIAC Chair
April 2014

Summary

1. The Department for Work and Pensions (DWP) currently gives priority to processing Industrial Injuries Disablement Benefit (IIDB) claims for some prescribed diseases with short life expectancies. In addition, claimants diagnosed with certain asbestos related cancers do not have to wait for 90 days from the onset of the disease before payment can start, and they automatically receive 100% assessments of disablement.

2. However, the application of these priority processing and advantageous entitlement conditions varies within the Scheme, with the potential that unequal treatment of claims could arise between claimants who share a similarly poor prognosis.

3. The Industrial Injuries Advisory Council (IIAC) has reviewed the matter and concludes that the list of 'priority' diseases for which claims are expedited should be amended to include the prescribed lung cancers Prescribed Disease (PD) C4 (lung cancer due to arsenic fumes) and PD C22b (lung cancer due to nickel refining), as well as angiosarcoma of the liver (PD C24); but that it should exclude diffuse pleural thickening after exposure to asbestos (PD D9).

4. In addition the Council recommends that the exceptional entitlement rules currently in place for PD D3 (mesothelioma) and PD D8/8A (lung cancer from exposure to asbestos with/without asbestosis) be extended to all other forms of lung cancer covered by the Scheme (PD C4, PD C22b, PD D10 (lung cancer due to tin mining and other chemical exposures) and PD D11 (lung cancer with silicosis)) as well as to PD C24 (angiosarcoma of the liver), as these diseases all carry a similarly poor prognosis.

5. The proposed changes are likely to apply to fewer than ten claims for IIDB annually, so costs associated with implementing them will be small. However, the changes are recommended in the interests of equity and fair treatment of all claimants with serious life-shortening illness.

6. The Council further recommends that all IIDB claims given an automatic 100% award be reassessed if still in payment after a period of three years. This will identify cases where survival has proved longer than originally anticipated and which may not be in keeping with the diagnosis of a terminal prescribed disease.

The Industrial Injuries Advisory Council and the Industrial Injuries Scheme

7. IIAC is an independent statutory body set up in 1946 to advise the Secretary of State for Work and Pensions in Great Britain and the Department for Social Development in Northern Ireland on matters relating to the Industrial Injuries Scheme. The Scheme provides non-contributory, 'no-fault' benefits for disablement because of accidents or prescribed diseases which arise during the course of employed earners' work.

8. A prescribed disease is one that has been added to the scheduled list of diseases as it has fulfilled the statutory requirements for prescription. The benefit is paid in addition to other incapacity and disability benefits. It is tax-free and administered by the DWP.

9. Claims for certain prescribed diseases with short life expectancies are accorded priority during processing by the DWP. This means that such claims are dealt with as quickly as possible. In addition, some asbestos-related malignant diseases with a short life expectancy attract exceptions to the usual entitlement rules: the 90 day waiting period before a claimant can make a claim is waived and 100% assessments of disablement are awarded automatically.

10. Arrangements vary, however, and Departmental representatives have drawn to the Council's attention the potential for inadvertent inequity to arise in the handling of claims for some seriously ill claimants. This report summarises the Council's recommendations in relation to the processing of such claims.

Current arrangements for claimants who are terminally ill

Non-Industrial Injuries Disablement benefits

11. 'Special rules' govern the procedures for assessment and entitlement of terminally ill claimants who claim sickness benefits and a range of other welfare benefits. These rules, which are defined in law, apply to Attendance Allowance (AA), Disability Living Allowance (DLA), Employment and Support Allowance (ESA), Incapacity Benefit (IB) and Personal Independence Payment (PIP).

12. In social security law[1] relating to these benefits, someone is terminally ill if "...at that time he suffers from a progressive disease and his death in consequence of that disease can reasonably be expected within six months...".

13. The special rules provisions were first introduced in 1990 for claimants of AA[2]. At the time the normal waiting period for that benefit was six months; the special rules were introduced to help people who, through terminal illness, were dying before they had completed the waiting period and so were unable to receive any payment. Later the rules were extended to recognise claimants in similar circumstances who were applying for DLA, IB, ESA and, more recently, PIP.

14. Special rules expedite assessment and in some cases affect the level of award. For AA, DLA and PIP, for example, the typical waiting period for benefit is waived when the special rules apply, and the benefits are payable even if a person does not need help with looking after themselves at the time of claim. For IB, the highest rate is payable at an earlier stage in the claim than would normally apply; and for ESA, the customer is automatically eligible for the support group which is paid at a higher rate.

