DARK TIMES FOR THOSE WHO CANNOT WORK:

NO COMPETENCE, NO COMPASSION IN INCAPACITY BENEFIT REFORM

Steve Griffiths

The case that there are over a million people receiving Incapacity Benefit who should not be, which has driven a major strand of welfare reform over fifteen years and which was a cornerstone of the New Labour project, was based from the beginning on selective use of evidence. This Thinkpiece presents an alternative narrative from a wide range of sources that have been overlooked by both major parties and by the media. Work is good for health, there is no doubt about it; nor is there doubt that many people who are unfit for work might be able to return to work with appropriate support. But the case has been fatally exaggerated. The health needs of people who are the subject of huge investment by the Department of Health have been treated counterproductively as invisible, or worse, as malingering, by the DWP and successive Work and Pensions ministers driven by a compulsion to judge and to privatise. GPs have been marginalised. This paper catalogues a failure of compassion, unacknowledged incompetence and injustice on a massive scale: a social policy tragedy.

It is a story of what happened, and didnôt happen, between two case studies. Here is the first, from a study in 1998, following the Toriesô replacement of Invalidity Benefit with Incapacity Benefit, applying an ôAll Work Testô that is tougher than before:

'Mrs. J has arthritis in her spine and knees, and asthma. She was found fit for work so incapacity benefit stopped. She appealed and signed on for Jobseeker's Allowance to avoid the 20% reduction in benefit. She found a job, worked two weeks, couldn't cope physically, started a different job, worked three weeks, had to give up, couldn't cope again, started third job, gives up. By now the linking period allowing a break of 8 weeks in entitlement to incapacity benefit without penalty was broken. So despite the fact that the appeal was successful and she was found again to be unfit for work she had to start again with a new claim for incapacity benefit at a lower rate'.[1]

This is the second, from the 2010 Citizensô Advice report on Employment and Support Allowance (ESA), introduced in 2009 with a more rigorous Work Capability Assessment (WCA). It had replaced the new and stringent Personal Capability Assessment, introduced five years earlier. The report is endorsed by eighteen disability, mental health, poverty and carersô charities:

'A Yorkshire bureau saw a woman in her forties who was working full-time and was enthusiastically looking forward to starting a new job, when she became ill. At first it was thought she had a viral illness, but she was subsequently diagnosed with lupus erythematosus and transverse myelitis. She was in a great deal of pain in her muscles and joints and had extreme fatigue. At times her balance was affected and she could not walk without someone to support her. Sometimes she lost sensation in her legs, and on her worst days she could not walk at all. Any exertion such as walking 40 or 50 metres led to days in bed. She had had a bad reaction to some of the treatment and an ECG showed her heart muscle had been damaged.

[1] Steve Griffiths, ôA profile of poverty and health in Manchesterô, Manchester Health Authority and Manchester City Council, 1998.

Her husband had to come home from work each lunchtime to help her. Her immune system was weakened, so she had to be careful when mixing with others. She claimed ESA but was given six points in the Work Capability Assessment (WCA) and found capable of work. Her doctor supported her claim and she is currently appealing, but under Incapacity Benefit she would probably have been exempt and would have avoided this process'.[2]

There is a vision of Incapacity Benefit which has informed Labour's Welfare to Work policies, carried forward by the new Coalition Government, driven by the former Labour Adviser Lord Freud, now Minister for Welfare Reform, who designed the second, privatising phase of the programme. Tony Blair, as so often, encapsulated the vision in 1999. Incapacity Benefit is:

> 'not a benefit which compensates those who have had to give up work because of long-term illness or sickness - it's an alternative to long-term unemployment or early retirement. That's why it must be reformed'[3]

The New Regime: Reducing Dependency, Increasing Opportunity

A succession of Green Papers, White Papers and legislation, too numerous to list here, leads us to the implementation of ESA, initially applied only to new claimants. The new regime was developed from a 2007 'Independent Report' by David Freud, an investment banker and deal-broker brought in to advise the DWP by Secretary of State John Hutton.[4] Freud, having been subsequently ejected by Peter Hain, then brought back by James Purnell, became an adviser to the Tories, was ennobled, and is now Minister for Welfare Reform. Freud's report repeats without analysis the New Labour aim to reduce the number of Incapacity Benefit recipients by a million. A trail of repeated assertion of this figure leads back to the early years of New Labour - to David Blunkett, Alastair Darling and to several research reports from Sheffield Hallam University which are discussed below.

Freud's Independent Report finds that:

> For people with health conditions and disabilities, the Pathways to Work programme is now breaking new ground and delivering an increase in employment outcomes of 9 percentage points.

He concludes:

> while there is no conclusive evidence that the private sector outperforms the public sector on current programmes, there are clear potential gains from contesting services, bringing in innovation with a different skill set, and from the potential to engage with groups who are often beyond the reach of the welfare state.

Based on this belief, most of the report is given up to discussion of desirable contracting arrangements, involving 'each region (becoming) the province of a sole prime contractor

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2 'Not Working – CAB evidence on the ESA work capability assessment', CAB Briefing, in association with Mind, March 2010. http://www.citizensadvice.org.uk/index/campaigns/policy_campaign_publications/evidence_reports/er_benefitsandtaxcredits/not_working

3 Tony Blair, The Observer, 23 May, 1999.

4 David Freud, 'Reducing dependency, increasing opportunity: options for the future of welfare to work: An independent report to the DWP', Department for Work and Pensions, 2007.

because of the complexity of the arrangements likely to be required with many other partiesö There is a political consensus which carries his programme forward.

The 2006 Green Paper, however, contains a curious aside: ó[t]he current Personal Capability Assessment process (is) already recognised by the OECD as being one of the toughest in the worldö[5] This does not prompt any self-examination. The Government is bolstered by mixed reactions to its next Green Paper in July 2008: many organisations representing disabled people support the direction of travel towards improving the access to the labour market of people who are, or have been, unable to work. At the time, many give the Government the benefit of the doubt, though the support is often conditional:

> ó[W]e support the emphasis of the new Work Capacity Assessment towards what individuals can do rather than what they cannot, although this will require assessors to be fully competent to judge the impact of a mental disorder on an individualös capacity to work in both the short and long termö
>
> *Mental Health Foundation*[6]

Claims for ESA, like earlier sickness benefit regimes, are supported by medical evidence that the claimant is unfit to work. If in work, the claimant will already have been getting Statutory Sick Pay, sometimes contractual sick pay, for 28 weeks, supported by medical certificates. If the claimant is getting Jobseekerös Allowance (JSA), ESA can be claimed after two weeks of sickness. After 13 weeks of claiming ESA at the JSA rate of £65.45, supported by GP certificates, claimants are subject to the new Work Capability Assessment (WCA), the last of a succession of ócapabilityöassessments introduced by the last Labour Government.[7]

The WCA is administered by Atos, a large French/Dutch company. It divides claimants into three categories:

- Support Group (so not required to undertake work-related activity - £96.85 a week after the assessment phase at the JSA rate);
- the ESA Work Related Activity Group, for those deemed fit for work with support and preparation (£91.40 a week after an assessment phase at £65.45); and
- Fit for Work, so transferred to Jobseekerös Allowance (£65.45).

