

Green Paper: A New Deal for Welfare: empowering people to work. 2006

An independent assessment of the arguments for proposed
Incapacity Benefit reform

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Foreword: this paper arises from curiosity and concern that the Green Paper on Incapacity Benefit reform should apparently have so little to say - virtually nothing, in fact - about the medical conditions that drive people to claim this benefit and to live on it, in many cases, for long periods or even for life. In the lead-up to the Green Paper and its publication on 24 January 2006, the media had a field-day at the expense of those enduring illness and disability, conveying the impression that, paraplegics and suchlike excepted, they were scroungers living at public expense. Comment both in Parliament and the press was almost all in favour of the proposals: an anomaly was being cleared up, a haemorrhage of public funds staunched, and the workshy sick given their deserts. The mismatch between this and my personal experience of severe, long-term illness within my own family led me first to look into the reportedly successful 'Pathways to Work' which are to be extended nationwide by 2008. Seeing the weakness of the evidence for their successs, I was then curious to look into the body of research and theory on which the Green Paper is based, which is used to validate its proposals. As I am retired, I have the leisure to do this, as well as some professional expertise in social research. I appreciate that few people would be able to make this much investment of time, and am therefore circulating this paper to those who would be interested and perhaps able to make use of it. My main concentration has been on the issue of seriously incapacitating illness/disability and I

make only passing references to other important themes as, for instance, the Green Paper's proposals concerning GPs and employers. For the reader's guidance, the headings of the paper are as follows:

IB Reform: what is the problem?

Scientific evidence-based research and rigorous evaluation?

Sickness and disability: assumptions of the Green Paper 'Gateways' to benefits

Comments on the political philosophy underpinning IB reform

Pathways to Work pilots

Official evaluations of Pathways to Work pilots

Pathways to Work: how effective and how affordable?

Incapacity Benefit reform: what savings? what outcomes?

Incapacity Benefit Reform: what is the problem?

The problem, as defined, is the number of people on Incapacity Benefit, which has more than tripled since 1979, to its present level of around 2.7 millions. This, we are told, cannot be afforded and is unacceptable. The cost of some £12.5 billions a year is unfair to taxpayers and to those genuinely too disabled to work, who should get more than they currently do.

It is difficult for a lay person to evaluate these numbers and sums or to understand how far it is relevant to compare today with 1979, when the working population was smaller and the industrial structure of the country very different. Other factors are an increase in women working and eligible to claim benefits, and an ageing population with growing numbers in their fifties and sixties who, as an official report puts it: 'are more likely to have health problems and claim incapacity benefits' (**Pathways to Work: helping people into employment, DWP 2002**)

p.7).

If we compare the UK with other countries, we find that our spending on disability benefits has in fact been consistently lower than in the EU and OECD. As a percentage of total public social expenditure, the UK figure is little more than half the 'EU11' average. We have a relatively low

benefit level and rigorous medical testing, while our proportion of sick and disabled, at 18% of the working-age population, bears comparison with an average of 14%. Our beneficiary rate of around 6.5% of the working-age population is on a par with most other countries. Like almost all, the UK experienced rising rates in the 1980-90s, but from 1995 they slowed dramatically. Since then, the in-flow has dropped by a third, so with an out-flow near 6% (compared to an international norm of 1% or less) the benefits population is static if not falling (**Transforming Disability into Ability - policies to promote work and income security for disabled people, OECD 2003 Table 2.1; Charts 3.1, 13-14; 4.1-2**). This leads a report of 2005 to conclude that: 'Contrary to some sensational headlines, IB is not escalating out of control.... There is no "crisis"' (**The Scientific & Conceptual Basis of Incapacity Benefits, TSO 2005 - henceforth referred to as S/C Basis - 4.8 p.75**). Nevertheless, and in spite of many reforms over the last decade, the presumption underlying the present proposals is that we have, in the words of the Secretary of State, a 'failing system'.

This not due to **fraud**, the level of which is universally agreed to be low, around 1% or less, and one of the lowest rates across the whole benefits system. As much as anything, it is due to elements inherited from past policy reforms, which make it complex and confusing both to

administer and to receive. More crucially, argues *S/C Basis* (the source of much of the Green Paper), the present system is based on the wrong model of sickness/disability, the 'medical model' that focuses on people's incapacity rather than their abilities. As such, it 'traps' them on benefits, in effect condemning them to lifetimes of dependency. Without acting in any way illegally, recipients take advantage of the system. The failure is the system itself, which gives 'something for nothing'. In particular, it is criticised for the 'perverse incentive' of giving people more the longer they stay on benefits (*Green Paper 2.13*) - although this misleadingly represents the actual situation where, apart from annual indexing, there are only two rises, at 28 and 52 weeks. Up to a million people, it is claimed, could with the right support return to work, and a million have expressed the wish to do so (this last is something made much of by the media, but it was dismissed as without foundation in *S/C Basis footnote 16*). The return to work of these and other targeted groups would bring the UK's employment rate towards the expressed goal of 80 % of working-age population, although, at 74.9%, it is already one of the highest in the world, above that of the USA, Japan, Germany, France and Italy.

