

ASSESSING THE EVIDENCE BASE ON HEALTH, EMPLOYABILITY AND THE LABOUR MARKET: LESSONS FOR ACTIVATION IN THE UK

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Abstract

This article draws on the research of authors participating in this Special Issue, as well as a broader evidence review on how health, disability, labour market inequalities and other factors contribute to high levels of benefit claiming among certain communities. We argue that the evidence points to a complex combination of factors feeding into high levels of disability benefits claiming in the UK and beyond, namely: concentrations of health problems and disability-related barriers; gaps in the employability and skills among certain disadvantaged groups; and labour market inequalities that limit the quantity and quality of work opportunities for people with health and disability-related limitations in some regions. The article then provides a comparative, critical commentary on the evolution of activation and welfare reform policies in the UK and Denmark. Specifically, we discuss the extent to which emerging active labour market policies, occupational health services and changes to the benefit system in both countries reflect the evidence on the nature of the barriers faced by people on disability benefits. The article concludes by identifying recommendations for health, employment and labour market policies.

Keywords: incapacity; disability; UK welfare reform; Denmark; activation

Introduction

Despite recent attempts by UK policy makers to restrict access to incapacity and disability benefits (hereafter DB), the numbers claiming remain high by historical terms, with approximately 2.5 million people receiving these forms of income support in 2014. Neither the UK, nor liberal welfare states in general, are unusual in facing persistently high levels of DB claiming (although disability claim rates in other than liberal welfare systems such as the US are also higher than the OECD average) (OECD 2010). Rather, above average levels of disability claiming have also been reported in Nordic welfare states like Sweden and continental welfare regimes such as the Netherlands (Lindsay and Houston 2013).

The need for policy action to assist people on DBs is not disputed. Spending long periods on these benefits has been associated with further deteriorations in health (Bambra 2011); the meagreness of payment rates in countries like the UK means that claimants experience increased poverty risks (Kemp and Davidson 2010); exclusion from work may undermine individuals' employability (Shuttleworth and Green 2011); and, given the context of an ageing labour force, there is a more general need for interventions that will assist people to manage health problems in the workplace rather than exiting to long-term welfare dependency (Vickerstaff *et al.* 2011). However, there remain concerns that current policy agendas are not equal to the task of moving large numbers of people from DBs into sustainable employment. Indeed, the main focus of UK Government policy appears to be on restricting access to DBs by tightening eligibility criteria and means-testing, with little sign of a coherent strategy to enhance the employability and health of those already on benefits (other than directing claimants to a generic, compulsory activation programme – The Work Programme – or other forms of 'work-related activity') (Lindsay and Houston 2013).

This article seeks to offer advice on more productive foci for welfare reform and activation policies. We do this by: reviewing the latest evidence on the ‘nature of the problem’ (i.e. the factors contributing to high levels of DBs among some groups and communities); analysing the appropriateness of current and recent policies in responding to these factors; and (briefly) contrasting the UK’s approach with that of Denmark, which has deployed a different set of policy instruments in its efforts to reduce DB numbers. In order to conduct this analysis of the nature of the problem and evaluation of policy solutions, we carried out a structured literature review identifying the most robust evidence from both academic sources and policy stakeholders. The reliability of this approach was strengthened by its coverage of research from a range of disciplines (reflecting the multi-disciplinary expertise of the authors) including: economic geography; social policy; clinical psychology; and public health policy analysis. The findings of our analysis are presented below. The analysis also draws on the latest research published elsewhere in this Special Issue of *Social Policy & Administration*. The article then concludes with a discussion of implications for future policy development.

Assessing the evidence base: factors behind concentrations of disability claiming

As noted above, over the past decade, successive UK Governments have deployed *relatively* consistent policies to address high levels of DB claiming. Much of the focus of policy has been on restricting access to, and increasing the conditionality associated with, welfare benefits, along with a greater emphasis on activation, first under the Pathways to Work initiative (2003-10) and now the Work Programme, the main activation programme for people of working age. However, it has been suggested that the general thrust of policy fails to reflect the complex combination of factors that explain concentrations of DB claiming

(Beatty *et al.* 2009). Following Lindsay and Houston's (2013) line of argument, we now assess the latest evidence on the extent to which three key issues can be identified as underlying the high level of disability benefits claiming in the UK, namely: concentrations of health and disability-related barriers among the claimant group; gaps in their employability and skills; and labour market inequalities and the impact of low quality work on opportunities for people with health and disability-related limitations. We will then go on to discuss the failure of policy makers to develop joined-up, spatially-focused solutions to these problems.

