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1

Fit for Work? Representations and Explanations of the Disability Benefits ‘Crisis’ in the UK and Beyond

Colin Lindsay and Donald Houston

Introduction

At the start of 2012, more than two and a half million people of working age were out of work and claiming disability benefits in the UK (see Box 1.1). Since 1979 the numbers on these benefits have more than trebled. Successive governments have argued that the large numbers of people spending long periods on disability benefits represents a social and economic crisis. Beyond the fiscal pressures placed on welfare budgets (which have become particularly acute in the context of recurring recession and public spending deficits), there is evidence that long periods spent on these benefits can further undermine individuals’ health (Brown et al., 2009), increase the risk of poverty (Kemp and Davidson, 2010) and feed into ‘risky behaviours’ (Waddell et al., 2007). From an economic perspective, it is argued that high levels of working age inactivity represent a waste of human capital, as skills and labour are haemorrhaged from the productive economy (Beatty et al., 2010). Finally, population ageing and pressures on pension schemes mean that, in the long term, there will be a need to keep older people working, and working for longer, with the ‘active management’ of health conditions bound to be a key element of any policy solution (Loretto et al., 2007).

Given this context, it is unsurprising that policy makers have expressed a determination to reduce the numbers claiming disability benefits. Recent policy responses in the UK have focused on the reform of disability benefit regulations in order to establish a more ‘active’ disability benefits regime; restrict eligibility; extend means-testing; limit payment levels; and introduce active labour market programmes (Pathways to Work from 2003, and its successor, the Work Programme since 2011).

This book explores whether these policy responses (see Box 1.2) are fit for purpose by: presenting evidence on why benefit rolls have risen and why
The Disability Benefits ‘Crisis’

The current benefits system for people with health problems arguably has its roots in the establishment of contributions-based Invalidity Benefit in 1971. For people with insufficient National Insurance contributions, support provided because of ill-health traditionally fell under the main general social assistance benefits (until recently Income Support, and before that its predecessors Supplementary Benefit and National Assistance). The first of a series of important reforms took place with the introduction of Incapacity Benefit to replace Invalidity Benefit in 1995. This reform was designed to tighten eligibility criteria via a more rigorous medical ‘all work test’ and stricter National Insurance contributions requirements. Further restrictions were applied with the introduction of the ‘Personal Capability Assessment’ and additional contributions requirements in 1999. Despite these changes, the numbers receiving disability benefits rose steadily during the 1980s and 1990s.

From 2008, new claimants have applied for Employment and Support Allowance, and all existing recipients – chiefly those on Incapacity Benefit – will be moved on to the new benefit by 2013. The new benefit divides claimants into a ‘Work-Related Activity Group’ considered capable of progressing towards employment and mandated to engage in activation programmes (previously participation was largely voluntary); and a ‘Support Group’, assessed as more sick or disabled, who are paid a higher rate of benefit and are excused from work-related activity. An even stricter medical ‘Work Capability Assessment’ has seen the majority of claims for disability benefits rejected, and most successful claimants directed towards work-related activity. The first large-scale activation programme directed specifically at Incapacity Benefit claimants was ‘Pathways to Work’, rolled out from 2003 to 2008. In 2011 Pathways to Work was replaced by a single ‘Work Programme’ providing activation for claimants of all working age benefits.

Box 1.1 What are disability benefits?

For the purposes of this book, we define ‘disability benefits’ as those monetary benefits granted under contributory and non-contributory state schemes and paid to people experiencing long-term sickness, disability or reduced work capacity as means of earnings replacement. This may include some early retirement schemes specific to disability or reduced work capacity (these operate in countries such as Denmark and Germany) and some broader social assistance schemes that have a specific disability component. Our focus is on the main state benefits, and not private disability insurance benefits. This definition is broadly similar to that used by recent cross-national studies (OECD, 2010).