These assumptions about numbers, costs and urgency are fundamental to the policy reform proposed in the **Green Paper**, which presents it as part of the Government's 'new vision of a reformed, coherent Welfare State' for the 21st century (*Green Paper 5.10*). It is to be understood in the context of a series of 'New Deals' set up since 1997 to address social issues (young people, the physically disabled, the over fifties, lone parents), designed to reduce people's dependency on the state and ensure that as many as possible exercise their 'fundamental human right' to work. Extending this to

people previously excluded by a benefits system that in effect incapacitates them, will 'liberate' their talents and capabilities and be 'good for the individual, good for families, good for communities and good for Britain' (*Green Paper 1.21*). The reformed system is to be delivered through partnerships of public, private and voluntary sectors and co-operation between all 'stakeholders'. The aim is nothing less than a reversal of the common attitude towards sickness, disability and capacity for work - 'a fundamental transformation in the way society deals with sickness and disabilities' (*S/C Basis p. 123*). In practical terms, it means opting out by the state of responsibility for a large section- estimated at two thirds - of those afflicted by illness or disability. In future, it will be harder to qualify for the benefit, while those already receiving it, in many cases over long periods, will despite assurances have justifiable anxieties about their future benefits status.

Scientific evidence-based research and rigorous evaluation?

The Green Paper proposals, we are promised, 'are grounded in evidence from this country and overseas... We will undertake rigorous evaluation of pilot measures... and we will publish the results openly.... We will ensure that statistical data produced by the Government allow straightforward comparison between the total number of cases under the old and new systems (*Green Paper 5.32*). It is true that its proposals appear to be backed by voluminous reports of recent years from the DWP, DOH, OECD and PM Policy Unit, with Parliamentary White and Green Papers, as well as consultations with many interest groups. Most of these publications bear the hallmarks of academic authority and objectivity. They are presented with what look like exhaustive bibliographies, references, footnotes, tables, graphs, diagrams and statistics, leading

readers to suppose that arguments for reform are supported by an inexorable logic and swaying them towards the conclusions reached, if necessary, by tedious repetitions and platitudes. There is a tendency to 'blind with statistics' that are manipulated towards sometimes dubious conclusions, as here, for instance: 'After 4-6 weeks of sickness absence with a common health problem, if someone is not allowed to return to work, they will then have a 10-20% risk of long-term incapacity. By 12 months, if they are still not allowed to return to work, the balance of probabilities is that [sic] will condemn them to long-term incapacity for years ahead' (*S/C Basis p.121*).

On closer examination, it appears that this entire body of work is largely self-referential - that is, it appeals for validation to itself and is all framed within the same political and policy agenda. *S/C Basis* (authors Gordon Waddell and Mansell Aylward) is particularly interesting in this connection. As the most comprehensive of all the studies, it is useful for revealing the thinking behind the Green Paper, which draws from it liberally, though surprisingly without any acknowledgment. Its source is the UnumProvident Centre for Psychosocial and Disability Research located in Cardiff University since 2004. One of its authors is an orthopedic surgeon with a special interest in back pain, and the other was until 2005 Chief Medical Adviser to the DWP. He is now head of the Centre, whose remit is 'to develop specific lines of research into the psychosocial factors related to disability, vocational rehabilitation, and the ill-health behaviours which impact on work and employment (www.cf.ac.uk/psych). UnumProvident, an American company, is the largest disability insurance company in the world and is involved in a number of lawsuits for 'bad faith' in refusing to honour disability insurance claims.

This reinforces the caution against taking this apparently impressive body of work at face value. It is not research undertaken in a spirit of open enquiry. It is commissioned research and, as such, pre-disposed towards ideologically determined outcomes.

Sickness and disability: assumptions of the Green Paper

The document that best explains the Green Paper's approach towards sickness and disability is *S/C Basis*, which draws heavily from academic Disability Studies concerned to demonstrate that barriers faced by disabled people are due not so much to any biological impairment as society's prejudices, and the way it is organized for the able-bodied. In *Box 4 p.23* we read:

'Disease is objective, medically diagnosed pathology.

