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Fit for work? Health, employability and challenges for the UK welfare reform agenda

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INTRODUCTION

Fit for work? Health, employability and challenges for the UK welfare reform agenda

Introduction

This special issue grew from a shared concern about the need to strengthen and expand the evidence base around the processes that have led to large numbers of people claiming disability benefits in the United Kingdom (UK) and ‘what works’ in helping people back towards employment. It brings together contributions from some of the UK’s leading labour market and social policy researchers to provide evidence and commentary on the recent and planned major reforms of ‘incapacity’ benefits in the UK. Some important findings are reported but authors identify significant remaining gaps in knowledge.

The special issue addresses the following key questions, which require clear answers if the UK government is to meet its target of a one million reduction in the number claiming incapacity benefits (IBs) by 2016:

- (1) What are the main causes of the long-term rise in the number of people claiming IBs?
- (2) What will reduce the number of claimants?
- (3) What is likely to deliver policy effectively and efficiently?

Before exploring these questions in more depth, this introduction to the special issue provides context to the welfare reform agenda, explains the UK system of IBs and its recent reform, and identifies five assumptions behind the reforms.

Health, employability and challenges for welfare reform

‘Activation’ has emerged as one of the dominant areas of reform in European Union (EU) welfare states (Serrano Pascual and Magnusson 2007). While the specific priorities of activation have differed across countries (reflecting diverse welfare regimes and traditions) there has been convergence around the idea that benefits and services for people of working age need to be more focused on re-connecting claimants with the labour market, through encouraging and compelling claimants to be ‘active’ in seeking employment.

In the UK, as in some other welfare states, the focus of recent activation reforms has switched from those claiming unemployment benefits (who, after a long series of reforms, are now required to be actively seeking employment with increasing levels of compulsion) towards those receiving disability benefits (‘incapacity’ benefits in UK parlance). This reflects concerns that numbers claiming IBs have remained high in the face of declining numbers on unemployment benefits over the last 15 years (at least until the recession which started in 2008). In 2003, at the outset of an ongoing programme of major welfare reforms in the UK, 7% of the working-age population were receiving IBs, which provide support for people of working age who are unable

to work because of sickness or disability. At the same time in the Netherlands just under 10% of people of working age were claiming similar benefits – the highest rate of IB claiming in the EU – followed by Sweden at 9% and Denmark at 7% (Kemp 2006). Such trends are of social and economic concern. Long-term benefit receipt, poverty and ill health have consequences for individual wellbeing. Barriers to moving back into work restrict labour supply, so that skills and experience become unavailable to potential employers. And in the longer term, there are concerns that an ageing population will place increasing pressure on welfare budgets (Loretto *et al.* 2007), so that there is a need for more citizens to be economically active and active for longer.

Large headline counts of people claiming IBs in the UK have also raised suspicions that these benefits can be accessed too readily. These concerns reflect wider political debates around whether citizens enjoy ‘rights’ without sufficient ‘responsibilities’. In the UK, policy-makers and the media often talk about a ‘dependency culture’, despite evidence that a substantial proportion of those claiming IBs want to return to work given appropriate support (Beatty and Fothergill 2005).

A number of welfare states have reformed disability benefits which variously aim to reduce the number of new claimants or increase the flow of people moving off such benefits. This is to be achieved in the UK by labour market activation programmes and the gradual replacement of Incapacity Benefit – the main IB in the UK – with the Employment and Support Allowance (ESA), which requires all but the most severely sick or disabled new claimants to prepare for work, for example by taking part in rehabilitation or retraining. Under current proposals, all existing IB recipients will be re-evaluated under the ESA by 2013.

For the Labour government elected in 1997, the main explanations for the large number of people claiming IBs lay in the manner in which these benefits were more ‘attractive’ to benefit claimants with ill-health seeking to avoid the greater compulsion and conditionality associated with the UK’s main unemployment benefit – currently Jobseeker’s Allowance (JSA). Consequently, from 2003 a range of measures were introduced to activate claimants of IB, most importantly the Pathways to Work scheme which introduced activation through compulsory Work-focused Interviews (WFIs) and support measures which could be taken up by claimants on a voluntary basis, culminating in the introduction of the ESA. With the introduction of such activation measures, the Labour government to some extent belatedly accepted the compelling evidence that high levels of incapacity claiming in fact partly represented unemployment ‘hidden’ as sickness (see, for example, Beatty *et al.* 2000). Similarly, by 2008 the Conservative Party in opposition had come to acknowledge that attempts to ‘hide unemployment in the sickness register’ were counter-productive.¹ Accordingly, for the right-wing Centre for Social Justice (2009, pp. 127–128): ‘The evidence is that the large numbers on incapacity-related benefits represent an employment problem and not one of overwhelming levels of disability ... taken together, the data suggests that the number of people receiving IB is hiding the “real” level of unemployment in the UK’.