Health and disability-related barriers

One of the distinctive features of the discourse around disability benefits in the UK is policy makers' reluctance to fully acknowledge that those claiming these benefits are indeed sick or disabled. Policy makers have partly sought to justify this position with reference to a well-established evidence base suggesting that industrial restructuring and job destruction in regions dependent on traditional employment sectors preceded increases in DB claiming. Seminal works during the mid-1990s by Beatty and Fothergill (1994), Green (1994) and Webster (1997) identified concentrations of DB growth in post-industrial labour markets, suggesting that Incapacity Benefit (IB, then the main disability benefit in the UK) was absorbing displaced workers and hiding the real level of unemployment. These authors wished to expose the 'hidden unemployment' problem in order to demonstrate the need for regional demand-side stimulus policies to generate more job opportunities for those trapped on benefits (Beatty and Fothergill 2005), but their argument has been appropriated by the political right as evidence of malingering among claimants (Centre for Social Justice 2009).

Yet this is a misrepresentation of both the evidence and the argument. Indeed, Beatty *et al.*'s (2000, 2009) seminal 'theory of employment, unemployment and sickness' hypothesized that

‘hidden sickness’ was as important as ‘hidden unemployment’ in explaining high disability claiming in some regions. They argued that there is substantial ill-health and work-limiting disability throughout the labour force – among those in work, job seekers who are available for work, and those receiving DBs. Labour market conditions decide whether those with health or disability-related barriers are able to find their way into work (due to employers’ willingness to adjust their demands in tight labour markets) and manage their conditions in the workplace. But this need not lead us to conclude those on DBs are feigning illness.

Rather, there is substantial evidence as to the reality of the health and disability-related problems faced by people claiming DBs. Targeted survey exercises have found that ill-health or limiting disability was the reason that most DB claimants left work in the first place; and that health problems are perceived to be a key barrier to work (Beatty *et al.* 2010; Kemp and Davidson 2010). Longitudinal surveys with claimants have found that those with multiple and/or more serious conditions are significantly more likely to be ‘permanently sick’ (i.e. remain on benefits); while those with fewer conditions are more likely to find work (Sissons and Barnes 2013). For those re-entering, but failing to sustain, work following a period on DB, a further decline in health has been identified as a common problem (Dixon and Warrener 2009). Large-scale national population surveys such as the British Household Panel Survey (BHPS) suggest long-term relationships between health and labour market status (Jones *et al.* 2010); and that ill-health is a predictor of exits to long-term DB (Disney *et al.* 2006). Analyses of national health surveys have identified a significant relationship between DB claiming and mortality (Bambra 2011). NHS professionals working with DB claimants confirm evidence of a range of health problems and disabilities (Lindsay and Dutton 2013). These NHS specialists and other health service providers have used well-established, clinically robust measures to identify health problems among the DB group, and

to register improvements following condition management interventions (Kellett *et al.* 2011). Other researchers have similarly used accepted clinical tools (such as the ‘Hospital Anxiety and Depression Scale’) to identify significantly poorer health among the DB claimant population that is resistant to increasing exposure to conditionality and/or ‘incentives’ as part of changes to the benefits system (Garthwaite *et al.* 2014). In summary, there is powerful evidence that health and disability-related limitations reported by those on DBs are real. As we will confirm below, other factors – and crucially the nature and extent of labour demand – tend to define whether such health and disability-related barriers can be managed in the workplace, or alternatively exclude people from the world of work.

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Employability-related barriers

We have seen above that, contrary to some policy makers’ claims, health and disability-related barriers are key to understanding the nature of the DB problem. Yet, successive UK Governments have been keener to portray the problem as rooted in the attitudes and behaviour of those claiming benefits. As we will see below, increased conditionality and compulsion in the DB system appear to reflect a consensus among policy makers on the need to use financial incentives and punitive sanctions ‘to generate positive behavioural effects’ (DWP 2010: 10).