15. Claimants who are terminally ill apply for these benefits through the normal procedures, but must provide form DS1500 with the usual claim form. DS1500 is a factual report completed by the claimant's doctor or consultant. It gives the relevant medical facts about the diagnosis and stage of the claimant's illness, but not a view on how long the claimant might live. Claims with accompanying DS1500 forms are fast-tracked and a health care professional uses the information on the form to advise the decision-maker on whether the claimant is terminally ill as defined in social security law (paragraph 12).

[1] Social Security Contributions and Benefits Act 1992 c.4 s. 66.
[2] There are no waiting periods for income replacement benefits such as IB and ESA.

Industrial Injuries Disablement Benefit

16. There are no 'special rules' covering IIDB and form DS1500 is not required when a claim for a terminal prescribed disease is made. However, claims for some prescribed diseases are automatically treated as 'priority' cases and processing is expedited. The test for dealing with these claims quickly is not set out in statute, as for 'special rules', but guidance is given to decision makers.

17. Currently, the prescribed diseases automatically receiving priority processing are:

PD D3	Diffuse mesothelioma (caused by exposure to asbestos)
PD D8	Primary carcinoma of the lung with evidence of asbestosis
PD D8A	Primary carcinoma of the lung after heavy exposure to asbestos
PD D9	Unilateral or bilateral diffuse pleural thickening (after exposure to asbestos)
PD D10	Primary carcinoma of the lung (linked to tin mining and other specified chemicals)
PD D11	Primary carcinoma of the lung with silicosis

In addition, claims for PD D1 (pneumoconiosis) where the claimant mentions work with asbestos and claims for PD D12 (chronic bronchitis and emphysema in coal miners) where the claimant is known to be terminally ill are also treated with priority.

18. It is important to note that where a claim form contains information that indicates a terminal illness of any kind, not necessarily that for which the claim is being made, then those who administer the Scheme are advised to put the claim forward for priority assessment.

19. The priority list does not include every malignant disease covered by the Scheme, but does include one non-malignant disease (PD D9 – diffuse pleural thickening). PD D9 has been accorded such priority, historically, because of its causal relationship to asbestos.

20. Some prescribed diseases also attract exceptions to the normal rules of payment. Claimants with mesothelioma (PD D3) or asbestos-related lung cancer (PD D8 and PD D8A) do not have to wait 90 days from the date of onset before receiving their benefit and the regulations mandate that these prescribed diseases are awarded at the maximum level of disablement (100%). The easements for these asbestos-related malignancies were introduced as a result of the Council's reports, Cm 3467[3] and Cm 6553[4].

Potential for inequity: coverage

21. In the Table below we list all of the prescribed malignant diseases, grouped by the primary site of the malignancy. Those that are subject to priority processing are highlighted in bold text, and those that currently receive an automatic 100% award within the Scheme are shaded in grey.

[3] Cm 3467 'Asbestos Related Diseases' 1996.
[4] Cm 6553 'Asbestos related diseases' 2005.

22. The data contained within the table clearly shows that the priority processing rules and exceptional entitlement conditions of waiving of the 90 day waiting period and the automatic right to a 100% assessment do not apply consistently to all prescribed cancers of a particular site, or to prescribed cancers with a similar prognosis.

Table of malignant Prescribed Diseases (PD) with estimated rates of 1-year and 5-year survival

PD	Description	Number of claims per annum‡	Number of awards per annum†	Site	Survival	
					to 1 year	to 5 years
D8	**Lung cancer with asbestosis**	300	110	lung	30%	10%
D8A	**Lung cancer after substantial asbestos exposure**	170	150			
C4	Lung cancer from exposure to arsenic	<10	<10			
D10	**Lung cancer in tin miners, coke oven workers* and after certain chemical exposures**	<10	<10			
D11	**Lung cancer with silicosis**	<10	<10			
C22(b)	Lung cancer from nickel refining	<10	<10			
C22(a)	Cancer of the nose and paranasal air sinuses from nickel refining	<10	<10	nose/ sinuses	80%	50%
D6	Carcinoma of the nasal cavity or paranasal air sinuses	10	<10			
D13	Primary carcinoma of the nasopharynx from exposure to wood dust	<10	<10			
A1	Leukaemia (except chronic lymphatic leukaemia)	10	<10	mixed	65%	45%
	Bone cancer				80%	50%
	Breast cancer				95%	85%
	Testicular cancer				98%	97%
	Thyroid cancer				>95%	>90%
C7	Acute non-lymphatic leukaemia from exposure to benzene	<10	<10	blood	65%	45%
C23	Bladder cancer arising from various chemicals	50	20	bladder	75%	55%
C24	Angiosarcoma of the liver	<10	<10	liver	20%	5%
D3	**Mesothelioma**	1,780	1,610	pleura	40%	5%
	ALL	2,330	1,890			

Bold text indicates prescribed diseases on the priority list for which claims processing is expedited.