Box 1.2 Disability benefits and employability policy in the UK

The current benefits system for people with health problems arguably has its roots in the establishment of contributions-based Invalidity Benefit in 1971. For people with insufficient National Insurance contributions, support provided because of ill-health traditionally fell under the main general social assistance benefits (until recently Income Support, and before that its predecessors Supplementary Benefit and National Assistance). The first of a series of important reforms took place with the introduction of Incapacity Benefit to replace Invalidity Benefit in 1995. This reform was designed to tighten eligibility criteria via a more rigorous medical ‘all work test’ and stricter National Insurance contributions requirements. Further restrictions were applied with the introduction of the ‘Personal Capability Assessment’ and additional contributions requirements in 1999. Despite these changes, the numbers receiving disability benefits rose steadily during the 1980s and 1990s.

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some people are more likely than others to become long-term claimants of disability benefits; critically assessing the content and outcomes of recent policy in the UK; and comparing experiences in the UK with those of other welfare states. A crucial conclusion is that, while the welfare system can in some instances hinder a return to work, the notion that insufficient work incentives and a lack of activation measures explain why so many people are on disability benefits is fatally flawed. Rather, labour market change and industrial restructuring, alongside individuals’ employability and health-related problems, combine to explain why some people find themselves on disability benefits for long periods.

The comparative element of this book is important because high levels of disability claiming are not unique to the UK. Social democratic states such as Sweden (Hytti, 2006) and leading ‘active' welfare states like the Netherlands (Koning and Van Vuuren, 2007) have faced similar problems, and even the liberal US welfare state, despite limited spending on benefits, saw a rapid growth in ‘social security disability' in the 1990s and 2000s (Autor and Duggan, 2006). Meanwhile, other countries represented in this volume, such as Germany and New Zealand, have managed to avoid (Germany) or limit (New Zealand) the growth of large benefit rolls, but face substantial problems of working age sickness and disability (OECD, 2010).

If policy makers in the UK and beyond are to get to grips with the disability benefits crisis, then they first need to appreciate the nature of the problem; and then assess the evidence on what might work (and has previously worked) in terms of policy solutions. We set ourselves the same challenge in this book. We have gathered evidence from experts in a wide range of disciplines including economic geography, social policy, sociology, occupational medicine, and public health studies. We also present comparative perspectives from four welfare states beyond the UK.

The remainder of this chapter sets out one of the central issues for the book – that the disability benefits crisis in the UK and beyond can only be understood as the result of a combination of three key factors:

- **labour market processes** of job destruction, polarisation, and work intensification that have limited opportunities for work in post-industrial labour markets, particularly for those with poor health;
- **gaps in individuals’ employability** and skills that mean they are left at the ‘back of the queue’ for those jobs that are available; and
- **health problems** that both explain why people claim disability benefits in the first place and limit their prospects of returning to work.

The UK evidence on these three interconnected issues is unpacked in Chapters 2 to 7, before we assess their relevance in other welfare states, and finally outline issues for policy. We first set the scene by providing more detail on how the disability benefits ‘crisis' has been represented and misrepresented and on how the three themes of the book – labour market
The Disability Benefits ‘Crisis’

change, employability, and health – interact to leave many people claiming disability benefits for long periods.

(Mis)Representations of the disability benefits crisis

According to the UK’s General Household Survey, around 15% of the working age population have a limiting long-term illness or impairment, a proportion that has remained fairly constant since the 1970s. Approximately half are currently employed, down from almost two-thirds in 1980 (Berthoud, 2011). Disability benefits claimants rose from below 3% of the working age population in 1980 to 7.7% in 2010. Assuming that the overwhelming majority of claimants would report a limiting long-term illness, almost half of sick and disabled people in the UK are therefore in receipt of disability benefits. Of those claiming benefits, over 80% say their health means they can either do no work or substantially limits the amount or type of work they could do (Beatty et al., 2009).