Yet the evidence on the existence of a ‘dependency culture’ among DB claimants is limited. Beatty *et al.*’s (2010) extensive survey research with DB claimants deployed a raft of attitudinal questions to tease out negative views around work, but instead found little

evidence of abnormally low levels of work commitment. Nor were DB claimants expert in ‘playing the system’ (i.e. particularly knowledgeable about benefit regulations). These findings add to a long-established evidence base that contradicts rhetoric about individual claimants choosing to live on benefits (Dean and Taylor-Gooby 1992) and popular myths about families defined by multiple generations of worklessness (Shildrick *et al.* 2012).

Rather, evidence from in-depth research with DB claimants finds that many report recurring poverty and insecurity when struggling to cope on benefits, while their experiences of the benefits system (and especially increasing conditionality) tend to be defined by stigma and distress (Garthwaite 2013).

That said, people on DBs tend to demonstrate a variety of views about work. Green and Shuttleworth’s (2013) attitudinal research with DB claimants found that a range of factors (most notably age and health) shaped people’s optimism and level of commitment to work. Kemp and Davidson’s (2010) longitudinal research similarly identified differences in levels of work commitment among the DB group, although other variables related to health and employability were more powerful predictors of individuals’ chances of returning to the labour market. Webster *et al.* (2013) argue that individuals’ perceptions of the severity of health limitations and regarding the state of the local labour market tend to be interconnected, and negative views can be mutually reinforcing, producing pessimistic self-evaluations of both health and employability.

So attitudes to work vary considerably – it’s just that there is limited evidence that individual motivation or commitment are decisive in explaining the labour market exclusion experienced by those on DBs (Kemp and Davidson 2010). Nevertheless, there is stronger evidence that long-term DB claimants face a complex range of other employability-related

barriers to work. Extensive survey work with those on DBs demonstrates that they are significantly more likely to report: basic skills problems; low levels of qualification; gaps in work experience and repeated periods of unemployment; limited social network ties to those in work; and barriers in accessing transport (Kemp and Davidson 2009, 2010; Beatty *et al.* 2010, 2013; Barnes and Hudson 2013). Such combinations of employability-related barriers are common among people excluded from the labour market, and call for holistic activation programmes that are flexible in addressing the complex problems faced by disadvantaged groups.

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Labour market barriers

Successive UK governments have been reluctant to acknowledge the spatial labour market inequalities that clearly shape the nature of the DB problem. As a result, governments have favoured ‘a nationwide, supply-side strategy’ (Little 2009: 877) over local and regional policies that reflect the differences in demand across labour markets. Yet, the evidence suggests that labour market inequalities are fundamental to explaining why people in certain communities are more likely to find themselves trapped on DBs. As noted above, Beatty *et al.* (2000, 2009, 2010, 2013) have amassed a compelling evidence base demonstrating that DB claiming is concentrated in those regional labour markets that experienced large-scale job destruction following industrial restructuring. For example, in post-industrial cities, processes of job destruction associated with the decline of manufacturing were never fully reversed during the ‘long boom’ of the 1990s and 2000s, which produced uneven growth, often in casualized and low-paid service work (Webster *et al.* 2013). Lindsay and Houston (2011:

707) have similarly mapped DB claiming (before and after the ESA reform in the UK) concluding that ‘the map of claim rates corresponds to areas of former industrial decline’. Put simply, there is nothing particularly distinctive about DB claimants in post-industrial labour markets, there just many more of them (Webster *et al.* 2010); and this can be explained by the fact that there are not enough jobs to absorb people who otherwise might be able to cope with their health conditions in the workplace. Elsewhere, in tight, ‘full employment’ labour markets where demand is strong, employers are required to adapt their expectations and people with health and disability-related limitations are more likely to be absorbed into the world of work (Beatty *et al.* 2013).

Employers and jobs may be of broader importance in understanding the DB problem. First, employers’ willingness to make adjustments to acknowledge health limitations – such as altering job content or work environment, or allowing changes to working hours or phased returns to work – can be crucial in facilitating re-integration for people on DBs (Kemp and Davidson 2010). Within the workplace, support from line managers has proved important in sustaining successful transitions from DB (Irvine 2008). Claimants regularly cite the identification of a ‘sympathetic employer’ as being central to their plans to return to work (Green and Shuttleworth 2010: 234). However, such support and willingness to make adjustments can be rare – instead, employers sometimes appear to target those with health limitations for redundancy (Easterlow and Smith 2003). Increasingly aggressive absence management policies can also exacerbate health problems among existing employees, while militating against a culture of adjustment and inclusiveness that might assist returners-to-work (Taylor *et al.* 2010).