Shaded areas indicate diseases currently afforded exceptional entitlement.

‡ Average number of claims per year for 2003-2011;

† Average number of awards per year for 2003-2011. Data have been rounded to the nearest 10. Numbers of claims and awards may not add up precisely to the totals provided due to rounding.

* Lung cancer in coke workers was added to the list of prescribed diseases in August 2012; a full year of data is not yet available so an annual estimate has been used

23. The Table includes estimates of the one-year and five-year survival rates for each primary site, for men and women combined, obtained from current survival figures for all cancers (whether acquired from occupational exposures or not) published by the Office for National Statistics[5] or, where not available there, from Cancer Research UK. These are average estimates and do not take into account differences in the stage of disease at diagnosis or other important factors such as co-existing illnesses; actual survival rates in individuals may vary from these figures.

24. A point to note is that, while survival rates vary by the site of tumour, they do not vary much by cause. Specifically, the Council is not aware of any evidence that occupationally-acquired malignancies or those caused by asbestos exposure have a prognosis that differs from malignancies at the same site with other causes; by the same token, survival rates for the lung cancers PD C4 and PD C22b should be similar to those for PD D8, PD D8A, PD D10 and PD D11 which currently benefit from one or both elements of the beneficial procedures currently in place.

25. Thus, the current arrangements and regulations for IIDB are potentially inequitable. The application of priority processing and, on diagnosis of some prescribed asbestos-related lung cancers (PD D8 and PD D8A), exceptional entitlement, may relatively disadvantage those who have a prescribed lung cancer that is unrelated to asbestos exposure.

26. The current arrangements potentially also disadvantage those claimants with a prescribed malignant disease which has a worse prognosis than that of the asbestos-related lung cancers. PD C24a, angiosarcoma of the liver arising from exposure to vinyl chloride, has a very poor prognosis with few patients surviving for a year after diagnosis.

27. The available evidence also seems to indicate that the current priority processing list may inappropriately advantage those with PD D9 (diffuse pleural thickening); between 2003 and 2010 an average of 430 people per year underwent assessment for this condition. Diffuse pleural thickening is a non-malignant asbestos-related disease which can cause reductions in lung function, but rarely has any impact on life expectancy.

[5] Office for National Statistics, *Cancer Survival in England: Patients Diagnosed, 2006-2010 and Followed up to 2011*, 2012

Potential for inequity: terms of award

28. The median survival of claimants claiming under the 'special' rules for non-IIDB benefits is about 18 months. For these benefits, entitlement under the special rules is reviewed after three years. No such provision for automatic reassessment exists for diseases awarded statutory 100% disablement assessments under IIDB.

29. Not all claimants with lung cancer (of whatever cause) are terminally ill, and a small proportion (about 10%) undergo treatment, particularly surgery, which may be curative. Claimants with lung cancer that have been successfully treated (or even cured) survive the longest and will receive the greatest amount of compensation under current IIDB rules. They may even receive benefit payment at 100% after a cure has been effected – a potential inequity relative to other claimants of the Scheme, and that is at odds with the prime aim of the Scheme to compensate for existing loss of faculty.

Impact

30. In all, about 2,330 claims and some 1,890 awards are made for malignant prescribed diseases annually. 97% of claims are already either accorded priority processing alone or both priority processing and exceptional entitlement. The suggested addition of the remaining lung cancers and angiosarcoma of the liver to these lists will increase this by less than 1% (fewer than ten cases per year).

Options considered by the Council

31. The Council believes that the current arrangements, while in absolute terms affecting relatively few claims, need adjustment to ensure equality for all claimants with rapidly fatal prescribed malignant diseases.

32. The Council has considered three options for achieving this:

    a. A whole-scale move to the 'special rules' system used for other benefits, including the adoption of the DS1500 form and the application of the standard definition of a terminal illness. In effect, this would replace all the current arrangements and regulations relating to priority processing and advantageous entitlement for IIDB. Claims procedures could continue to be fast-tracked and decisions based on medical advice without the need for a face-to-face assessment. Doctors providing medical advice in IIDB claims are likely to have experience of operating the special rules arrangements for other benefits.
    b. A set of discrete adaptations to the existing arrangements for IIDB claimants could be instituted. These could comprise:
        i. Priority processing: Minor additions to the list of diseases to be accorded priority processing, to ensure that all prescribed malignant diseases with a prognosis similar to that of asbestos-related lung cancer are covered – in practice all other forms of lung cancer (PD C4 and PD C22b) and angiosarcoma of the liver (PD C24). Removal of PD D9 from the list as its prognosis is far better than that of asbestos-related lung cancer. This would require only a change to the guidance used by decision makers.

ii. Entitlement: Extension of the existing exceptional entitlement rules for PD D3 and PD D8/8A to all other forms of lung cancer (PD C4, PD C22b, PD D10 and PD D11) and angiosarcoma of the liver (PD C24). This would require regulatory changes.

c. The introduction of a 'lump sum' award for terminal prescribed diseases. Such awards are already in place – in addition to IIDB – for individuals with mesothelioma, under the Pneumoconiosis etc (Workers' Compensation) Act (1979) and for those whose disease has been caused during self-employment or by vicarious exposure under the Diffuse Mesothelioma Scheme (2008).