In what respect – indeed if at all – this situation can be represented as a ‘crisis’ depends very much on one’s point of view. From the government’s perspective, the ‘crisis’ is the increase in the numbers claiming such benefits and the associated cost to the taxpayer over the last 30 years (DWP, 2010). From a social justice point of view, the ‘crisis’ is that the employment rate of the sick and disabled is significantly lower today than 30 years ago (Berthoud, 2011). From a social exclusion point of view, the ‘crisis’ is low income levels on benefits and the large numbers claiming concealing the true extent of involuntary worklessness (Beatty and Fothergill, 2012). From an economic point of view, the ‘crisis’ is cast as lost labour supply and increased pressure on pension schemes already stretched because of population ageing (OECD, 2010). On the other hand, the situation may not be seen as a ‘crisis’ at all, but merely a reflection of appropriate mechanisms of social protection for the sick and disabled who are unable to work in an increasingly competitive labour market.

The dominant rationales for policies to deal with the disability benefits crisis are arguably to reduce the cost to the state and to place more economic responsibility on citizens (DWP, 2010). Political and popular discourses typically revolve around disability benefits being: overly generous; too easily accessible for people who should be ‘insufficiently’ sick to qualify; excessively complex to administer; and too passive in that they do not place enough obligation on recipients to move off benefits (Freud, 2007; DWP, 2008, 2010; OECD, 2010). Thus, there is an assumption behind recent welfare reforms in the UK and beyond that the root cause of the high numbers claiming lies with the nature of the benefits system itself and its influence on the behaviour of individuals. These ideas are closely linked to the notion of ‘dependency culture’, which lies behind the emphasis on activation, coercion, and ‘responsibilisation’ within welfare reform
Colin Lindsay and Donald Houston

(Mead, 1986; Halvorsen, 1998; Peck, 2001). If the operation of the benefits system has led citizens to disengage from the labour market – so the reasoning goes – reforms to the system can ‘correct’ undesirable behaviour (Beck and Beck-Gernsheim, 2002). However, this behaviourist reading of the disability benefits problem appears to have run up against a more complex reality.

What factors might explain the disability benefits crisis?

A labour market problem?
The history and geography of disability benefits claiming in the UK indicate very clearly that job availability plays a pivotal role in determining the number of people on disability benefits. Disability benefits claimants in the UK are heavily concentrated in areas of industrial job losses (Beatty et al., 2007; Beatty and Fothergill, this volume). All periods of economic slowdown since the late nineteenth century have coincided with rises in disability insurance/benefit claiming (Macnicol, this volume). This was as true before the introduction of the Beveridge welfare state as it was after. Similarly, in many other states, claims of disability benefits have risen most strongly in the years following economic slowdowns (OECD, 2010).

Beatty et al. (2000, 2009) have made a convincing case that area-specific economic restructuring and ‘job destruction’ in traditional sectors during the 1980s and 1990s came to ‘hide’ unemployment among increasing numbers claiming disability benefits in disadvantaged labour markets, where there have been fewer opportunities available, and where those with health problems and other barriers have been pushed to the back of the jobs ‘queue’. Such processes of job destruction have resulted in persistently high levels of worklessness and claiming of disability benefits in depressed urban labour markets (Webster, 2005), seaside towns (Beatty and Fothergill, 2004), former coalfield communities and industrial towns (Beatty and Fothergill, 2005) and some rural areas (Beatty and Fothergill, 1997).

There is a strong evidence base to support this theory. First, survey evidence suggests that there is little ‘different’ about the health or personal characteristics of people on benefits in ‘high disability rate’ labour markets – it’s just that there are lots more of them (Brown et al., 2009). Second, spatial inequalities have remained remarkably consistent over time. The areas reporting the highest levels of benefit claiming barely changed from the early 1990s to the middle of the first decade of the 2000s (Beatty and Fothergill, 2005) and similar inequalities remain in place today (Beatty et al., 2010). These differences between areas seem resistant to changes to the benefits system (Lindsay and Houston, 2011), and to the introduction of active labour market strategies (Webster et al., 2010).