The first WCA Official Statistics for ESA were released by the DWP in April 2010. In the first eight months to August 2009, Atos assessments broke down as follows:

- Support Group ï 9%
- Suitable for the ESA Work Related Activity Group - 23%
- Fit for Work, so transferred to Jobseekerös Allowance - 68%.

The assessment is usually endorsed by a DWP officer with an ease which has been criticised by the House of Commons Work and Pensions Committee:

> We note widespread concerns that decision makers appear to give excessive weight to the conclusions of DWP medical assessments over other evidence claimants may provide. If a

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5 Organisation for Economic Co-operation and Development, 2003, ó[T]ransforming disability into ability, policies to promote work and income security for disabled peopleö, OECD.

6 White Paper, ó[R]aising Expectations and increasing support: reforming welfare for the futureö, Appendix A ï Responses to the public consultation. DWP,December 2008.

7 Current (2010/11) benefit rates are given throughout.

claimant is able to provide statements from specialists, who have regular contact with them, this evidence should be given due consideration.[8]

The Government stance on consideration of independent medical evidence has been rather different. Here is an extract from a DWP Press release during James Purnellôs tenure as Secretary of State:

> ôWhen I (James Purnell) was speaking to Job Centre Plus staff, they said they felt that the sanctions regime could be improved. They didnôt want to be double-guessed by doctors about the fitness of claimants for work. They wanted to have a system of graduated sanctions and they wanted greater freedom to use the sanctions that currently exist.... Iôve asked (for) a review which will include the sanctions applied to customers playing the system and how we might best use advisorsôdiscretion in tailoring services to meet the needs of citizens. These new sanctions will tackle those people who can work and choose not toô[9]

This antagonism to ódouble-guessing doctorsôshould be considered in the context of the evidence of this paper, not least that from official sources. The role of independent medical evidence was raised from early in the implementation of Incapacity Benefit.[10]

In 1998, the Patient Affairs Officer at Manchester Royal Infirmary describes the system as having become ôin many ways very punitiveô[11]

The 2010 Citizens Advice report describes new procedures which sideline evidence from the claimantôs doctor. It recommends a return to pre-2008 procedures. It expresses concern about the testing of many capacities under the new regime, but none more than mental health:

> ôIn many cases, the wrong decisions are damaging the work done by the community mental health teams, thus costing further resourcesô

The reportôs detailed examination of the Work Capability Assessment guidance reveals some extraordinary detail, including the suggestion that six points for frequent forgetfulness or loss of concentration should not be awarded if the person does not need ôadditional input to manage all tasks involved in daily life such as remembering to get washed or dressedô As the report notes:

> Forgetting to get dressed in the morning is an extreme sort of memory loss and clearly ought to be awarded more than six points. How many employers would take on someone who forgot to get dressed?ô

A Manchester GP has summed up the perception of many:

> ôAs an inner-city GP I am beginning to see first-hand the heavy-handedness of this new policy. Patients with mental illness seem to be particularly affected. Three patients come to mind: a middle-aged woman with long-term psychosis who denies her illness but is clearly grossly

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8 House of Commons Work and Pensions Committee, ôDecision making and appeals in the benefits systemô, 2010.

9 DWP Press release, 20 February 2008.

10 NACAB, ôAn Unfit Testô, 1997.

11 Steve Griffiths, op.cit.

dysfunctional; a Kurdish refugee tortured in Iran who suffers severe post-traumatic stress disorder and is very depressed; a man in his 40s, who has drunk alcohol heavily all his life, in crisis having begun to acknowledge the abuse in his childhood. All have failed the incapacity test. In my opinion none are capable of work. The Department for Work and Pensions no longer asks GPs for our opinion.....I fear for the consequences: destabilising patients and increasing pressure on those already hard-pressed mental health and primary care servicesô[12]

The bypassing of GPs is also taken up by the Disability Alliance:

ôPrior to the introduction of ESA, medical certificates could indicate people should be exempt from the Incapacity Benefit Personal Capability Assessment examination. Further information was then requested from their doctor (on a form IB 113). This has not been replicated within the ESA system which instead includes an ESA50 limited capability for work questionnaire form being sent to a claimant automatically (unless they are terminally ill). We believe the pre-October 2008 practice for information gathering had greater credibility and allowed more appropriate weight to be given to the evidence of peopleôs own GP where necessaryô[13]

The Disability Alliance also draw attention to the removal under the ESA regime of a number of severe medical conditions which previously, under the Personal Capability Assessment, triggered automatic exemption from assessment. They include people experiencing:

- ôa severe and progressive neurological or muscle wasting [sic] disease;
- a severe and progressive form of inflammatory polyarthritis;
- progressive impairment of cardio respiratory function which severely and persistently limits effort tolerance;
- a severe and progressive immune deficiency state characterised by the occurrence of severe constitutional disease, opportunistic infections or tumour formation; and
- a severe mental illness [sic] which severely and adversely affects mood or behaviour and which severely restricts social functioning or awareness of the immediate environmentô

The Disability Alliance remark:

ôWhilst disability and advice organisations support all disabled people having access to work opportunities and not being ôwritten-offô by the system, it has been reported to DA that people with such recognised serious illnesses are being found fully fit for work and not even reaching ESA work-related activity group categorisationô

How many successful appeals against disallowance does it take to suggest a wider problem?

One disquieting thread runs throughout the reform of incapacity benefits. It is the level of successful appeals against disallowance. Cumulatively, hundreds of thousands of people who are unfit for work appear to have been disallowed benefits wrongly.

As Incapacity Benefit was rolled out, 60% of disallowances were appealed between April 1995 and October 1996; more than half were reinstated.

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12 Letters, Guardian, Dr. Tim Greenaway, Manchester, 16 October 2009.

13 Disability Alliance response to DWPôs Call for Evidence on The Work Capability Assessment, September 2010: http://www.disabilityalliance.org/r66.pdf

On the introduction of the Personal Capability Assessment, in the quarter to March 2006, 57% of oral hearings of appeals against disqualification were found in favour of the appellant ï 74% where both the appellant and a representative attended.