33. The Council has decided against the first of these options, in part because the definition of terminal illness employed in the 'special rules' was pragmatically based on a benefit waiting time, rather than scientific evidence. In addition, the Council believes that extending the use of the form DS1500 would be more cumbersome administratively, and more complex legislatively, than extending the guidance to decision makers based on a simple closed list of prescribed diseases.

34. The second option, to amend the priority processing guidance to decision makers, and change regulations to extend exceptional entitlement to certain other poor prognosis diseases, has much to recommend it. As some 97% of relevant claims for malignant prescribed diseases already receive one or both of the beneficial procedures currently in place and claims for terminal illness are otherwise uncommon under the Scheme, the cost of implementing this change is likely to be small – the proposal would most likely apply to fewer than ten claims annually.

35. The third option, of awarding a lump sum, also has attractions when judged from an equity standpoint. The Council has previously noted that claimants with terminal illness may, by virtue of their life-shortening illness, achieve less compensation than more moderately affected claimants drawing benefits over a longer time course. However, the affordability of lump sum payments (which, to be meaningful, would raise the cost of compensation to terminally ill claimants, perhaps by a significant margin) would doubtless require careful evaluation and scrutiny at the present time. Paying a lump sum for a limited period of, say one year, followed by reassessment or reversion to a weekly benefit payment, would potentially be more affordable; but it would be less helpful to claimants and administratively more complex, representing a new departure in benefits administration for some (but not all) prescribed diseases that would require legislative underpinning.

36. In the interests of encouraging early implementation of the recommendations in this report, the Council has decided against recommending a new system of lump sum payments; but asks that this option be borne in mind for the future, should a general review of payment mechanisms within the Scheme be undertaken.

37. Finally, assuming implementation of the measures in this report, the Council has considered whether disablement should be reassessed in claimants with poor-prognosis diseases who are in receipt of an automatic 100% payment and who survive longer than might have been expected at the time of their award. It has been concluded that such an option should exist and that a suitable interval before review would be three years from the date of the award.

Recommendations

38. The Council recommends that the list of 'priority' prescribed diseases for which claims are expedited be amended to include all types of prescribed lung cancers, and angiosarcoma of the liver; and to exclude diffuse pleural thickening after exposure to asbestos. The amended list used in guidance by decision-makers would be as follows:

    Diseases automatically to be considered for priority processing

PD C4	Lung cancer from exposure to arsenic fumes
PD C22b	Lung cancer from nickel refining
PD C24	Angiosarcoma of the liver
PD D3	Diffuse mesothelioma (caused by exposure to asbestos)
PD D8	Primary carcinoma of the lung with evidence of asbestosis
PD D8A	Primary carcinoma of the lung after heavy exposure to asbestos
PD D10	Primary carcinoma of the lung (linked to tin mining, other specified chemicals or work with coke ovens)
PD D11	Primary carcinoma of the lung with silicosis

39. In addition, the Council recommends that the regulations relating to exceptional entitlement, currently in place for PD D3 and PD D8/8A (i.e. waiving of the 90 day waiting period and the automatic right to a 100% assessment), be extended to cover all other forms of lung cancer (PD C4, PD C22b, PD D10 and PD D11) and to PD C24 (angiosarcoma of the liver) which also has a poor median prognosis. (This list is identical to that for the recommended 'priority' prescribed diseases above.)

40. The Council recommends no change in relation to the treatment of PD D1 and PD D12 for priority processing, but considers instead that currently applied rules should be retained, along with the process of priority processing for all claims where any terminal illness is mentioned on the application.

41. The Council further recommends that exceptional entitlement awards for survivors with the diseases on this list be routinely reassessed, with appropriate sensitivity and delicacy, after a period of three years.

Diversity and equality

42. IIAC is aware of issues of equality and diversity and seeks to promote them as part of its values. The Council has resolved to seek to avoid unjustified discrimination on equality grounds, including age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, gender and sexual orientation. During the course of this review of terminal prescribed diseases no diversity and equality issues were apparent other than the substantive issue with which this report is concerned – equitable treatment of those with terminal prescribed malignant diseases.

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ISBN 978-1-4741-0177-6

Department for Work and Pensions

April 2014

www.gov.uk