However, even if both main parties have come to acknowledge – at least implicitly – that the incapacity problem is partly an employment problem, current policy has arguably struggled to break free from the somewhat simplistic supply-side labour market analysis that has defined the broader UK activation agenda. While there is a

new consensus that high numbers on IBs mask hidden unemployment, the solution is seen as involving increased compulsion upon claimants and conditionality in the receipt of benefits. Indeed, the Labour government's Green Paper *No one written off: reforming welfare to reward responsibility* was significant in its unambiguous argument for substantial increases in the compulsion faced by claimants of IBs, arguing that 'the individual's right to support comes in exchange for taking clear steps to improve their own circumstances' (Department for Work and Pensions [DWP] 2008, p. 26). The emphasis on 'responsibility' and increased compulsion within the Green Paper was balanced by a commitment to provide a 'universal offer of personalised support' (DWP 2008, p. 65), and such promises of individually tailored services have more generally emerged as a key theme in activation policies directed towards people claiming IBs (Stafford and Kellard 2007, Lindsay *et al.* 2008). Meanwhile, the Conservative Party has moved further towards supporting a workfare model of activation, arguing for time-limited benefits and US-style 'work-for-dole' programmes (Conservative Party 2008).

Previous research has convincingly demonstrated that demand-side economic development strategies are required if the numbers claiming IBs in these areas are to be substantially reduced (Beatty and Fothergill 2005). However, there remains limited acceptance among policy-makers of the evidence that processes of job destruction help to explain raised levels of incapacity numbers (except perhaps the substantial concentrations of claimants in former industrial areas). Nor is there a full acknowledgment that some claimants often face complex health and employability-related barriers to work, which current and proposed supply-side policies are not always able to adequately address (Lindsay *et al.* 2007, Kemp and Davidson 2009).

The reform of incapacity benefits (IBs) in the UK

The UK's system of IBs was designed to provide income replacement for those of working age unable to work due to sickness or disability. Employers are usually required to pay Statutory Sick Pay for the first six months of incapacity for work, after which an individual would become eligible for IB (or ESA from October 2008). Those becoming incapacitated while *not* in employment are eligible for IB/ESA if they have a recent record of employment. Some sick or disabled individuals without a recent employment record are also eligible for IBs, in particular those with more severe disabilities and lone parents. Incapacity for work was usually initially certified by the family doctor or General Practitioner (GP). Once receiving benefit, claimants were subject to a medical assessment conducted by a doctor working under contract to the DWP. Apart from periodic medical assessments, there were no ongoing obligations on most claimants.

There are three important features that distinguish the old system of IBs from JSA, each of which is thought to have contributed to a diversion of claims from JSA to IB over the last 25–30 years or so. First, there was no mandatory activation requirement on IB recipients. Second, IB was paid at a higher rate than JSA. Third, the amount of JSA payable is means-tested against household income for the majority of JSA claimants, whereas IB was not (although with some exceptions).

The introduction of the ESA in the UK has seen a significant change in how individuals experience claiming. New claimants of ESA are allocated to one of two groups: the Work Related Activity Group (WRAG) who are judged to be able to do

some work now or in the future; or the Support Group (SG) who are judged to be unlikely to ever be able to work on grounds of sickness or disability. In addition, there are of course those who are deemed fit to work and are quickly moved off the ESA altogether, usually onto JSA. In order to sort claimants into these groups, the ESA regime has replaced the 'Personal Capability Assessment' (PCA) medical examination with a more stringent Work Capability Assessment (WCA), which effectively places the medical bar higher to qualify as incapacitated for work. Claimants allocated to the WRAG are mandated to participate in a series of WFIs after which a personalised programme of work-related activity such as training or rehabilitation will be devised with a view to re-entering employment in the future. Although this is not as stringent as the job search requirement under the JSA regime, it does represent a form of increased activation and a presumption that individuals in the WRAG will be on ESA only temporarily. Benefit levels for the first 13 weeks of a claim and for those claimants refusing to take part in work-related activity are set equal to JSA.