Furthermore, the nature and quality of jobs may negatively impact on the opportunities open to people with health and disability-related limitations. As noted above, post-industrial labour markets may not have enough jobs to absorb people with health problems who could nevertheless manage some work. But the low quality of jobs in these labour markets may also contribute to the DB problem and throw up barriers to work for claimants. For example, exits to DBs are likely to be more common in labour markets dominated by casualized and short-term employment, where employers can more easily ‘manage out’ employees with health problems (Little 2009). More specifically, underemployment (where employees are unable to secure sufficient hours or pay) seems to feed into the DB problem. Low-paid, part-time employees whose wages fail to meet the minimum National Insurance threshold are not eligible for employer-paid Statutory Sick Pay, and are therefore more likely to leave work to claim DBs. For people at the bottom end of a polarized labour market, the benefits system is therefore ‘working as a functional equivalent of sick pay’ (Kemp and Davidson 2009: 598).

The nature of the working life in poor quality jobs may also be relevant. Claims that low-paid, entry level positions remain a stepping stone to better jobs appear contradicted by widespread ‘cycling’ between work and repeated benefit claiming (McCollum 2012). Finally, in workplaces that are intensified and ‘Lean’, or where employees have little control over the standard operating procedures that define how and where they work, there may be less scope to manage health issues (Carter *et al.* 2013). Baumberg’s (2014) research – modelling a combination of health variables drawn from the BHPS and job content data from skills surveys – presents compelling evidence that a decreasing sense of control among employees over the past two decades has contributed to ill health and even higher levels of disability claiming. As Andreassen (2013: 389) notes, such jobs ‘oblige employees to be subjected to working regimes that make demands on when, where, with whom and with which standards

the work tasks have to be performed. Employable workers must live up to culturally and socially defined norms of appropriate behaviour and appearance... Assessing work capacity in a narrow sense of the term omits the labour market's many social and cultural demands which construe people as employable or not'. There are few spatial studies quantifying the impact of changing quality across different regional economies, but we might hypothesize that the dominance of low quality jobs in post-industrial labour markets (Shildrick *et al.* 2012) could be an additional factor contributing to concentrations of DB. As Patrick (2012: 313) concludes, sick and disabled people seeking to return to work 'face a range of demand-side barriers, including the impact of stigma and discrimination, physical challenges around access and transport, and issues around the availability of suitably flexible job opportunities'. Our review of evidence of above adds substantially to this final point, demonstrating that the labour market inequalities – reflected in spatial differences in both the quantity and the quality of jobs – may be crucial in shaping individuals' capacity to cope with health problems or disability in the workplace.

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In summary, a review of the most recent literature, including research presented elsewhere in this Special Issue, adds to the evidence that a complex combination of factors have combined to produce concentrations of DB claiming in disadvantaged labour markets and communities. Some of these factors reflect individual barriers, but there is little evidence that these can be simplified into a dependency culture that can be addressed through punitive welfare reforms or behavioural interventions. Rather, a combination of health/disability limitations and employability-related barriers to work combine to leave some people at the back of the queue

for jobs (Beatty *et al.* 2009). This disadvantage is exacerbated in post-industrial labour markets where there are not enough opportunities, and where the jobs that are available represent a difficult context within which to manage health conditions (and in some cases may contribute to ill health). A coherent strategy to provide routes into sustainable employment for people on DBs will therefore require: a range of employability-related services to provide learning and development opportunities; integrated condition management provision to assist claimants to cope with health and disability-related limitations; and spatially-focused economic development and workplace strategies designed to ensure that there are viable job opportunities for those leaving welfare to enter work. As we will see below, the current UK policy agenda falls well short of meeting these demands.

Assessing the policy agenda: welfare-to-work for people on disability benefits in the UK and lessons from abroad

Current policy in the UK

To what extent is the evidence presented above reflected in the UK policy agenda on helping people from disability benefits into work? The current policy agenda demonstrates clear continuity with work-first approaches to activation. Within such approaches, the nature of the problem is seen as mainly rooted in the individual's attitudes and behaviour, with the logical conclusion that strengthening conditionality and compulsory activation can affect positive change in and for the individual (Lindsay and Dutton 2013). This 'behaviourist' logic has become more pronounced under the 2010-15 Coalition Government in the UK. Thus, for UK policy makers 'low jobseeking expectations can affect outcomes... partly driven by the expectations imposed by the benefits that respondents [are] claiming' (DWP 2013: 67) – i.e.

it is assumed that compelling people to engage in work-related activity will produce job outcomes.