Following the abolition of Incapacity Benefit for new claimants, the first wave of ESA Work Capability Assessments up to November 2009 found 68% of claimants fit for work. Of claims up to June 2009, 32% of those found fit for work had appealed and had a hearing by May 2010. 40% of these had the decision reversed in their favour. The figures are presented in this way because ôit is likely that there are more appeals that have not yet been heardô the DWP report noted (published July 2010): when the backlog of appeals is dealt with, the proportion may be higher. Initial assessment was still in progress six months after the cut-off point in 4% of ESA cases.[14]

Until now this has been largely unchallenged outside the advice sector, and almost entirely unreported. The case studies given above communicate a flavour of what it is like for one individual who is unable to work and is wrongly disqualified.

The Work and Pensions Committee reported in 2010:

> During our visit to Leeds, the Tribunals Service told us that its appeals intake had risen significantly this year. In 2007ï 08 its total intake was 229,130 and in 2008ï 09, 242,830. The intake for 2009ï 10 was at 140,854 up to the end of September, and by the end of the year, it expects this figure to have risen to over 300,000. We were told the bulk of the increase was a result of a rise in the number of appeals for ESA and Incapacity Benefit.[15]

Gathering clouds

Protests from disability organisations and the advice sector are beginning to be heard. A Citizens Advice Scotland press release late in 2009 reported that it had been "flooded with complaints" about the new ESA.

> ôMany claimants have been judged ineligible, despite clear evidence from their GPs that they were not fit to work. It has created barriers to entitlement, and caused unnecessary financial distress and emotional strain to sick and disabled people all over Scotland. And this is not just a few isolated cases. Evidence from CABs throughout the country shows a catalogue of errors, from the first day the system was introduced right up until the last few weeksô[16]

Before the election, there was some support for this concern from leading Liberal Democrats.

> "If the experience we've had over the last few months is anything to go by, there will be thousands, tens of thousands, maybe hundreds of thousands of incorrect decisions that are made. Tens of thousands of appeals will follow, and that will be a system, then, that is close to meltdown. The fact is that the process isnôt working and that genuinely vulnerable people are being denied money as a result.ò *Danny Alexander, now Chief Secretary to the Treasury.* [17]

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14 Working Age Benefits Division, DWP: ôEmployment and Support Allowance - Work Capability Assessment: Official Statistics, DWPô, July 2010.

15 House of Commons Work and Pensions Committee, op.cit.

16 BBC, 27 October 2009.

17 Interviewed prior to the General Election for BBC Scotland ï ôWhoôs Cheating Who?ô, 25 May 2010.

The new Government have announced a review of the Work Capability Assessment by Professor Malcolm Harrington, due to be published late in 2010.[18] It could be argued that the whole programme of extending the Atos medical examinations to existing Incapacity Benefit claimants, due to start in October, should be put back until Harrington has reported. Professor Paul Gregg, the architect of the sanctions regime in the two most recent Welfare Reform Acts, has urged the Government to make radical changes to the way that ESA operates before what is called the ómigrationô of Incapacity Benefit claimants begins. On the Today programme in May 2010 he said:

> ñThere are too many on Jobseekers Allowance inappropriately. It was not designed to help people with health problems. The idea propounded by ministers that there is a massive scrounger culture was always misplaced. These people will end up clogging up JSA rather than getting the programmes they need.ò

In April, a National Audit Office report on óPathways to Workô found:

> A DWP programme to reduce the number of people claiming incapacity benefits and help them into work has had a limited impact and, while a serious attempt to tackle an intractable issue, has turned out to provide poor value for money**.....** it is therefore important that the Department learns from the experience. In the future it should base its programme decisions on a robust and clear evidence base, follow best contracting practice and establish a measurement regime which allows it to understand better what happens to those whom they may have helped..... Pathways is led by Jobcentre Plus in some areas but is contracted out to third sector and private organisations in over 60 per cent of the country. The National Audit Office found that there is no evidence that the programme is performing better or costing significantly less in contracted out areas than in those run by Jobcentre Plus..... Contractors have universally underperformed against targets set by the Department, and the Department has had to make concessions as part of contractual renegotiations to support the continuation of businesses and services....With a third of contracts making a financial loss, the programme's contracted out delivery does not appear to be sustainable.[19]

The position of Labour is a difficult one. Lord Knight of Weymouth, previously M.P. and DWP Minister Jim Knight, neatly encompassed it in his first contribution as a peer in a debate on ESA in the Lords on 20 July:

> óThe situation in which I find myself is slightly odd. This is my first time at this Dispatch Box scrutinising the legislative work of the noble Lord, Lord Freud, but I am afraid that it is not a chance to show my great forensic skills in unpicking the inadequacies of the regulations. That is, of course, because the regulations were inspired by the previous Government's White Paper, which was written by the Minister before he jumped ship and joined the other side. They were then signed in March by my friend Jonathan Shaw, when he was working with me as a Minister at the Department for Work and Pensions. Therefore, the Labour Governmentôs regulations are now being tabled by the Tory Minister who inspired them when he was a Labour adviser. As the shadow Labour Minister, I can assure your Lordships that I am not opposing the regulations.ô[20]

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18 DWP, The Work Capability Assessment, A Call for Evidence, July 2010.

19 National Audit Office, óSupport to incapacity benefits claimants through Pathways to Workô, May 2010.

20 House of Lords debate on ESA Regulations 2010, 20 July 2010.

Under the new Government, the Work Capability Assessment is being trialled on 1,700 existing Incapacity Benefits claimants in and around Aberdeen and Burnley, having started in October 2010. 1.5 million claimants will be reassessed nationally from February 2011. This process will take place over the following three years. Considerable concern has been expressed about the capacity of Jobcentre Plus to carry this forward.[21]

An assumption of substantial savings hangs on this. The tone of political discourse does not allow much room for sober consideration of evidence. As George Osborne put it in a BBC interview in September 2010:

> "People who think it is a lifestyle to sit on out-of-work benefits...that lifestyle choice is going to come to an end. The money will not be there for that lifestyle choice".[22]

Health: some counter-evidence

As the NHS Next Stage Review Interim Report put it in 2007:

> "There are currently over 15 million people in England with a long term condition and who are proportionately far higher users of health services. They account for 55% of GP appointments, 68% of outpatient and A&E attendances and 77% of inpatient bed days".