In terms of delivery, ESA will see an expansion in the contracting-out of work-related activation to private and voluntary-sector service providers on a 'pay-by-results' basis (i.e. the number of claimants moved into employment), following recommendations in the Freud Report (Freud 2007). This mode of delivery is not unique to the ESA but the numbers of claimants involved will mean contractors will be delivering services to benefit claimants on an unprecedented scale.

The reform of IBs in the UK arguably reveals five key assumptions about the causes of people claiming these benefits. First, there is some form of 'dependency culture' in which people's work ethic has declined and they therefore require mandatory measures to reactivate their engagement with the labour market. Second, many people currently on IBs should not really be there because they are not 'sufficiently' sick or disabled, hence the introduction of a tougher medical test. Third, individual deficiencies are the cause of non-employment rather than labour market structures and opportunities (or lack of), hence the need for work-related activity including confidence-building, retraining and rehabilitation. Fourth, that employability declines with time spent on benefits, hence the need to move people quickly off benefit before 'dependency' sets in. Finally, that private and voluntary-sector contractors will be more effective at moving people from benefits into employment than government Jobcentre Plus offices.

Challenges for the reform of incapacity benefits (IBs) in the UK

The three questions identified near the beginning of this introduction structured a roundtable discussion held at a seminar in March 2009 at Edinburgh Napier University attended by the contributors to this special issue. We synthesise here the main points put across during that discussion, as well as providing pointers to some of the findings and conclusions in the articles in the special issue.

What are the main causes of the long-term rise in the number of people claiming incapacity benefits (IBs)?

The sharp decline in manual employment in the UK during the 1980s and early 1990s is closely linked to the rise in numbers claiming IBs. Not only did large-scale

industrial job losses coincide with the timing of the sharpest rises in numbers claiming these benefits, but the geography of IBs almost exactly matches the spatial pattern of industrial decline (Beatty *et al.*, this issue). Continued sluggish demand for labour in these areas has kept numbers on IBs high, although in very recent years (at least prior to the recession starting in 2008) numbers have come down but only after unemployment rates have finally fallen to historically low levels (Webster *et al.*, this issue). These findings all lend support to the idea that a substantial proportion of the increase in numbers claiming IBs was ‘hidden unemployment’ (Beatty and Fothergill 2005).

A second, related, factor thought to have contributed to the rise in numbers on IBs is the marginalisation of certain groups in the post-industrial labour market. Specifically, those with low skills and qualifications and those with experience in manual occupations are at a greater disadvantage in today’s labour market than in the former industrial jobs market. Similarly, poor health and disability make it difficult for some individuals to secure jobs in an apparently more competitive labour market with employers demanding more ‘flexibility’. Articles in this special issue provide evidence of processes of marginalisation, for example in terms of the low qualifications and substantial health barriers to employment among claimants of IBs (Green and Shuttleworth, this issue) and the continuing rise in numbers of ‘National Insurance Credits Only’ incapacity claimants who are by definition people without recent employment histories (Anyadike-Danes, this issue).

What will reduce the number of claimants?

Just as substantial employment decline in certain parts of the UK lay at the heart of the rise in numbers claiming IBs, sustained employment growth in the same geographic areas is required to move claimants back into employment – although out-migration can also make some contribution to improving the balance of labour supply and demand. Indeed, numbers claiming IBs started to come down towards the end of the ‘long boom’ starting after the recession in the early 1990s but only – as noted previously – once unemployment was at a historic low. After a generation or more of economic stagnation, modest recovery finally came by the 2000s to some of Britain’s former industrial areas, and it is in precisely these areas where the sharpest declines in numbers claiming IBs have been recorded in recent years. Whereas in economically buoyant areas the claim rates for IBs are low and difficult to reduce further, in areas with high caseloads there are greater numbers of claimants with less severe barriers to employment who are more able to move into employment when jobs become available (Webster *et al.*, this issue).

Notwithstanding the importance of the demand for labour, recent reductions in numbers claiming IBs were accompanied by the piloting (mostly in parts of the country with high claim rates) and subsequent national roll-out in April 2008 of the Pathways to Work scheme aimed to help IB claimants back to work, which clearly helped some individuals become ‘work-ready’ and take advantage of improved economic conditions (Pathways to Work was similar to the activation measures in the ESA but on a non-mandatory basis and without the more stringent medical test). Despite some apparent successes of Pathways to Work (Bewley *et al.* 2007), there were concerns expressed at the roundtable discussion that the accurate evaluation of

national programmes is difficult because of the myriad of local initiatives running alongside and spatial and temporal variation in labour market conditions.