Much of the policy of successive governments in the past decade has focused on increasing conditionality and restricting access to benefits (Harris and Rahilly 2011). The replacement of ‘Incapacity Benefit’ with ‘Employment Support Allowance’ (ESA) as the main DB for new claimants from 2008 reflected these priorities. The ESA reform restricted access to the most generous benefit replacement rates to only those assessed as facing severe health/disability barriers, who are placed into a ‘Support Group’. Those assessed as less disadvantaged are placed into a ‘Work-related Activity Group’ where receipt of ESA is conditional on engaging in work-focused interviews and other activation provision (see discussion below). Unlike its predecessor Incapacity Benefit, ESA’s contributions-based benefit is also limited to one year for the Work-related Activity Group. Those still claiming ESA after this time duration are required to transfer to a means-tested version of the benefit (meaning that those with other sources of household income will be denied payment).

Central to the ESA reform was the establishment of a stricter medical assessment – the Work Capability Assessment (WCA) – as a means of determining benefit entitlement. The WCA was introduced for all new ESA claimants by the Labour Government. The Conservative-led Coalition Government then committed to re-assessing all existing benefit recipients from 2011; and there is also the expectation that all ESA claimants will be repeatedly re-assessed within two years (whereas previously Incapacity Benefit claimants often reported several years between benefit eligibility assessments) (Harris and Rahilly 2011). As noted above, the WCA has been designed to separate the most disadvantaged, who are directed to the Support Group and receive DBs without condition, from those who might be able to make progress

towards employment and are subject to compulsory activation – the Work-related Activity Group.

The measures of disability and work capacity deployed in the WCA process specifically sought to ‘raise the bar’ in order to restrict access to benefits (for a detailed discussion of WCA content and scoring, see Harris and Rahilly 2011). Government clearly communicated that its expectation was that only a small minority of claimants should be directed towards the unconditional Support Group, and in its first year of operation the WCA found only 10% of claimants to be so sick or disabled as to justify this status; 24% of claimants were directed to the Work-related Activity Group; and 66% were judged fit for work and denied ESA.

Initial independent reviews confirmed the inadequacy of the WCA process, which was assessed as ‘mechanistic’, ‘lacking empathy’ and impractical in attempting to capture the impacts of many chronic and/or mental health conditions (Harrington 2010: 31). These problems were exacerbated when the 2010 Coalition Government eliminated a ‘work-focused health-related assessment’ element of the WCA (a battery of questions designed to provide a realistic evaluation of the work that claimants might be capable of, and the workplace adjustments that they might require) (HoC 2013). Both Jobcentre and Work Programme staff have reported that people with very severe (indeed, sometimes terminal) health conditions have been directed towards work-related activity by WCA assessors (Harris and Rahilly 2011). Many claimants have been able to reverse WCA decisions on appeal (Patrick 2012). More recent data suggests that the WCA is being applied more sensitively – probably in response to the high numbers of successful appeals – in the first quarter of 2013, for example, approximately two-fifths of completed WCAs directed claimants to the Support Group.

The second, inter-connected element of the current UK model involves extending the reach of compulsory activation to many of those on DBs. The first major activation programme targeting disability claimants was 'Pathways to Work' (PtW), piloted by the Labour Government from 2003 and rolled out fully by 2008. The initiative was initially led by Jobcentre Plus, with health-oriented condition management services organized by National Health Service (NHS) organizations. As PtW was rolled out nationally, leadership of the initiative was contracted out to (mainly private sector) 'Lead Providers' in most regions, which quickly saw health condition management marginalized within the programme content (Lindsay and Dutton 2012). The main content of PtW instead centred on five compulsory work-focused interviews that claimants were required to undergo with Jobcentre Plus or Lead Provider personal advisers; and a range of voluntary work preparation programmes based on existing 'work-first' activation provision (Grant 2013). Attendance at work-focused interviews was enforced by the threat of benefit sanctions. As noted above, an NHS-led health 'condition management programme' was initially promoted as a key feature of PtW (at least in those areas where Jobcentre Plus led the initiative), but take-up of the programme was low and DWP officials wound-up these services on the grounds that they were not cost-effective in assisting people into work (DWP 2012), a peculiar criticism given that the condition management programme was never charged with achieving job entries for its participants (Lindsay and Dutton 2013). Condition management provision was more fragmented in those areas where PtW was led by contracted providers, which were not required to work with NHS organizations to develop health-focused interventions (Grant 2013). Overall, the outcomes delivered by PtW were disappointing, with no significant employment effect associated with claimants' participation (NAO 2010).

