The misuse of evidence in incapacity benefit reform

Steve Griffiths

The use and misuse of evidence in the benefits debate

The idea that there are over a million people in Britain receiving Incapacity Benefit who are not entitled to it has driven a major strand of welfare reform for more than fifteen years, and was a cornerstone of the New Labour project. Yet this proposition was based from the beginning on selective use of evidence - and there is a persuasive alternative narrative, available from a wide range of sources, that has been determinedly overlooked by both major parties and by the media. There is of course no doubt that work is often good for health; and nor is there doubt that many people who are unfit for work might be able to return to work with appropriate support. The problem is that this case has been fatally exaggerated, while, on the other hand, large numbers of people with severe health needs - who are themselves the subject of huge investment by the Department of Health - have been treated as invisible (or, worse, as malingering) by the DWP and successive Work and Pensions ministers. It is hard to avoid the conclusion that those in charge of Work and Pensions have been driven by a compulsion to judge and to privatise, with any consideration of the population's health needs deliberately excluded from their policy framework.[1]

During the years of reform, this lack of engagement with critical discourse has adversely affected several hundred thousand people with severe and chronic health problems. The scale of this failure, and the airbrushing out by the media and political establishment of a stream of evidence that would, if taken on board, undermine their whole approach, should properly be seen as a democratic deficit - and one that has had a disproportionate effect on a particularly vulnerable section of our population. Such denial of the evidence will need to be confronted if there is to be a progressive realignment in our politics.

The alternative narrative is based on a number of elements. First there is the need to subject to close analysis the assertion, endlessly repeated by politicians of both main parties, that very large numbers of people have been dumped on incapacity benefit when they are in fact capable of work. Second, there is a need to acknowledge the context in which the debate takes place, which is one of growing health inequality, and evidence that a large section of the working-age population lives with limiting long-term illness. It is this that is the underlying driver of the abandonment in public discourse of the concept of 'security for those who cannot work', and its replacement by a denial that there are significant numbers who are ill or disabled enough not to be able to work, or that society owes such people a duty of financial care, akin to the promise of the NHS. Third, the assertion that 'work is good for you' should be understood in the context of rather more subtle findings - that the right kind of work is good for you if you are able to take advantage of it, and the wrong kind of work does not enhance health and wellbeing. Finally, there is the need to make an estimate of the numbers incorrectly and unjustly deprived of their incapacity benefits since the beginning of this reform in 1995.

Background

In 1995, the Tory government replaced Invalidity Benefit with Incapacity Benefit, applying an 'All Work Test' that was tougher than the previous one. The subsequent New Labour government's view of Incapacity Benefit was that it still was not tough enough. Tony Blair, as so often, encapsulated the vision. Incapacity Benefit was:

> 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.[2]

This approach informed Labour's Welfare to Work policies throughout its period of government, and has been carried forward by the Coalition government. A succession of Green Papers, White Papers and legislation, too numerous to list here, led us to the Pathways to Work scheme, followed by a new Work Capability Assessment, which acts as the gateway to Employment and Support Allowance (initially only applied to new claimants from 2009). This 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.[3] Freud, having been subsequently ejected by Peter Hain, was brought back by James Purnell, became an adviser to the Tories, was ennobled, and is now Minister for Welfare Reform for the coalition. His report accepts uncritically the New Labour aim of reducing the number of Incapacity Benefit recipients by a million. (A critique of the research basis for this figure is outlined below.)

Freud's Independent Report concludes that:

> 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 because of the complexity of the arrangements likely to be required with many other parties'. There is no need for any extensive discussion of the arguments, since there is a pre-existing political consensus to carry the programme forward. The 2006 Green Paper, however, did contain a curious aside: 'the current Personal Capability Assessment process [is] already recognised by the OECD as being one of the toughest in the world'.[4] Unfortunately though, this recognition did not prompt any self-examination.

The government was subsequently boosted by the mixed reactions to its next Green Paper, in July 2008, from a number of organisations representing disabled people. This was largely based on support for the direction of travel towards improving the access to the labour market for people who would otherwise have been unable to work - though the support was often conditional:

> We 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 individual's capacity to work in both the short and long term.[5]

Once the new scheme was underway it became easier to make an informed judgement of its effects. Claims for Employment and Support Allowance (ESA), as in earlier sickness benefit regimes, have to be 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 twenty-eight weeks, supported by medical certificates. If the claimant is in receipt of Jobseeker's Allowance (JSA), ESA can be claimed after two weeks of sickness. After thirteen weeks of claiming ESA at the JSA rate of £65.45, supported by GP certificates, claimants then become subject to the new Work Capability Assessment (WCA).[6] The WCA is administered by Atos, a large French/Dutch company. It divides claimants into three categories: the Support Group, who are not required to undertake work-related activity, and are entitled to £96.85 per week after the assessment phase at the JSA rate; the ESA Work Related Activity Group, who are deemed fit for work with support and preparation, and receive £91.40 per week after an assessment phase at the JSA rate; and the 'Fit for Work' group, who are transferred back to Jobseeker's Allowance. 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 - 9%
- Suitable for the ESA Work Related Activity Group - 23%
- Fit for Work, so transferred to Jobseeker's Allowance - 68%.