Although sufficient demand for labour in the areas where claimants of IBs are concentrated is an essential pre-condition to bring numbers down, it will not easily do this on its own because of the considerable barriers to employment faced by many claimants. For this reason, intensive and sustained activation and support measures are required (Beatty *et al.*, Green and Shuttleworth, Kemp and Davidson, Lindsay and Dutton; all this issue).

Despite labour market processes being a key factor in the production of the large number of people claiming IBs, a number of articles in this special issue point to health as a major obstacle to the *re*-employment of claimants (Anyadike-Danes, Beatty *et al.*, Kemp and Davidson, Lindsay and Dutton; all this issue). For example, Kemp and Davidson's longitudinal study of new IB claimants shows an improvement in health to be the single greatest predictor of a return to employment, while Beatty *et al.* find health to be the dominant reason for job loss among claimants. It would therefore be a mistake to implement the ESA as a straightforward labour market activation regime – ESA claimants often face considerable health barriers to employment which must be addressed if they are ever to return to sustainable employment. As Lindsay and Dutton argue in their article, the complex health problems faced by many IB/ESA claimants means that flexible health condition management services are likely to be of increasing importance in helping people towards work. For Lindsay and Dutton, the apparent increasing marginalisation of condition management services – and especially those operated by NHS organisations/professionals – is a matter of concern.

In his article, Anyadike-Danes points to significant gaps in knowledge on why the proportion of incapacity claimants with mental health problems has risen over time and on what particular support needs such claimants have in returning to employment. Furthermore, he cites important caveats in two key reports on the links between health and employment used by the government to support its claim that employment is good for health and the 'work first' philosophy for the sick and disabled embedded in the ESA. The caveats are that low-status jobs can harm health (Waddell and Burton 2006) and that the mental health of *employed* young people in the UK is deteriorating (Bartley *et al.* 2005).

Two articles in this special issue specifically examine whether a 'dependency culture' contributes to high numbers on IBs but neither finds evidence in support of this. First, Kemp and Davidson find no difference in their 'work commitment' measure among claimants who returned to work compared with those who remained on benefits. Second, in-depth interviews with claimants conducted by Beatty *et al.* found little existing knowledge of the incapacity system prior to claiming, that claimants were reticent to tell friends and neighbours they were 'on the sick' and some felt ashamed or embarrassed about claiming. In contrast, however, Personal Advisors working with claimants of IBs refer to a 'benefits culture' with the inter-generational transmission of worklessness (Green and Shuttleworth).

Even if unable to detect a 'dependency culture' effect on employment outcomes, Kemp and Davidson document three processes associated with duration on IB. First, labour market engagement declines; second, stated barriers to employment increase; and, third, the likelihood of moving off benefit reduces. Similarly, Beatty *et al.* find that optimism about ever working again declines with duration on an IB. Taken

together, these findings suggest a loss of confidence and motivation the longer someone has claimed an IB. Therefore, there is merit in the ESA initially dealing only with new claimants and trying to move some back into work quickly *if their health permits*.

What is likely to deliver policy effectively and efficiently?

The appropriateness of the content and structure for current and planned services to activate IB/ESA claimants is also a matter of considerable debate. People with health problems who have been out of work for long periods are likely to face complex barriers to progression, and there are concerns that programmes such as Pathways to Work and the interventions under the ESA are too focused on achieving quick job entries for the most able, and may not be able to deliver the range of support required by those with more severe problems. It is also unclear as to what outcomes will flow from continuing changes to the governance regime for the ESA, which has replaced a public-sector partnership model established during the initial piloting of welfare-to-work services for claimants with a system of contracting-out that emphasises private-sector delivery.