From 2011, PtW and all other UK Government activation programmes were amalgamated within the Work Programme. The Work Programme's content varies across areas. A 'black box' funding model affords Prime Contractors considerable autonomy in shaping services, although a payment-by-results regime that offers limited up-front funding means that there is an incentive to target 'quick wins' through work-first interventions (such as short, relatively inexpensive motivational and job search courses). Accordingly, there is substantial evidence of 'creaming and parking' among Work Programme activation providers charged with improving the employability of those on DBs (HoC 2013). The meagre health-focused provision supported under PtW appears to have been further marginalized, with few Work Programme providers prioritising condition management services (Ceolta-Smith 2014 in this volume). The severity of the barriers faced by many disability claimants, the inadequate and inappropriate funding model for the Work Programme, and the resulting 'parking' of those with health/disability-related limitations, help to explain the disappointing job outcome figures achieved by the programme for people on ESA (Rees *et al.* 2014).

It is important to note that compulsion and conditionality remain crucial components of the Work Programme's interaction with the sick and disabled (and also defines other work-related activities that can be demanded of ESA claimants). Failure to engage in work-related activity required by Work Programme providers can result in a loss of benefits for four weeks for a first offence, rising to thirteen weeks for repeated non-compliance (HoC 2013). There is evidence that personal advisers working for both Jobcentre Plus and Work Programme providers have been reluctant to report 'misbehaviour' that would result in benefit sanctions – these street-level professionals appear to be aware of both the vulnerability of many DB claimants, and that sanctioning is likely to undermine attempts to build a relationship of trust between claimant and adviser (Barnes *et al.* 2010). Consequently, under both the Work

Programme and its predecessor PtW, sanction rates have been relatively low (Grant 2013). However, inadequate expertise and information exchange between Jobcentre Plus and Work Programme providers (along with the vagaries of the WCA process) continues to see inappropriate sanctioning of vulnerable sick and disabled people (HoC 2013).

In summary, a narrow work-first focus defines current activation strategies for people on DBs. Policy makers remain reluctant to programme health provision as a central element of their approach, despite evidence as to the substantial health and disability-related limitations faced by claimants. Nor is there evidence of government interest in the role of employers – or the broader nature, level and location of labour demand – in shaping the disability benefits problem. It is perhaps unsurprising then that the outcomes produced by the UK Government’s focus on conditionality and activation have been disappointing. As noted above, while increasing the conditions required both to access and receive benefits may reduce on-flow, there will be no progress in terms of improving people’s employability or health. Yet we know from the review of evidence above, and analyses of the characteristics of returners-to-work, that improving employability and health are both key to positive transitions for DB claimants, and that labour market and workplace factors define the opportunities available to them (Sissons and Barnes 2013). We now turn to evidence from a very different welfare state – Denmark – in an attempt to identify any lessons that can be learned from its policy and practice in seeking to assist the sick and disabled from welfare to work.

Lessons from abroad: current policy in Denmark

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WORK-FIRST/CONDITIONALITY-FOCUSED MODEL IN THE UK?