This figure apparently derives from the General Lifestyle Survey (GLS). Looking at people of working age, the 2008 GLS finds 1.96 million people aged 16-44 with a long-term limiting illness; and 3.15 million aged 45-64. The existence of 2 million people unfit for work, many of them suffering from the very conditions so central to the Department of Health agenda, should be seen in this context. But the connection seems never to have been made between two major Government workstreams serving the same people. People on Incapacity Benefit die early, that is acknowledged by Government. But it is as if in benefit terms, they were just expected to drop off their perches rather than suffer chronic illness and be the beneficiaries of a progressively vanishing "security for those who cannot work".[23]

Trends in Limiting Long-term Illness through the General Lifestyle Survey are informative. For this paper, the trend between 1975 and 2008 was examined for the age bands 16-44 and 45-64. The frequency of General Household / Lifestyle Surveys increased greatly after 1997, so means for 1995/6, 1998/2003, and 2004/2008 were calculated to maintain some regularity of comparison. In the age group 16-44 (blue line in graph below), the level rose by half from the 1975 baseline to 1995/1996; and declined by a fifth from 1995/6 to 2004-8. In the 45-64 age band (much greater in number) (red line) the increase to 1995/6 from the 1975 baseline was nearly a quarter; and the fall from 1995/6 to 2004-8 was 13%. This is surely one important factor in explaining the increase in claims for incapacity benefit.

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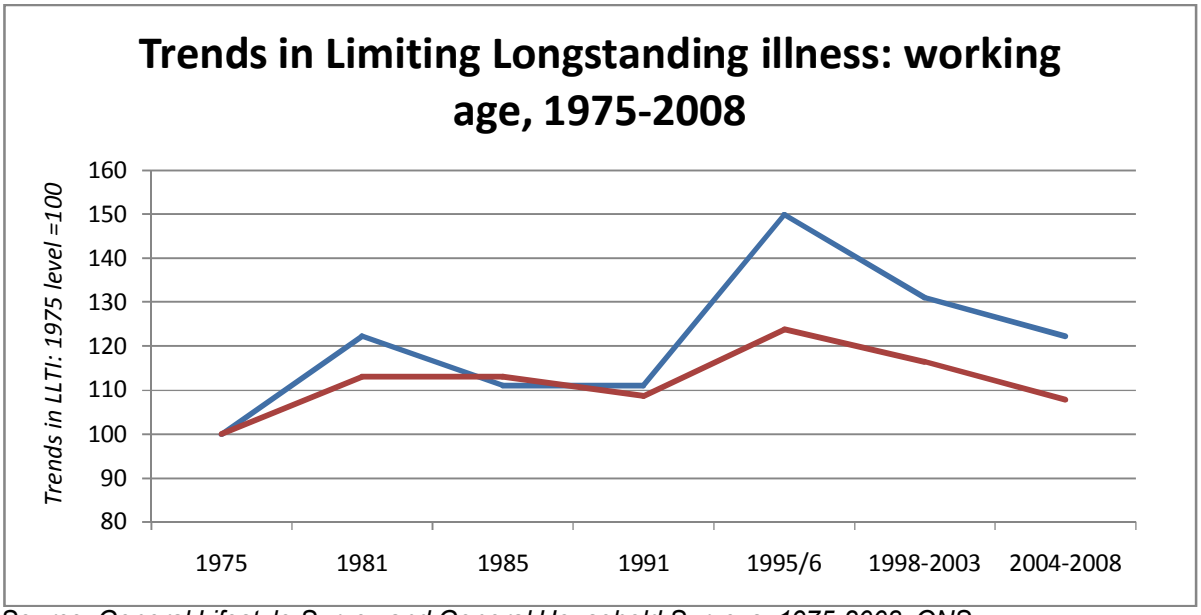
21 This is well summarised by Baroness Thomas of Winchester in the above debate.

22 BBC Interview with Nick Robinson, 9 September 2010.

23 "A new contract for welfare – principles into practice", DSS, 1998.



Source: General Lifestyle Survey and General Household Surveys, 1975-2008, ONS.

Health Inequality

The link between the degree of inequality and ill health - not the level of poverty, but the degree of inequality ï has been strongly established during these years. Wilkinson and Pickettôs õThe Spirit Levelôdraws together much of this evidence,[24] but there was a strong body of published evidence from early on in the Labour administration. Here is one extract:

> ....in the early 1970s, the mortality rate among men of working age was almost twice as high for those in class V (unskilled) as for those in class I (professional). By the early 1990s, it was almost three times higherô[25]

Again, this body of evidence was never applied to understanding the rise in claims for incapacity benefit.

One small local piece of research did look at the relationship between demands on the NHS and receipt of incapacity benefit. It was a ward-based analysis of a basket of ten indicators of deprivation and the relationships between their distribution in Waltham Forest in 2000.[26] Seven out of nine indicators showed a strong and significant correlation with emergency hospital admissions (all causes, age under 65). But the distribution of incapacity benefit claimants showed the strongest association of all seven with the emergency admissions indicator.

The last of a succession of excellent reports, and many initiatives, on health inequality under the last Labour government was the Marmot Review. It found in February 2010:

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[24] Richard Wilkinson and Kate Pickett, õThe Spirit Level ï Why Equality is better for everyoneö, Allen Lane, 2009.

[25] Chairman: Sir Donald Acheson, Independent Inquiry into Inequalities in Healthö, The Stationery Office, 1998.

[26] Steve Griffiths, Spotlight on Social Exclusion, London Borough of Waltham Forest, 2000.

> "People in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability.....even excluding the poorest five percent and the richest five percent the gap in life expectancy between low and high income is six years, and in disability-free life expectancy thirteen years".[27]

This is in the context of a *mean* Disability-free Life Expectancy in the UK in 2005/7 of 62.5 years in men, and 63.7 in women. If that is the mean, many will become disabled much earlier.[28]

There was a disassociation between the connections being made across the academic world and the reach of much health policy development on the one hand, and the "Reducing Dependency" agenda of New Labour. Where did that disconnect come from? One explanation for the immense stress and error imposed by the introduction of ESA is that there has been a major policy misdiagnosis based on selective attention to evidence.

The Hidden Unemployed: An Evidence Base

Reports by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University from 1997 onwards appear to have had a major impact on the direction taken by New Labour. Alistair Darling as Work and Pensions Secretary was an early pioneer: his "one million disabled people say that they want to work but are not being given the chance" (1998) echoed early findings of CRESR. By 2005, David Blunkett as Work and Pensions Secretary was saying "about half of the 2.7 million people ñ on the sick' are capable of working".