It would be simplistic, however, to suggest that job availability alone explains the patterns and trends in benefit claiming. In the UK, industrial
redundancies largely affecting men in manual occupations explained a lot of the increased inflow onto disability benefits in the 1980s and early 1990s, which was dominated by men over 50 years of age in industrial districts. Since the mid-1990s, however, the inflow has come to be more varied with women and younger workers (aged 35–50) claiming in greater numbers. In parallel, poor health has replaced redundancy as the most common reason for job loss among disability claimants, and anxiety and depression have become more prevalent among claimants (Beatty et al., 2009). Despite these changes in the characteristics of claimants, the geography of claiming in the UK – including the inflow since major reform in 2008 – has remained heavily concentrated in areas of former industrial job losses that continue to be characterised by sluggish economic growth (Lindsay and Houston, 2011). This suggests that through time shortfalls in labour demand are transmitted onto those least able to compete for scarce jobs (Beatty et al., 2009).

Deindustrialisation has led to a reduction in the number of hazardous work environments in the labour market, which could be expected to reduce levels of disability among the working age population. Yet reported levels of disability have remained constant since the 1970s. An explanation may be that there has been an intensification of work and the emergence of new occupational hazards in the service sector relating more to mental than physical stress (Baumberg, 2012). Consistent with this is the fact that levels of depression and anxiety in the population have increased (although increased divorce and separation may also account for some of this rise) and that the proportion of disability benefits claimants recorded as having mental illness has also risen. Increased pressures for productivity have been noted in a range of workplaces in both public and private sectors (Loretto et al., 2010). Consequently, work intensification may be part of the explanation behind reduced employment rates among people with disabilities or poor health.

Furthermore, Davidson and Kemp’s (2008) work on ‘sickness benefits in a polarised labour market’ pointed to the greater vulnerability faced by people with health problems working at the bottom end of the labour market. Individuals in weaker labour market positions may be less able to negotiate with employers for workplace adaptations, a change of work role or reduced hours; and those in casual or fixed-term positions may be more likely to be made redundant if they take time off for health problems. Many temporary and agency workers are also not entitled to statutory sick pay in the UK, while other casual staff can find themselves denied sick pay by employers – accordingly, disability benefits may ‘act[s] as a functional equivalent of sick pay for people in poor health working in temporary jobs’ (Kemp and Davidson, 2010, p. 213). In short, it seems that ‘the inequality between those in “good” and “bad” jobs, in relation to both job security and other terms and conditions of employment, is reinforced while in sickness’ (Davidson and Kemp, 2008, p. 229).
The first two chapters following this introduction closely connect with issues around how labour market inequalities shape the experiences of people on disability benefits. Christina Beatty and Steve Fothergill (Chapter 2) ask if the high level of disability claiming in some regions of the UK is best seen as ‘an issue of health or jobs’. Some commentators have sought to caricature Beatty and Fothergill’s previous work as focusing solely on ‘hidden unemployment’ as a cause of rising working age disability, but it is important to note that ‘hidden sickness’ has always been as important to their analysis (see, for example, Beatty et al., 2000, 2009). Beatty and Fothergill maintain such a balanced approach in these pages. Their recent research reported here, based on survey work with thousands of claimants, confirms health to be an important factor (most of their respondents left work because of health problems and reported substantial limitations as to the work that they could do), but again identifies spatial concentrations of disadvantage as the result of weak labour demand in regions that have experienced industrial restructuring. It’s a problem of health and jobs.

John Macnicol (Chapter 3) provides an invaluable historical perspective, telling a recurring story of vulnerable people with health problems being shaken out of the labour market as a result of economic crisis or the ‘redistribution of work’ across regions and sectors. These first three chapters, along with the overwhelming weight of evidence from previous studies, show that labour market inequalities provide the crucial context for the worklessness experienced by many people with health problems and disabilities. As we have noted elsewhere:

the weight and range of evidence is such that we can say that it is simply a fact that labour market changes, and especially the long-term impacts of area-specific industrial decline and job destruction, are essential to explaining the rise in, and continuing high levels of, [disability benefits] in some parts of the United Kingdom.

(Lindsay and Houston, 2011, p. 710)

Of course, Beatty and Fothergill and Macnicol acknowledge that while labour markets and the uneven distribution of job opportunities frame the disadvantage encountered by many, individual factors, including gaps in employability and skills, explain why certain individuals rather than others are excluded.