The assessment made is usually endorsed by a DWP officer - and with an ease that 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 claimant is able to provide statements from specialists, who have regular contact with them, this evidence should be given due consideration.[7]

In March 2010, Citizens' Advice published a report on the WCA, endorsed by eighteen disability, mental health, poverty and carers' charities. The main findings were that: seriously ill people were inappropriately subjected to the Work Capability Assessment; the assessment did not effectively measure fitness for work; and that application of the assessment was producing inappropriate outcomes.[8] The Disability Alliance has come to similar conclusions, and has set out exhaustive evidence for their case.[9]

Following a highly critical report by the National Audit Office, the House of Commons Public Accounts Committee produced a report on the way Pathways to Work was implemented, under the guidance of the current Minister for Welfare Reform.[10] Its findings echoed those of the National Audit Office:

- 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'.

The hidden unemployed: the 'evidence' base

The arguments underpinning this new regime can be traced back to reports by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University, from 1997 onwards, which 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, when he was Work and Pensions Secretary, was saying 'about half of the 2.7 million people "on the sick" are capable of working'.

CRESR's 1999 report 'Incapacity Benefit and Unemployment', the second in a series of three, estimated that there were 'around three-quarters of a million "hidden unemployed" men on Incapacity Benefit', and that 'over ten years the number of male ICB claimants might be reduced by half a million; and … a similar proportional reduction among women would reduce the number of claimants by a further quarter of a million'.[11] Further reports had by 2005 led to a more ambitious estimate, which may be seen as uncannily prophetic of the Atos findings in their administration of 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 severe problems, the appropriate share of new claimants finding their way onto the higher benefit might be as low as one in ten.[12]

The question that is rarely asked of this research is the nature of the data and projections on which it was based - even though many advice and disability bodies report a very different picture on the ground. Has it been a case of making the reality fit the research? Do the numbers - and does the case - add up?

On closer examination it can readily be seen that the hypotheses on which the report's projections were based were deeply flawed. The 1999 report adopts three main types of projection in order to arrive at possible totals of 'hidden unemployed'. The first of these - the 'real unemployment' indicator - at least makes some attempt to take account of health data. As a guide to what is achievable in a fully employed economy, it uses the rate of 'permanent sickness' among men of working age in the South East of England, as recorded by the 1991 Census. Basing itself on this data sample, it concludes: 'Therefore levels of sickness in excess of this level - 3.4 per cent of the male working age population - should be regarded as hidden unemployment'. The most obvious criticism here - though there are many others - is that this projection completely disregards regional health inequality, and generalises on the basis of benchmark figures from the least deprived region in England. And its optimism is particularly misplaced given the widening of the gap in life expectancy between 1972-77 and 2002-2005.[13]

The second projection was based on the percentage of people who, in reply to a survey question, responded with 'health not main reason for last job ending'. There are a number of difficulties with an assumption that anyone who does not give health as the main reason for having left a job must be capable of working. Not least of these, in this research, was its accompanying disregard of the high proportion of respondents (two-thirds) who, while they 'didn't say they can't do any work', did say that their health limits what they can do 'a lot'. Then there is the known health impact of unemployment itself: though people may not have lost their jobs because of ill health, once becoming unemployed they are more likely to become ill. Acheson is instructive on the double disadvantage for people with chronic sickness or disability: 'their ill-health puts them at greater risk of unemployment, and the experience of unemployment in turn may damage their health still further'.[14] So this projection too served to greatly exaggerate the numbers of 'hidden unemployed' on incapacity benefit.

The third projection of the research was based on those who stated that they 'want a full-time job'. This of course has nothing to do with capacity to work.

The report criticises those who 'explain away the vast increase in sickness claimants in health terms alone': yet surely this must be considered a possible factor. In adopting this stance, the CRESR research is marginalising issues of health. For, though there will indeed be a significant number of people who may be able to work with support, encouragement and - where appropriate - sanctions, this is only a small part of the story.