CRESR's 1999 report "Incapacity Benefit and Unemployment" is the second of a series that includes "The Real Level of Unemployment" (1997) and "The Real Level of Unemployment 2002". It concludes modestly in the context of later claims made by politicians:

> "Given that we have estimated that there are around three-quarters of a million hidden unemployed men on Incapacity Benefit, it would not be unreasonable to suppose that over ten years the number of male ICB claimants might be reduced by half a million. This assumes that the government's reforms are effective in reducing the inflow onto Incapacity Benefit, and that many of the existing claimants clustered in their 50s and early 60s gradually reach retirement age. A similar proportional reduction among women would reduce the number of claimants by a further quarter of a million".[29]

Further reports led to a more ambitious estimate by 2005, which may be seen as prophetic in terms of the performance of Atos in administering the Work Capability Assessment:

> If our survey data on self-reported heath limitations is any guide, then in the context of 2.7m on incapacity benefits no more than perhaps 0.7m would be eligible for the new, higher benefit. Moreover, because there is always a flow on and off incapacity benefits among those with less

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27 Michael Marmot (Chair), "Fair Society, Healthy Lives", Strategic Review of Health Inequalities in England post-2010, The Marmot Review, 2010.

28 Office for National Statistics.

29 Christina Beattie and Stephen Fothergill, "Incapacity Benefit and Unemployment", CRESR, Sheffield Hallam University, 1999.

severe problems, the appropriate share of new claimants finding their way onto the higher benefit might be as low as one in ten.[30]

However, the result on the ground is deeply disturbing. Is it a case of making the reality fit the research? Do the numbers, and does the case, add up?

In the 1999 report, one of three main types of projection to arrive at possible totals of óhidden unemployedô does attempt to take account of health data. It is called the óReal unemploymentô indicator.

As a guide to what is achievable in a fully employed economy, it uses the rate of ópermanent sicknessô among men of working age in the South East of England recorded by the 1991 Census. óTherefore levels of sickness in excess of this level ï 3.4% of the male working age population ï should be regarded as hidden unemploymentô Regional health inequality is completely disregarded for the purposes of this projection. Given the history of geographical inequality in health, it is ill-conceived to use the least deprived region in England as a benchmark. Its optimism is particularly misplaced given the widening of the life expectancy gap between 1972-77 and 2002-2005.[31]

The second projection is based on óhealth not main reason for last job endingô This is from survey data which is discussed, and its interpretation questioned, below.

The third is ówant a full-time jobô This has nothing to do with capacity to work.

The report concludes:

> óWhat is striking is that these three indicators converge at broadly the same order of magnitude, giving weight to the view that there may be around three-quarters of a million hidden unemployed men among sickness benefit claimantsô

There are some elisions of logic that contribute to an impression that people who claim incapacity benefit may not be ill, or not as ill as their benefit status might suggest: the suggestion that ó*ill health or injury was a factor cited in male ICB claimants*ô*last job endingô*ó*in only three-quarters of cases overall'* leads to an identification of óan estimated quarter of ICB claimants who say that ill-health or injury was not a factor at allô But is the reason for leaving work significant? Acheson has some light to cast on this:

> óSome of the excess morbidity and mortality associated with unemployment may be a result of people in poorer health being more likely to become unemployed, rather than vice versa. The evidence suggests that selection of unhealthy people into unemployment does indeed occur, but it is not the dominant factor explaining the observed relationship between unemployment and excess risk of ill-health. It does, however, illustrate the double disadvantage that people with chronic sickness or disability may face: their ill-health puts them at greater risk of unemployment, and the experience of unemployment in turn may damage their health still furtherô[32]

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30 CRESR, Memorandum to the House of Commons Work and Pensions Committee Inquiry into Pathways to Work, 2005.

31 Michael Marmot, op.cit.

32 Chairman: Sir Donald Acheson, op.cit.

It is not exactly news that unemployment can make you ill, or more ill once you are unemployed. This analysis was available to the researchers. The apparent slanting of this finding prevents the researchers making a connection with their own finding on the next page, that ówhen ICB claimants are asked why they are not looking for work the overall majority ï 94% - cite óill health or injuryô. The next paragraph advises caution in interpreting claimantsô self-assessment of health because óall claimants will at some stage have gone through a medical procedure which assessed them as ounfit for workô. This judgement and their benefit status are likely to influence the way they see their healthô. Other kinds of self-assessment, particularly concerning the wish to work, are taken at face value.

This self-assessment reports that for 96% of male ICB claimants, their health limits the work they can do. Of those 96%, 26% say they can't do any work at all. The report concludes, ófor the remaining three-quarters the issue is about what type of work or how much of it they are able to doô. But a further table asks those who ódidn't say they can't do any workô, ódoes your health limit how much you can do?ô 66% say their health limits what they can do óa lotô. A more balanced interpretation would be that overall, 76% are either unable to do any work or their health limits what they can do óa lotô. Another 18% overall say their health limits what they can do óquite a lotô. That suggests a radically different message; but it does appear rather more balanced.

The report goes on to list financial óincentivesô for unemployed men to claim Incapacity Benefit, as if doing so were a matter of choice - ignoring the role of medical assessment, disallowance and successful appeal reported in this paper. Just to take two of these óincentivesô: income from a company pension (since income counts against means-tested Jobseeker's Allowance, but not against contribution-based ICB); and savings above £3,000 (which reduce means-tested JSA and eliminate it entirely above £8,000). A few pages earlier, the report has noted that ICB claimants in the study have a more substantial work history than JSA claimants. But here, the greater likelihood of ICB claimants having work pensions and lump-sum redundancy payments is taken to have been an incentive to claim ICB, not Jobseeker's Allowance, rather than a consequence of claimants who are unfit to work being more likely to have a substantial work record. These interpretations are noted later in the report: but why present them here without qualification?

There is a particular problem with the discussion of Disability Living Allowance:

> Some ICB claimants are able to claim other non-means-tested benefits as well, notably Disability Living Allowance which provides assistance with the costs of care / mobility.

What is being implied here? DLA is non-means-tested: anyone can claim it, receiving Incapacity Benefit or not, on the grounds of severe disability. The assertion appears to be that the availability of DLA is an incentive to claim ICB, which is simply not true.

Regression analysis compounds the confusion by leaving out key factors and imputing causality in a way that is poorly informed about the administration of benefits.

> ...putting aside the obvious effect of health, it is pension income and to a lesser extent age that are the most important factors in tipping men towards ICB and away from JSA.

This again takes no account of the greater likelihood that having a more substantial work record, ICB claimants are more likely to have a work pension. It is not a valid conclusion. And why put aside "the obvious effect of health"?

A key pillar of the report is the comparison of maps showing unemployment and incapacity benefit claims, finding that:

> there is an uncanny resemblance between the geography of sickness-related claimants and the geography of unemployment-related claimants

Setting aside the use of the word "uncanny", this is set in a context of a swathe of labour market research, and almost nothing about health. There is no intention in this Thinkpiece to "explain away the vast increase in sickness claimants in health terms alone", as the report imputes to those who raise the increase in long-standing illness among adults of working age between 1975 and 1996. It is also not to say that there may be a significant number of people who may be able to work with support, encouragement, and where appropriate, sanctions. But health is important and has been marginalised. And it is not the only major factor.