Impairment is significant, demonstrable, deviation or loss of body structure or function.

Symptoms are bothersome bodily or mental sensations.

Illness is the subjective feeling of being unwell.

Disability is limitation of activities and restriction of participation.

Sickness is a social status accorded to the ill person by society.

Incapacity is inability to work associated with sickness or disability... It is important to note this is not a linear causal chain. These are different elements of the human predicament that underlies incapacity, and the social security dilemma often lies in discrepancies between the elements.'

The only condition seen as 'objective', therefore, is disease, which afterwards is mentioned scarcely at all throughout the monograph. On the other hand there are repeated references to 'common health problems', and where references are supplied they are often seen to

relate to depression and 'low back pain', which are held not to be barriers to work. Depression, musculo-skeletal and cardio-vascular conditions, we are told elsewhere, 'can be managed effectively with the right advice and support from the health community' (***Choosing Health White Paper 2004 p.156***).

Sickness, according to *S/C Basis*, 'is essentially a temporary status that is normally expected to recover, sooner or later, to a greater or lesser degree'. Illness is characterised by **illness behaviour** which is 'all the things that ill people say and do that express and communicate their feelings of being unwell'. It 'depends first and foremost on the severity of the symptoms, eg intensity of pain - the more ill you are, the more ill you are likely to behave'. But 'different people with similar illnesses may or may not be incapacitated', for it also 'depends on individual attitudes and beliefs, emotions, distress, and how the individual copes; and on motivation and effort', as well as 'the social context and culture in which it occurs' (*S/C Basis p.91, Box 7 p.39*).

The authors see 'glaring paradoxes' when, nationally, 'objective measures of health are improving... people are living longer and staying healthy longer, particularly over age 50 years'. Another paradox is people's 'failure to recover' when, 'with medical discoveries and innovations and increased NHS expenditure, health care and clinical outcomes should be improving but more and more people are staying on benefits longer'. Unemployment has fallen but numbers on long-term benefits remain 'stubbornly high'. All this is to be explained, not by medical conditions but 'more by personal, contextual and labour market factors' (*S/C Basis p.83-5*). The same arguments and even phrases were used in debate around the Green Paper and reveal much of its rationale.

In the view of *S/C Basis*, it is a mistake of the 'medical model' of illness to assume that the sick must be 'cured' before being fit enough to go back to work. 'Crucially, it is often inferred that sickness absence is justified until this is achieved'; but 'most common health problems are manageable, and most people should recover, usually quite quickly. There is usually no permanent impairment and long-term incapacity is not inevitable.... There is strong evidence that health-related, personal and social/occupational factors can aggravate and perpetuate incapacity. Crucially, they may continue to act as obstacles or barriers to recovery and return to work' (p.140). The present benefits system ignores the therapeutic value of work, as set out on p.17:

(Box 2) 'Work is beneficial for people with sickness or disability, in terms of: symptom management; recovery and rehabilitation; self-esteem and confidence; social identity and role; "normalisation" of activities and participation; improved social functioning; quality of life; social inclusion. Long-term worklessness leads to: loss of fitness; physical and mental deterioration; poor physical and mental health; psychological distress and depression; loss of work-related attitudes and habits; increased suicide and mortality rates; poverty; social exclusion'.

(Box 3) 'Long-term worklessness is one of the greatest known risks to public health: the risk is equivalent to smoking 10 packs of cigarettes per day; young men who have been out of work for 6 months have a 40x increased risk of suicide; that is a greater risk to health and life expectancy than many "killer diseases"; it is a greater risk than the most dangerous jobs in building sites or the North Sea.' (references are supplied).

'Gateways' to benefits

Initially, the sick person decides to stop work 'with or without the advice or agreement of health professional(s)'

and influenced by many factors, the key ones being 'the individual's perception of his or her symptoms, the nature of work demands and the psychosocial and cultural context' (*S/C Basis p.105*). From here, it is easy to 'drift' onto long-term benefits with the encouragement of GPs.

The DWP has no involvement in this 'primary gateway' and only enters comparatively late in the process through the 'secondary gateway', the Personal Capability Assessment (PCA), by which time the damage has been done. GPs, who first certify claimants, do not 'understand the importance of work for health' or 'consider carefully whether sick certification is really necessary and in the patients' best long-term interests' (*S/C Basis p.106*). This reviews different ways of bypassing them, including access to confidential GP-patient records, but without arriving at definite recommendations. Even the Medical Services doctors who administer the PCA should be curbed. Their clinical expertise applies only to the 25-30% of claimants with severe conditions. 'For common health problems and future capacity for work, the doctors' *opinion* is unfounded, of limited value and can be counter-productive'... they 'should simply state that there is no objective physical or mental health barrier to rehabilitation or (return to) work' (*S/C Basis p.145-6*).