Discussion and conclusions

Our review above confirms the disconnect between the evidence on the nature of the disability benefits ‘problem’ and an increasingly narrow and behaviourist policy agenda under successive UK governments. Policy makers have taken the easy option of presenting high numbers of people on DB as a problem of individuals’ attitudes and behaviours, leading to a logical conclusion of increasing conditionality in the benefits system and compulsory activation. The 2010-15 Coalition Government in particular has appropriated and misrepresented the debate on hidden unemployment in post-industrial labour markets in an attempt to manufacture evidence of malingering. A fair review of the evidence points to a different and messier reality. People trapped on DBs for long periods often face substantial health problems and disability-related limitations, which explain why they left the workplace, shape their attitudes towards work, and predict trajectories in and out of employment. Many of the same people also report employability-related barriers, ranging from gaps in basic skills to isolation from social networks. And crucially, the geography of labour markets defines the opportunities open to DB claimants facing a combination of health and employability-related barriers. Such people will inevitably be at the back of the queue for jobs, but their disadvantage is accentuated in post-industrial labour markets where the employment destroyed during the 1980s and 1990s has never been fully replaced, and where the jobs that are available are characterized by casualization and insecurity, low-pay, work intensification and low control. There are fewer jobs; the jobs that are available are not the sort that allow people to manage health conditions in the workplace; and the low quality of work may instead be contributing to concentrations of ill health. These factors are crucial to explaining much higher levels of DB claiming (even after controlling for area-based health inequalities) in depressed labour markets.

The preceding literature and evidence review can be seen as largely confirmatory, adding to the analyses presented in previous multi-sourced reviews of research (see, for example, Beatty *et al.* 2009; Houston and Lindsay 2010; Bambra 2011; Lindsay and Houston 2011). However, while our discussion specifically draws upon and confirms the analysis provided by, for example, Lindsay and Houston (2013), there are areas where this article – and much of the evidence presented elsewhere in this Special Issue – offer new insights. First, in this article and elsewhere in this volume, authors have broadened the multi-disciplinary approach to researching the nature of disability claiming and potential policy solutions. For example, we have drawn attention to robust clinical studies that have identified both significant health barriers among those on DBs (Kellett *et al.* 2011; Garthwaite *et al.* 2014) and apparent progress following well-evidenced clinical interventions (see Kellett *et al.* 2014 in this volume). Elsewhere, we have sought to highlight a broader evidence base on how the workplace and labour market shape opportunities and barriers for people on DBs (Baumberg 2014; Beatty and Fothergill 2014 in this volume).

We have also sought to link this updated and expanded discussion of the ‘nature of the problem’ to a sharply critical evaluation of the current UK policy agenda. We have argued that there is a disconnect between the multi-faceted complexity of the DB problem and the rationale and content of UK policy, which is rooted in a behaviourist logic and largely relies upon a combination of increased conditionality and work-first activation. Such approaches might reduce on-flow in the short-term – it is self-evident that any determined effort to enhance regulation to restrict benefit-claiming will reduce the number of successful claims. Indeed, policy makers’ justification of their welfare reform and activation agendas tend to rest upon such tautologies. Policies are seen as working where new conditions have limited

access to welfare benefits or, for example, where a strengthening of compulsion has indeed produced more of the compulsory activity. Accordingly, for policy makers, using the WCA to restrict access to disability benefits and instead direct people to JSA is justified by the following redundancy: ‘disabled people claiming JSA, which requires claimants to look for work, are much more likely to look for work’ (DWP 2013: 67).

But it is difficult to see how such policies have any relevance to improving the long-term employability and health (or mitigating the disability-related limitations) of people on DBs. It is therefore unsurprising that job outcomes for people on ESA have been disappointing under the Work Programme, as they were for Incapacity Benefit claimants under PtW. More generally, after almost twenty years of compulsion, conditionality and work-first (*and little else*) in the content of UK activation policy, the geographical concentrations of the benefit claiming, the people affected, and the barriers that they face, remain largely unchanged.

Finally, we have seen that alternative policy approaches are possible. Denmark has grappled with its own disability benefits problem, but has adopted very different policy responses, rooted in a more sophisticated measure of work capacity, a stronger role for human capital-oriented activation, and collaboration with employers to facilitate adjustments in the workplace and/or job content. The continuing high levels of claiming in parts of Denmark highlight the limitations of any supply-side policy in addressing the complex combination of issues that trap people on benefits for long periods. However, there are principles in the Danish model – especially the engagement of employers as full partners in assisting people to make transitions from welfare to work – that would appear to be of value in the UK context.