Between 1979 and 1997, the number of men receiving incapacity benefit tripled. The number of women in receipt increased 7½ times. In 1997-2004, the number of men receiving incapacity benefit fell by 7%. The number of women increased by 18%. The change in the gender balance in the workforce is a major issue: the more women are in work and paying contributions, the more they become eligible for sickness benefits if they become unable to work.[33]

To respond to the absence of analysis of health needs in this influential research, I looked at the relationship in the male population (as in the Sheffield Hallam report) between the spread of incapacity benefit and unemployment across 326 English local authorities in 2004, and two contemporary health indicators.

I obtained:

- the male unemployment rate age 16-64 for the year to December 2004, using contemporary local authority boundaries, from the Annual Population Survey.
- Incapacity Benefit data, males, by local authority, for May 2004 from the DWP (subtracting Severe Disablement Allowance), calculating local authority percentages of male population age 16-64 using Mid-Year Estimates for 2004.
- Directly age-standardised mortality rates from all causes for males aged 15-64 by local authority from the NHS Information Centre for Health and Social Care (NCHOD)
- Emergency hospital admission rates (all conditions) of males (all ages) by local authority. I did not have the resources to commission age-specific data (as I had employed in Waltham Forest – see above).[34]

I carried out regression analysis between these datasets to examine whether there was a significant difference between the health indicators in relation to the distribution of unemployment and incapacity benefit. The data covered 326 English authorities; however, since in 12 of these in the South of England unemployment was so low at the time as not to be reflected with confidence in the Annual Population Survey, they were removed from the whole

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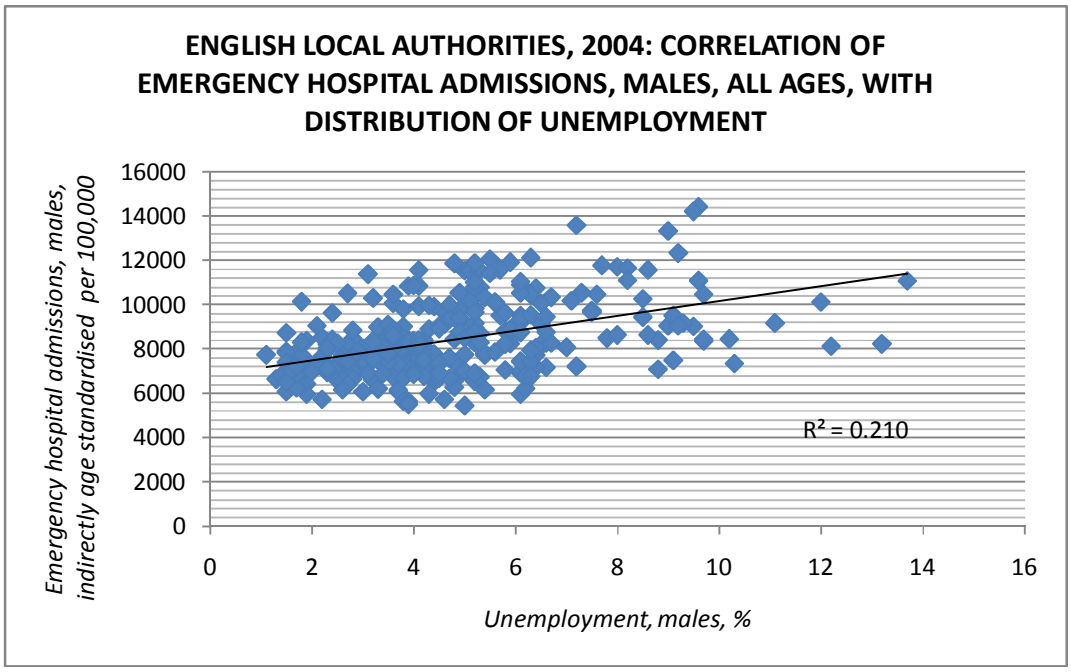
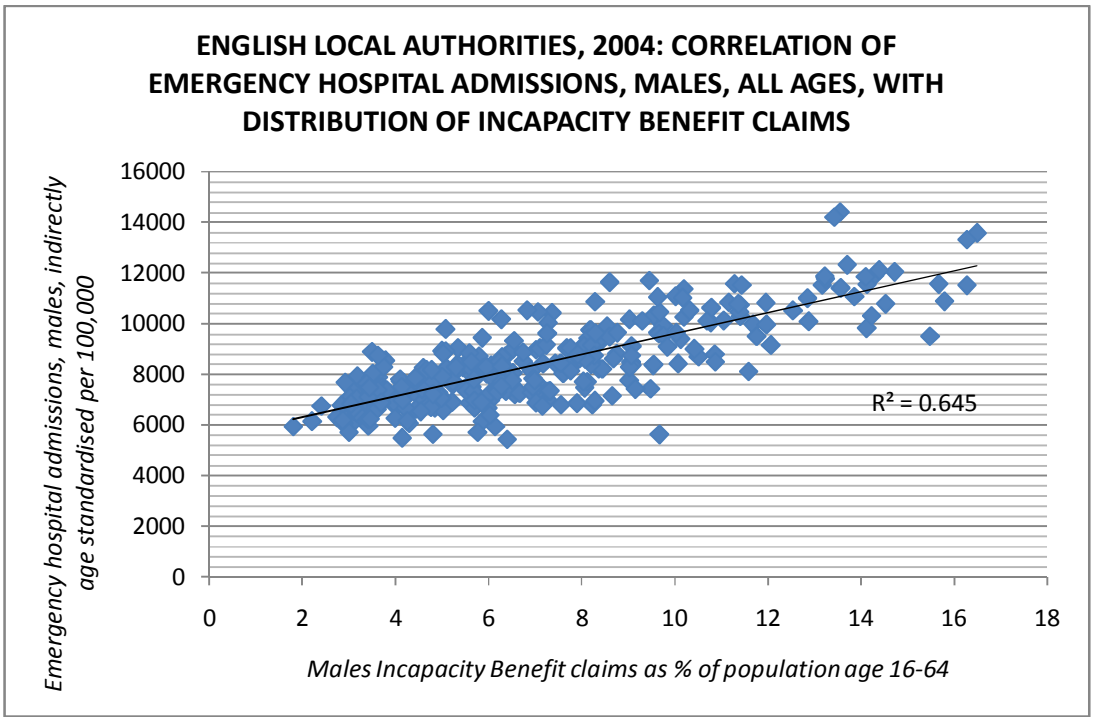
33 DWP statistics; author's calculations.