In an attempt to remedy this overlooking of health factors, I did some research on the relationship between two contemporary health indicators - mortality rates and emergency admissions to hospital - and the spread of incapacity benefit and unemployment in the male population across 326 English local authorities in 2004. In focusing on the male population I was looking at the same group as the Sheffield Hallam report. However, it should be noted that a key factor in the overall increase in incapacity benefit claimants is the steep rise in numbers of women receiving incapacity benefit as a result of their growing participation in the workforce. Between 1979 and 1997, the number of men receiving incapacity benefit tripled, while the number of women increased seven and a half times. In 1997-2004, while the number of men receiving incapacity benefit fell by 7 per cent, the number of women increased by 18 per cent.[15] This reason for the increase in IB recipients is one that is rarely highlighted.

My research found a significant association between the distribution of unemployment and mortality rates, as would be expected from a wide body of research evidence; and the relationship between incapacity benefit and mortality rates was substantially stronger. The relationship between unemployment and emergency admissions to hospital was less strong: and it was a third of the strength of the association between emergency admissions and incapacity benefit distribution.[16] In short, my findings lead to the conclusion that the health status of males claiming incapacity benefit is not simply comparable with that of the unemployed population; it appears to be far poorer.

The evidence base for a huge army of 'hidden unemployed' stands in need of thorough review, with development of a far stronger emphasis on health support. Such an approach is far more likely to be cost-effective.

Trends in long-term illness and health inequality

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.

The total 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 these 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. Instead what actually happens is that they continue to suffer chronic illness, dependent on a progressively vanishing 'security for those who cannot work'.[17]

The statistics on 'Trends in Limiting Long-term Illness' in the General Lifestyle Survey are informative. In the age group 16-44, the level of those suffering from LLTI rose by half from the 1975 baseline to 1995/1996; and it declined by a fifth from 1995/6 to 2004-8.[18] In the 45-64 age band (much greater in number), the increase to 1995/6 from the 1975 baseline was nearly a quarter; and the fall from 1995/6 to 2004-8 was 13 per cent. This is surely one important factor in explaining the increase in claims for incapacity benefit. And a new report for the Institute for Social and Economic Research confirms the importance of these trends in the growth of incapacity benefit claims.[19]

One factor in these increasing levels of ill health is the now well established link between the degree of inequality in society and ill health - not the level of poverty, but the degree of inequality. Wilkinson and Pickett's *The Spirit Level* draws together much of this evidence, but there is also a strong body of published evidence that supports this thesis from early on in the Labour administration.[20] For example, the Independent Inquiry into Inequalities in Health, chaired by Sir Donald Acheson, found that:

> … 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 higher.[21]

The Marmot review, in February 2010, found that:

> 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.[22]

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, clearly many people will become disabled much earlier.[23]

In Waltham Forest in 2000 there was an all too rare piece of local of research that did look at the relationship between demands on the NHS and receipt of incapacity benefit. In looking at ten different indicators of deprivation, it found that seven of them showed a strong and significant correlation with emergency hospital admission for all causes (looking at those under 65).[24] But being in receipt of incapacity benefit was the factor that showed the strongest association of all seven with the emergency admissions indicator.

Yet none of this body of evidence has ever been applied to understanding the rise in claims for incapacity benefit. Throughout the period of the 'one million myth' there has been a failure to make connections between findings being made across the academic world - and the reach of much health policy development - and the 'Reducing Dependency' agenda of New Labour. Where did that disconnection come from? One explanation for the immensely high levels of stress and error that have been imposed by the introduction of ESA is that there has been a major policy misdiagnosis, based on selective attention to evidence.

'Work is good for you'

It is regarded as a truism that work is good for health. This belief has driven welfare reform from the start. One report, by Gordon Waddell and Kim Burton, has been repeatedly referred to, as if it had made this case without any qualification.[25] But, though its core statement is 'Work is generally good for health and well-being', its analysis is far more nuanced than would be supposed from its widespread political use. As CPAG projects director Nick Jones has pointed out: 'to recap: there is a lack of direct evidence on the subject, but the indirect evidence suggests that work is generally good for your health and wellbeing, provided you can get a job. Not just any job, but a good job'.

According to Waddell and Burton:

> … in terms of promoting health and wellbeing, the characteristics that distinguish 'good' jobs and 'good' workplaces might include: safety; fair pay; social gradients in health; job security; personal fulfilment and development; investing in human capital; accommodating, supportive and non-discriminatory; control / autonomy; job satisfaction; good communications.