The manner in which private and third-sector providers were invited to lead the delivery of Pathways to Work in most of the UK suggests that the underlying assumptions of the DWP-commissioned Freud Report (Freud 2007), which has argued for an expansion of the contracting-out of activation services for people requiring additional support, have been accepted by policy-makers. Indeed, even 'pre-Freud' the government had made clear that it expected that 'future Pathways to Work provision will be delivered primarily by the private and voluntary sector with payment by results' (DWP 2006, p. 6) – an approach designed to tap the expertise of 'voluntary and private sector organisations, with their distinctive understanding of the social and economic environment in a local area' (DWP 2006, p. 18). The Freud Report, largely welcomed by the DWP, retains the assumption that contracting-out can deliver innovation and engage people who are beyond the reach of traditional state-run welfare services. However, it is important that current governance systems – whether based on contracting-out or more partnership-based approaches – are assessed in terms of the benefits they deliver in relation to improved services and outcomes for benefit claimants. Reservations about the evidence base for the benefits of contracted-out delivery were expressed in the roundtable discussion and are again highlighted in the article in this special issue by Lindsay and Dutton. Indeed, the 'pay-by-results' model of delivery has already run into financial difficulties because providers are not achieving 'results' on the scale required to generate sufficient payment to meet their costs.

In terms of the effectiveness of contracting-out to large-scale providers, Green and Shuttleworth point to the loss of local knowledge accumulated among local voluntary-sector organisations previously involved in service delivery. Even after holding a contract for a period of time, many large providers find it difficult to build up a detailed local knowledge because of high staff turnover. Such local knowledge can be valuable in tailoring services and advice to individual customers, for example working around local labour market conditions and perceptions and being able to refer clients to other services available locally. Lindsay and Dutton find benefits in Pathways to Work condition management services being managed and delivered by

the NHS, with professional stakeholders interviewed pointing towards the management expertise in the NHS in delivering a health-focused programme; and the high level of trust in, and credibility of, the NHS in the eyes of claimants. Lindsay and Dutton also conclude that the experience of Pathways to Work condition management services suggests that large public-sector organisations can effectively deliver services working in partnership with Jobcentre Plus, challenging the assumptions of the UK government's contracting-out agenda.

The new ESA regime is set to make extensive use of contracting-out delivery to voluntary and private-sector providers. For UK policy-makers, such contracting-out of support services is seen as vital to making individualised, personalised support work – it is argued that the inclusion of such bodies in the delivery of activation (combined with increasingly intensive personalised case management) has brought greater choice into the system, with the Pathways to Work programme consistently highlighted as an example of particularly good practice in this respect (DWP 2006). However, there is evidence that promoting a genuine sense of choice among *participants* in compulsory activation programmes can be difficult (Wright 2008).

Conclusion

The 'answers' to the three questions set out near the beginning of this introduction appear to be – in brief – as follows. First, labour market restructuring and marginalisation have driven the rise in numbers claiming IBs. Second, economic regeneration in Britain's less prosperous areas coupled with intensive and sustained supply-side support measures (including activation) will – slowly – bring numbers down. Third, delivery needs to be flexible and tailored to individual needs and needs to be able to access local and expert knowledge in a range of organisations, including Jobcentre Plus and the NHS as well as in the private and voluntary sectors.

Evidence presented in this special issue provides clear support for only one of the five assumptions behind the ESA identified previously. Evidence of a 'dependency culture' is difficult to find (assumption one). The cause of the rise in incapacity caseload appears to be driven mainly by labour market restructuring rather than individual deficiencies (assumption two). The predominance of health issues among those on IBs challenges the claim that many claimants are not sufficiently sick or disabled (assumption three). However, there does appear to be a loss of confidence and motivation the longer an individual has been on an IB (assumption four). Finally, in relation to assumption five, there are concerns over downsides of 'contracting-out' – in particular more limited use of local and expert knowledge and the under-utilisation of the NHS which generally brings trust and credibility.

Organisation of the special issue

We have sequenced the articles in this special issue so they move from the general issues of the causes of the rise in numbers claiming IBs (Beatty *et al.*, Webster *et al.*), through questions of what might help reduce the number of claimants (Anyadike-Danes, Kemp and Davidson) to issues of policy delivery (Green and Shuttleworth, Lindsay and Dutton). The special issue is concluded with a radical critique of the ESA reforms from a disability perspective (Grover and Piggott). Most articles, however, address more than one of the three key questions articulated at the start of

this introduction, so it has not been possible (or desirable) to neatly divide this special issue into three parts.

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Note

1. Speech by David Cameron MP on Conservatives' Green Paper on welfare reform, 8 January 2008 at www.conservatives.com/News/Speeches/2008/01/David_Cameron_A_real_plan_for_welfare_reform.aspx

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