34 All Crown Copyright. Benefit, unemployment and population estimates from Nomis.

analysis. Control analysis recording them as zero unemployment produced minimal variation in the findings.



Source: As text above.



Source: As text above.

There was a significant association between the distribution of unemployment and mortality (r^2=0.393), as would be expected from a wide body of research evidence. However, the relationship between incapacity benefit and mortality was substantially stronger (r^2=0.604).

The relationship between unemployment and emergency admissions to hospital was less strong (r^2=0.210). The relationship between incapacity benefit distribution and emergency admissions to hospital was three times stronger (r^2=0.645).

The health status of males claiming incapacity benefit is not simply comparable with the unemployed population; it appears to be far poorer. While there are people who need support back to work, and there is no arguing with powerful evidence that work is associated with better health[35], the evidence base for a huge army of õhidden unemployedô stands in need of thorough review, with development of a far stronger emphasis on health support and links with the Department of Healthôs Long-Term Conditions programmes referred to above. Such an approach is far more likely to be cost-effective. The analysis here goes some considerable way towards explaining the evidence above of pervasive injustice against those who are genuinely unable to work.

Warnings in the DWP's own commissioned research

The DWPôs own research programme has produced many warnings of the mismatch between Government assumptions and what was happening on the ground. Some of them echo the conclusions of Acheson more than ten years earlier. They range from 1998 to 2010. They were disregarded.

õThe high level of reported health problems (among disallowed leavers of incapacity benefit) is reflected in a large proportion of leavers who return to incapacity benefit.....The majority reported experiencing continuing disadvantage in the labour market, which they linked to their condition.....35% of the disallowed had returned to incapacity benefit. By the follow-up study, those saying they had recovered (from the condition associated with their spell on benefit) had risen to 25%. Nearly all these recoveries were limited to those who had left voluntarily or who had decided not to appeal. Among disallowed leavers without jobs, seven out of ten classified themselves as sick or inactive rather than as unemployedô[36]

õThe most important factor in finding work was how health conditions were perceived and managed, although a proportion of customers worked despite health conditions..... Pathways In-Work Support advisers commonly identified customers with mental health conditions, such as depression and anxiety or low self-confidence, as the most significant customer group. The nature and severity of such conditions varied. Some customers were seen to need ójust a bit of extra encouragementô. However, commonly these customers had more intensive support needs..... Those with physical health conditions, according to providers, were less likely to need intensive support. The most dominant issue for this customer group was managing to fulfil their work obligations without experiencing pain or risking a worsening of their health conditionô[37]

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[35] Gordon Waddell and A. Kim Burton, õIs work good for your health and wellbeing?ô The Stationery Office, 2006.

[36] Richard Dorsett et al, õLeaving Incapacity Benefitô, Research Report no. 86, DSS, 1998.

[37] Josie Dixon and Martha Warrener, National Centre for Social Research, õPathways to Work: Qualitative study of in-work supportô, DWP Research Report No 478, 2008.

"Existing customers on Pathways to Work were often dealing with health conditions and disabilities that greatly limited their day-to-day activities. Their conditions, though varied, were commonly long-term and for the large majority they were not improving.... Nearly all existing customers (95 per cent) had a health condition or disability at the time of survey interview, 13 months after their start on Pathways to Work. Three in five (59 per cent) reported that their health condition limited their everyday activities "a great deal"... Only ten per cent of existing customers reported an improvement in their health in the period after their start on Pathways.... The significant barriers they faced meant a large proportion of existing customers (80 per cent) were not in paid work and not seeking work around 13 months after the start of the Pathways to Work programme. Over half either did not expect to work again or did not know when they would be able to look for a job in the future..... The state of customers' health dominated work outcomes. Health problems were the most frequently mentioned barrier to finding, and staying in, work and most frequently the cause of work ending".[38]

"Despite considerable commitment to the aims of ESA, Benefit Delivery Centre staff and JobCentre Plus and Provider advisers expressed concerns at the perceived stringency of the Work Capability Assessment, and the unexpectedly severe health problems of many customers in the Work Related Activity Group. The scope for helping some of these customers back to work was felt to be limited, and advisers felt hindered by their lack of discretion; the providers interviewed, who have more scope to determine how to work with customers, were in some cases targeting adviser resources explicitly on those closer to the labour market..... ".[39]

"In all areas there was adviser frustration that management pressure to focus on job ready clients was leading to less time being spent with clients who are further away from work. A strong sense of what needed to be done for business survival and job security saw creaming (working intensively with some clients) viewed as appropriate behaviour in a target-setting environment. Parking (giving other clients a bare minimum of service) was seen as appropriate practice, where there was a clear management steer, for disengaged clients lacking in motivation and for clients who were seriously ill or awaiting treatment".[40]

Thus DWP research reports identify a high level of poor health in disqualified claimants, as an obstacle to sustaining employment in large numbers taking part in the Pathways to Work programme, the shock and concern of staff at this, the "parking" by contractors of those in worst health or who are least ready for employment, and the "creaming" of those most likely to yield a positive result. These findings have not received sufficient attention.

Conclusion

This can be described as a social policy tragedy in which leading politicians of both main parties, and more recently all three, have had a hand. For people who cannot work, it has

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[38] Jon Hales, Oliver Hayllar, Christianah Iyaniwura and Martin Wood, National Centre for Social Research, "Findings from a survey of existing incapacity benefits customers in the first seven pilot areas (on the introduction of the mandatory Pathways to Work programme), DWP Research Report No 527, 2008.

[39] Helen Barnes, Paul Sissons, Jane Aston, Sara Dewson, Helen Stevens, Ceri Williams and Ruth Francis, Institute for Employment Studies, "Employment and Support Allowance: Early implementation experiences of customers and staff", DWP Research Report No 631, 2010.

[40] Maria Hudson, Joan Phillips, Kathryn Ray, Sandra Vegeris and Rosemary Davidson, the Policy Studies Institute, "The influence of outcome-based contracting on Provider-led Pathways to Work", DWP Research Report No 638, 2010.

been a long-term political strategy built, and regularly renewed, with selective use of evidence. It has repeatedly failed to make connection with a parallel, powerful body of evidence about the impact of growing inequality on health; and about the impact of its own policies, reflected with clarity in official statistics and in research commissioned by the DWP itself.

At the heart of this is Employment and Support Allowance and its gateway the Work Capability Assessment. Here are the main findings of the Citizensô Advice briefing ôNot Workingô

Seriously ill people are inappropriately subjected to the Work Capability Assessment (WCA). Under Incapacity Benefit if someone was seriously ill, information was sought from their own doctor and if the diagnosis was confirmed, they were exempted from the assessment. There are fewer exemptions for ESA, which means that people with debilitating conditions or serious disabilities are being subject to the WCA, and some are found ineligible for the benefit. Others in difficult but short-term situations are being found ineligible, just when they are most in need of the support of ESA.