An employability problem?
We have noted above that labour market change has seen some regions and localities shed jobs that would otherwise be accessible for people who instead end up on disability benefits. So it would appear to be that spatially sensitive, and to some extent demand-oriented, economic policies will be required to address the labour market inequalities faced by people
in these areas (see Chapters 12–13 for further discussion). However, the evidence suggests that the characteristics of individuals also matter, if only in explaining why some people rather than others are at greater risk of finding themselves ‘towards the end of the jobs queue’ (Beatty et al., 2009, p. 961) and consequently on benefits. Numerous survey exercises have been conducted with disability benefit claimants in the UK (Kemp and Davidson, 2010; Beatty et al., 2010; Green and Shuttleworth, 2010), so that we know that they are relatively more likely than most people of working age to report barriers to work including:

- low levels of occupational and basic skills (including gaps in literacy and numeracy);
- holding few or no qualifications;
- poor work records with long periods of unemployment or sickness absence;
- work experience concentrated in peripheral sectors characterised by low-paid and unstable job opportunities;
- fewer social networks linked to people in work;
- low household incomes and recurrent experiences of poverty;
- limited or no access to transport.

These problems are significant predictors of claiming benefits in the first place, and are associated with reduced chances of re-entering employment. Accordingly, if we want to help people claiming disability benefits to compete for jobs against people ‘further towards the front of the jobs queue’, then supply-side policies will be required to help improve their employability and skills.

There is little evidence, however, that disability claimants hold particularly negative attitudes towards work, as implied by the notion that the benefits system has produced a ‘dependency culture’—for example, survey work by Beatty et al. (2010) found little evidence of prior knowledge of the benefits system or ‘learned dependency’, and in-depth qualitative interviews with claimants revealed strong latent desires to work being short-circuited by poor health and other obstacles to employment.

The chapters contained within the ‘employability’ strand of this book add to this evidence. Helen Barnes and Paul Sissons (Chapter 5) report the results of more than 3,000 interviews, during which disability claimants described a range of factors limiting their employability, with the weakness of work histories (often due to ill-health) emerging as a key barrier. Like the other authors of this book, Barnes and Sissons refuse to see employability and health as isolated issues, noting that illness and disability in themselves limit the employability of people on benefits. To this end they are sceptical about recent welfare reforms, which were meant to ensure that two groups—the permanently disabled and those who could work with support—were
no longer ‘conflated’ within a single benefits regime (see Beatty et al., 2009 for discussion). Instead, Barnes and Sissons argue that multiple groups can still be identified among disability claimants, ranging from some who are engaged and near work-ready to others living with severe, limiting illness.

Anne Green and Ian Shuttleworth (Chapter 4) report on their survey research with more than 800 disability benefits claimants in Northern Ireland. As well as the sort of employability-related barriers uncovered by previous studies, they note how community divisions can reinforce a sense of spatial isolation for some disability claimants (a reminder that highly specific social and labour market contexts will shape perceptions at the local level). Green and Shuttleworth also find evidence of negative attitudes towards to work among a minority of respondents, but they understand this less as a symptom of a supposed ‘dependency culture’ than a reflection of the very real barriers faced by many who accurately identify their chances of re-employment as severely limited.

A health problem?

One reason for ongoing interest in the high numbers of disability benefit claimants in the UK is that there has not been clear evidence of a corresponding rise in ill-health among the general population. Reviews of the General Household Survey and other national social surveys have found no consistent evidence that health trends predict changes in disability benefit rates (McVicar, 2008). Indeed, claimant disability rose during the 1980s and 1990s at the same time that life expectancy was increasing (Beatty et al., 2009). Furthermore, work by Beatty et al. (2007) on the ‘real level of unemployment’ has used control measures for differences in health among the general population to demonstrate that the spatial inequalities in disability benefit claiming cannot be understood solely as a function of the geography of health. Although industrial districts have higher rates of disability and poor health, it is job loss that has moved disabled people from employment to benefits.