A number of lessons for policy are discernable from the preceding discussion. If individuals are to be assisted into sustainable employment (rather than merely prevented from claiming benefits) there is a need for well-funded, targeted activation programmes that are flexible enough to deal with the range of employability-related barriers faced by people on DBs. Arriving at a more holistic, evidence-based approach to addressing employability-related barriers will need UK policy makers to grow out of their fixation with narrow, behaviourist approaches to ‘incentivising’ claimants to return to work. As we note above, individuals’ attitudes and motivations around work vary considerably, and there is a case to be made for interventions that seek to improve the self-efficacy of people on DBs (Fear 2009). But the evidence suggests that such factors are an important, but far from crucial, element in the disadvantage experienced by people on DBs. A supply-side policy agenda that relies almost entirely on benefit sanctions, harsh conditionality and work-first activation is not fit for purpose (Lindsay and Houston 2013). Meanwhile, current policies to limit benefit uprating and increase the reach of means-testing are less likely to incentivize job seeking than to increase the risk of poverty among claimants (Beatty and Fothergill 2014 in this volume) and so further undermine their employability.

People claiming DBs face a range of health and disability-related barriers, which vary in their complexity and severity. Accordingly, there is a need to retain a system that separates out a ‘work-related activity group’ who can be helped towards a return to work, from those facing the most severe barriers. The establishment of this distinction under ESA was positive in eliminating a system that previously ‘conflated two groups – those whose health problems so severe that they would remain on sickness benefits in all circumstances and those who would have been able to work if suitable jobs had been available’ (Beatty and Fothergill 2005: 844). However, the UK can learn from many other EU states, including Denmark, which use more

sophisticated measures of work capacity (rather than the UK's simplistic WCA) to identify both barriers and capabilities. Better quality capability measurement can help to inform both health-focused condition management programmes and workplace adjustments that will be needed if we are to assist people to move from welfare to work. Clearly, any assessment of work capacity needs to be based on robust clinical measurement rather than pre-set government targets for removing people for benefits (Harris and Rahilly 2011). Most importantly, policy makers must accept that the vast majority of DB claimants face health and disability-related barriers, and that condition management support and occupational health services will be an essential element in helping people to cope with these limitations in the workplace.

There is also a need for health and employability provision to be joined-up with policies to address the labour market and workplace aspects of the DB problem. Inequalities in the quality and availability of work are crucial to explaining the concentration of DB claiming in post-industrial regions. Demand-side interventions that promote jobs growth will therefore be required to address these inequalities. A further contribution of this article, and others in this Special Issue, is to emphasize the need for workplace interventions. Too many of the jobs that are seen as appropriate destinations for people leaving DBs are in fact defined by content and conditions that are uncondusive to managing health and disability limitations at work.

There is a need for renewed a partnership between the state and employers – the state should incentivize adjustments to the work environment and job content that might facilitate returns-to-work for people on DBs; employers need to play a proactive role in identifying potential adjustments and creating a management culture that assists the re-integration of those managing health conditions or disabilities. Some may claim that this suggestion makes unrealistic demands of employers, but the regional variations in DB numbers are partly

explained by the manner in which recruiters in tight labour markets *are already* making informal adjustments to their expectations and job demands. In ‘full employment’ regions, employers are more likely to recruit people with health or disability-related barriers given the absence of ‘slack’ in local labour markets (i.e. where nobody else is available, employers are forced to adjust their demands to facilitate the employment of people with health conditions or disabilities). Policy makers should engage with employers to formalize and transfer a culture of flexibility and adjustment across all labour markets and workplaces.

None of the critics of current UK policy advocate doing nothing to activate those on DBs who could potentially return to work. For Bambra and Smith (2010: 76) ‘more passive approaches have often exacerbated the labour market exclusion experienced by people with a disability or chronic illness’. Similarly, Beatty *et al.* (2009: 718) criticize the policy inertia of the 1980s and 1990s that saw all stakeholders ‘turn a blind eye to the scale of the issue’. There is a clear need for policy action. Increasing conditionality and means-testing, and compelling DB claimants to participate in work-first activation, may discourage some from claiming benefits – the ‘deterrence effect’ often celebrated by work-first advocates (for discussion, see Daguerre and Etherington 2009) – but these measures are unlikely to produce long-term improvements in employability or health. We believe that our review of evidence above, lessons from countries like Denmark, and the findings of research presented elsewhere in this Special Issue, point to the need for a different approach. A renewed commitment to evidence-based policy in this area would produce holistic strategies to address health, employability and labour market-related barriers – the complex and inter-connected factors that explain why too many people in the UK remain trapped on long-term disability benefits.

References

To be added.