The assessment does not effectively measure fitness for work. It does not take sufficient account of variable symptoms. There is little recognition of generalised pain and exhaustion, or the seriousness of an underlying condition. It takes no account of the context of the work environment, including a personôs education, skills and circumstances, or the discrimination they may face in looking for work, all of which can significantly affect the scale of the personôs barriers to work. The guidance for the health care professionals (HCPs) administering the test gives extreme examples, which is likely to lead to very harsh decisions.

Application of the assessment is producing inappropriate outcomes. Citizens Advice and other organisations have been concerned for many years about the quality of medical assessments for benefits. We still hear repeated reports of rushed assessments, assumptions being made without exploration, inaccurate recording and poor recognition of mental health problems.

These problems create major difficulties for our clients and undermine the Governmentôs aims for ESA. People with serious illnesses and disabilities who could not reasonably be expected to work are being found fit for work. Other people who might, with considerable support, be helped into work, are effectively being ówritten offô by being found fit for work and therefore ineligible for ESA. Many of these people are too ill to sign on, or are not eligible for any other benefit, and so are left with reduced incomes and no help or support to find work. Furthermore, many of those found ineligible for ESA also lose access to an extremely helpful route into sustainable work through the disability element of tax credits.

Research shows that claimants who move off benefits and (re-)enter work generally experience improvements in income, socioeconomic status, mental and general health, and well-being. However it also shows that ñthose who move off benefits but do not enter work are more likely to report a deterioration in health and well-beingò

Even this does not do justice to the reality of what is happening on the ground to thousands of individuals in poor health. Here is one story of many from Citizensô Advice:

A bureau in the South West saw a man who had had severe arthritis and had just had both his hips replaced. He was still finding it difficult to cope and was also struggling with a stoma bag. He had previously had bowel cancer and had had a colostomy. Despite all of this he was keen to return to work but knew he couldnôt cope at that time. He went for a WCA, was found fit for work and his ESA stopped. He had no entitlement to Jobseekerôs Allowance, but felt he needed

to contribute to the family income, so felt he had no option but to try and return to work. He returned to work and fell, damaging his hip, so he was off work again, and waiting for another hip replacement. He was so stressed that he was unable to eat and lost five stone in weight, while the NHS has incurred the cost of repeating the hip operation.

The Disability Alliance have come to similar conclusions, setting out exhaustive evidence for their case.[41] The Inquiry into the operation of the Work Capability Assessment is a start, but is inadequate. Even this appears to have been objected to by the then Shadow Minister for Work and Pensions in June 2010:

> We have been urging the new government to complete the implementation of those reforms and hope they will do so. We would be very concerned if they were to rip up the new test and the medical evidence just to reach an arbitrary target for spending cuts - that would be deeply unfair.[42]
>
> *Yvette Cooper, Shadow Secretary of State for Work and Pensions, 28 June 2010, Labour Party Website*

Further to the National Audit Office findings, the Public Accounts Committee has produced a report on the way Pathways to Work was implemented under the guidance of the current Minister for Welfare Reform.[43] Its findings and recommendations echo those of the National Audit Office, and include the following:

- Effective implementation of the programme was hampered by a flawed process of piloting and evaluation, which gave too positive a view of how well Pathways could be expected to perform.
- There is a lack of robust information on what happens to those claimants who fail to participate in Pathways.
- The controls in place are insufficient to manage the risk of providers submitting inaccurate contract payment claims.
- The Department lacks the information it needs to understand the supply chain for employment support, which conflicts with its objective of ensuring a healthy market....
- As ESA is extended to all existing claimants, there is a risk that some of those who are re-assessed and found fit to work will not receive the employment support they need.
- Early evidence shows that the new medical assessment, introduced with ESA, will deliver a significant reduction in the number of incapacity benefits claimants. The Department should evaluate the accuracy of the new medical assessment robustly to evaluate that it is fit for purpose.
- Many existing incapacity benefit claimants .....will move on to Jobseeker's Allowance. The Department has no information on claimants who are refused incapacity benefits. It should monitor them to know how many move onto JSA. The Department has also not yet fully evaluated its capacity to support large numbers of people who transfer in this way. It should undertake such an assessment and put in place the additional support required before the medical assessment is rolled out.

41 Disability Alliance, op.cit.

42 http://www2.labour.org.uk/incapacity-benefit,2010-06-28

43 Public Accounts Committee - First Report: Support to incapacity benefits claimants through Pathways to Work, House of Commons, September 2010.

This Thinkpiece summarises a comprehensive catalogue of policy failure, with profoundly unacceptable consequences, over a period of fifteen years.

There is a real argument to be had about whether a thoroughly reformed three-tier structure of ESA could still be an effective vehicle to deliver security for those who cannot work, and support and preparation for appropriate work for those with limited capacity and those who are in recovery. It would appear that Citizens Advice and its partners are making detailed recommendations for improvements to the existing structure, rather than its scrapping.

There is no doubt that a such a reformed scheme should have a major preventive and rehabilitative health dimension, linked with the Department of Healthôs work on Long Term Conditions, in a way that reflects the compelling evidence of the challenge faced by people receiving Incapacity Benefit. Claimants werenôt just áabandoned on benefitsô, or making a ólifestyle choiceô. The health of hundreds of thousands of people has been abandoned and undermined by a selective, incompetent and judgemental vision. One small source of health-related support available through ESA, the Work Focused Health Related Assessment, has just been suspended for two years by the Coalition Government. [44]

There should be:

a) urgent remedial action to ensure that people whose capacity to work is restricted:
   - are not written off on inappropriate benefits;
   - do not have to undergo avoidably stressful and costly appeals; and
   - have access to support to seek, secure and retain appropriate employment opportunities.[45]
b) an urgent, comprehensive and truly independent Inquiry to examine what has happened and develop a coherent, evidence-based and cost-effective approach to the above objective, which fully integrates provision for appropriate health-related support and fulfilment of the historic promise to provide security for those who cannot work.
c) a major exercise to identify, compensate, and provide appropriate support to thousands of ill and disabled people who have been wrongly deprived of benefits they should have received.

This is perhaps our greatest domestic challenge in the remaking of a progressive and robust politics of informed compassion. It represents a test of the courage of the new Labour leadership. It means addressing a democratic deficit that has had major consequences for too many, and for far too long.

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44 Letter from DWP To members of JCP Customer Representative Group Forum, 24 June 2010.

45 Objectives from the Disability Alliance paper referred to above.