However, policy makers should not conclude that malingering is at the root of the disability benefits problem. Rather, it is important to remember that Beatty et al.’s (2000, 2009) theory of ‘employment, unemployment and sickness’ did not merely identify ‘hidden unemployment’ as a component of rising disability benefit numbers, but also that ‘hidden sickness’ plays a key role – that is, those who claim disability benefits tend to have experienced ill-health while in work, and it is merely that there are fewer opportunities to cope with sickness in the workplace (and fewer jobs in general) in depressed labour markets. Beatty et al. (2009) argue that long-term sickness is widespread throughout the labour market, among those coping in the workplace, the unemployed and those claiming benefits. In ‘full employment’ labour markets, people with health conditions are more likely to sustain their employment, while in depressed labour markets people with
similar ill-health face increased risk of labour market exclusion (Lindsay and Houston, 2011).

There is a substantial evidence base to support this argument. Survey research with disability benefits claimants has found that many left their previous job owing to ill-health (Beatty et al., 2010); most consistently identify health/disability limitations as a key barrier to work (Green and Shuttleworth, 2010); and the number and severity of these limitations has been shown to be a significant predictor of claimants’ chances of returning to employment (Kemp and Davidson, 2010). Analyses of national datasets have demonstrated that ill-health and disability significantly affect long-term employment outcomes (Berthoud, 2011); and clinical professionals providing services for disability claimants have confirmed the presence of a range of work-limiting conditions (Lindsay and Dutton, 2010).

Jon Warren, Kayleigh Garthwaite, and Clare Bambra (Chapter 6) report on in-depth research to confirm as real the health problems faced by disability benefits claimants. Clinical measures (validated in other mental health settings) are used to expose the severity of the psychological and other health problems faced by many, adding to a growing evidence base that spatial health inequalities, and perhaps worsening health as a result of unemployment and deprivation, are important (Bambra, 2011). If we want to understand factors limiting disability claimants’ employability in depressed labour markets, then we must not lose sight of the range and complexity of health problems that explain ‘how they got there’ in the first place.

David Webster, Judith Brown, Ewan B. Macdonald, and Ivan Turok (Chapter 7) acknowledge the need for more detailed population health data if we are to fully understand how place, employability, and wellbeing interact to exclude some people from the labour market. Building on their previous case study research centred on Glasgow in the UK (Webster et al., 2010), they note that both health and labour market inequalities explain the high levels of disability benefits claiming in that city. Responding directly to the remit of the ‘health’ strand of this book, Webster and his colleagues also argue that the experience of long-term labour market exclusion may shape attitudes towards health and disability.

Implications for the policy in the UK

Christina Beatty, Steve Fothergill, and Donald Houston (Chapter 8) then take us full circle by returning to lessons for the current UK welfare reform agenda. They consider an emerging policy agenda that is based on a tightening of eligibility criteria for the new benefit, Employment and Support Allowance; increased compulsory work-related activity; and the introduction of means-testing for those claiming benefits for more than a year. They conclude that the current punitive welfare reform agenda may well achieve the previous government’s target of getting ‘a million people off benefits’
(Beatty and Fothergill, 2012), but that many of these people will not find employment. Instead, the risk of poverty and long-term labour market exclusion will be exacerbated for the least employable, those with complex health problems and people residing in depressed regions.

Some will argue that it is unrealistic for Beatty and colleagues to call for a dramatic recalibration of policy towards integrated health and employment services and demand-side regional economic development. Yet these suggestions should find favour with those who claim to be concerned about delivering value for money in public services. We know that previous ‘Work First’ active labour market programmes have failed to deliver significantly better employment outcomes for people on disability benefits (National Audit Office, 2010). If imposing compulsory ‘Work First’ activation on a client group facing complex barriers to work has been shown to offer poor value for money, then policy makers need to consider the evidence on the true nature of the problems faced by those trapped on disability benefits in order to identify effective solutions.