These are fundamental qualifications, particularly in a society where poor employment conditions are rife. And there is plenty of evidence that inappropriate work has a detrimental effect on health. The informedcompassion.com website lists, from a wide range of sources, a long succession of reports giving evidence of people being subject to disallowance of incapacity benefit and as a result having to undertake inappropriate work, which has in turn resulted in detrimental effects on their health. This is an important strand of evidence that successive governments and media reports have chosen to ignore.

How many people who are unfit for work have been wrongly disallowed incapacity benefit and ESA?

Close analysis of tribunal data and other source material since the introduction of Incapacity Benefit in 1995 suggests, at a very conservative estimate, that half a million people have been wrongly disallowed Incapacity Benefit, or, more recently, ESA. More than 300,000 have had their benefit restored at appeal after disallowance - at great public expense and personal and health cost.

However, many more never reach a tribunal. In November 2010, Richard Thomas, Chair of the Administrative Justice and Tribunals Council, pointed out in a *Today* programme interview that:

> The cases heard by tribunals are probably the 'tip of the iceberg', and there must be tens of millions of [social security and other Tribunal] cases that are not heard. If a million people need to appeal, there must be cases beneath that where people feel aggrieved or the decision has been wrong in the first place [but they] don't reach a tribunal.

Thomas went on to criticise inadequacies in social security decision-making, and to chastise officials, stating they must make much more effort to reduce the number of successful appeals made against them:

> In many cases we are particularly concerned that the public body does not learn [from] the outcome of the tribunal appeal. They might put it right in that particular case, but they don't change their system … so the same mistakes [are] being repeated time and time again. Now that is obviously a waste of taxpayers' money [and] it's stressful for the people concerned.

Over fifteen years, about 1.5 million people have failed the All Work Test, the discredited Personal Capability Assessment and the harsher Work Capability Assessment. DWP research in 1998 found that 35 per cent of the people 'disallowed' subsequently ended up sick and back on the benefit. So it would be a very conservative estimate that there are approximately 200,000 more people who have been wrongly disallowed but are unable to appeal due to lack of confidence, literacy or advice and support - compounded by poor health.

What would happen if, in the criminal justice system, half of appeals were found in favour of the appellant? It would be evidence that there was something deeply wrong. There would be a high profile debate about wrongful imprisonment. Yet these disallowances, which affect the financial support of hundreds of thousands of very poor sick and disabled people, go largely unreported. It is evidently a matter that is unworthy of our attention. It is my contention that this represents a shameful democratic deficit.

Steve Griffiths is a freelance consultant and researcher in health and social policy. A former welfare rights worker, he has written practice guidance for three Government departments, and reports about inequalities and preventive investment for major charities, local authorities and PCTs. This article is adapted from a recent Thinkpiece for Compass.

Notes

1. For more information on the use and misuse of evidence in the evolution of welfare reform see www.informedcompassion.com.

2. Tony Blair, *Observer*, 23.5.99.

3. 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.

4. Organisation for Economic Co-operation and Development, *Transforming disability into ability, policies to promote work and income security for disabled people*, OECD 2003.

5. Mental Health Foundation response, White Paper, *Raising Expectations and increasing support: reforming welfare for the future,* Appendix A - Responses to the public consultation, DWP, December 2008.

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

7. House of Commons Work and Pensions Committee, *Decision making and appeals in the benefits system*, 2010.

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

9. See particularly the Disability Alliance response to DWP's Call for Evidence on The Work Capability Assessment, September 2010: www.disabilityalliance.org/r66.pdf.

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

11. Christina Beattie and Stephen Fothergill, *Incapacity Benefit and Unemployment,* CRESR, Sheffield Hallam University 1999.

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

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

14. Sir Donald Acheson (Chair), *Independent Inquiry into Inequalities in Health,* The Stationery Office 1998.

15. DWP statistics; author's calculations.

16. A fuller account of evidence to support this case is available on www.informedcompassion.com.

17. 'A new contract for welfare - principles into practice', DSS 1998.

18. The frequency of General Household/Lifestyle Surveys increased greatly after 1997, so means were calculated for 1995/6, 1998/2003 and 2004/2008, in order to maintain some regularity of comparison.

19. www.iser.essex.ac.uk/publications/working-papers/iser/2011-03.

20. Richard Wilkinson and Kate Pickett, *The Spirit Level - Why Equality is better for everyone,* Allen Lane 2009.

21. Acheson report, op cit.

22. Marmot report, op cit.

23. Office for National Statistics.

24. Steve Griffiths, *Spotlight on Social Exclusion*, London Borough of Waltham Forest 2000.

25. Gordon Waddell and Kim Burton, *Is Work Good for your Health and Wellbeing?*, The Stationery Office 2006.