The need for interdisciplinary and cross-national research

Another way to seek a deeper understanding of the UK’s disability benefits crisis is to examine experiences in other welfare states. The chapters contributed to this book by experts on the situation in Germany, Sweden, The Netherlands and New Zealand highlight some similarities with the problems faced by UK policy makers, but also how distinctive welfare state and labour market features shape different experiences. Martin Brussig and Matthias Knuth (Chapter 9) note that there is no direct equivalent of the UK crisis in Germany, where the numbers on long-term disability benefits remain low by comparison, reflecting strict gatekeeping rules that restrict access to payments, and that social assistance is paid at a level that is relatively unattractive for claimants. Yet there are similarities with the UK, in terms of a substantial problem of ill-health and disability among those claiming unemployment benefits, an increased risk of poverty among these individuals, and spatial inequalities limiting labour market opportunities for some. Germany is arguably leaning towards an increasingly ‘Work First’-type model of active labour market policy, again suggesting some shared thinking with the UK. However, Brussig and Knuth describe a more sophisticated understanding of variations in individuals’ work capacities, with health assessments seeking to capture whether claimants are capable of full-time, part-time or no work at all.

Some similar and distinctive themes emerge from Rickard Ulmestig’s discussion of the situation in Sweden (Chapter 10). Once again, the problem is less ‘unemployment hidden as sickness’ than that many people with health problems have found themselves directed towards an activating employability regime in order to restrict access to disability benefits, in
Ulmestig’s words ‘without any visible change in capacity for work’. Recent attempts to reduce Swedish disability claiming may reflect legitimate concerns that these benefits had become an early retirement tool for older workers, and Rik van Berkel identifies similar issues underlying the welfare reform agenda in the Netherlands (Chapter 11).

From the 1990s into the 2000s, the Dutch disability benefits crisis was seen as being more severe than the UK’s. For van Berkel, there was clear evidence that government and social partners were complicit in using disability benefits to mitigate the social consequences of job losses during this period. Policy responses that have since stemmed the flow on to benefits share some similarities with the UK welfare reform agenda – eligibility requirements have been tightened; health assessments made more stringent; and the 2006 WIA reform (presaging the UK’s Employment and Support Allowance) created dichotomous groups judged permanently disabled and fit for activation. However, an important lesson from the Netherlands is that part of the solution has involved placing additional requirements on employers, who are responsible for providing sick pay for, and the reintegration of, many employees reporting health and disability problems.

Neil Lunt and Daniel Horsfall’s chapter on New Zealand (Chapter 12) identifies striking commonalities with the UK policy agenda on disability benefits. The seemingly contradictory themes of empowering individuals with health/disability limitations while also increasing conditionality and activation in the welfare state were common to the ‘Third Way’ (UK) and ‘social development’ (New Zealand) reform agendas of the early 2000s. Like the UK, New Zealand has more recently seen a shift away from a more progressive policy agenda, with a greater focus on restricting access to benefits through stricter capability assessments and an ‘end to macro-level ambitions’ to improve job availability for all citizens.

Towards an evidence-based welfare reform agenda

There is a need for better-informed policy and a commitment to use the evidence in order to avoid the mistakes of the past. Indeed, elsewhere we have discussed how weak and inappropriate policy responses have contributed to – or at the very least exacerbated – the disability benefits crises experienced by the UK and other countries (Lindsay and Houston, 2011).

The authors gathered for this publication are drawn from the disciplines of economic geography, social policy, sociology, occupational medicine, and public health studies. We have come together in order to share evidence from across different labour market and welfare state contexts, and to attempt to move towards an interdisciplinary approach to understanding the problems faced by those on disability benefits for long periods. Crucially, we want to move the debate beyond simplistic constructions of a disability benefits crisis rooted in a mythical dependency culture and a supposedly passive...
welfare system. Our reading of the evidence is that the disability benefits crisis can only be understood as a function of the interaction of labour market, employability, and health problems. The chapters that follow present evidence on how these factors contribute to the disadvantage experienced by those on disability benefits, and lead us towards an understanding of ‘what’s needed’ in terms of policies to facilitate sustainable transitions from welfare-to-work.

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