In the system proposed in the Green Paper, there will be only one 'gateway' to incapacity benefits. People will be required to use up their allowance of sickness benefit and then move to the basic Jobseeker Allowance, until they pass a new PCA, the revision of which was considered but not thought necessary in *S/C Basis*. This new test (which will be given a different title to reflect its 'enabling purpose' - *Green Paper 2.70*) will distinguish between 'eligibility for the benefit and capability for work', and it may be conducted by other health professionals

than doctors (*Green Paper 2.65*). The mental health component of the present PCA, which applies to about 40% of claims, will be reviewed to reflect 'the type of conditions prevalent today' (*Green Paper 2.72*). Only after the test, unless their condition is deemed so severe as to exempt them, will claimants proceed to the **Employment and Support Allowance** replacing Incapacity Benefit.

The critical challenge, however, is how to distinguish between those with such severe conditions that they cannot be expected to work in the foreseeable future, and those who can. 'Severe and permanent impairments' and 'mild/moderate mental health conditions' are discussed at length in *S/C Basis*, without arriving at any conclusive recommendations (such as, for instance, the inclusion of chronic fatigue diseases with other 'exempt' conditions). For all practical purposes and 'pragmatically, claimants fall into three broad groups' (references given here are to three studies of self-management of various conditions, including giving up smoking). These groups are those (1) nearly ready to return to work and needing minimal help; (2) thinking about returning but needing help; and (3) not able or prepared to return, which may be 'because of the nature and severity of their health condition, or more a matter of attitudes, perceptions and expectations (which may or may not be accurate, and however these have developed). In essence, it is a question of what the claimant cannot do vs what they will not do.... Any progress will depend on personal change..... It remains to be seen whether or to what extent Pathways can be effective with this group, and conditionality may also be a necessary ingredient' (*S/C Basis p.144*). In any case, 'considerable work is still needed to develop any practical method of classifying claimants to different levels of support' (*S/C Basis p.144*).

Two further groups are to be brought into the new regime: lone parents and the over fifties. As they are not necessarily associated with sickness/disability - although the over fifties are said to form about half of current incapacity benefits recipients - they are not addressed in *S/C Basis*. In the Green Paper the over-fifties are associated with a new initiative for cities that is to involve local employers, amongst others (*Green Paper Ch.5*).

Comments on the political philosophy underpinning IB reform

Before proceeding to examination of **Pathways to Work**, which is the template for the new incapacity benefits system, the political philosophy underpinning the reform should be considered. The broad context is the Government's 'new vision' of a reformed welfare state, where relations between state and citizen constitute a 'contract' in which rights of the citizen are balanced by obligations, and conditions are attached to any benefits received - the principle of 'conditionality' which, it is claimed, enjoys strong public support. The sick and disabled are not exempt from this contract, the only difference being that they are entitled to the state's support to help them fulfil their side of it. This then gives much opportunity for protestations of concern for those previously failed by the system and 'condemned to a life dependent on benefits, extending to poverty in retirement' (*Green Paper 1.1*).

Under the 'contract' the obligations of claimants are to: 'recognise that symptoms, feeling unwell, sickness and incapacity are not the same; accept an appropriate share of responsibility for managing one's health condition, rehabilitation and return to work; ...return to work when reasonably able to, even if still with some symptoms'. To this is added: 'The greater the subjectivity and

personal/psychological elements in incapacity, the greater the degree of personal responsibility' (*S/C Basis p.162*). Should they fail to carry out their obligations, claimants must be subject to **sanctions** - for 'human nature requires the presence of some kind of ultimate sanction to set the limit on acceptable behaviour' (*p.167*).

The assumptions about illness/disability made here and in the Green must give rise to the following concerns:

(1) Because the 'medical model' is dismissed as part of the 'medicalisation of modern life' (*S/C Basis Box 12, p.51*), we are not here or in any of the innumerable DWP reports given the sorts of information that would help us understand the rise and spread of certain diseases and their impact on our society. Such information would, for example, be age, sex and spatial distributions and the epidemiology of different conditions. Doubtless such data are available to the DWP and they occasionally surface in tables; but, as in the *DWP Research Report 259* discussed below, nothing is made of them because the whole emphasis is on de-coupling health problems and medical conditions from unfitness for work. We are expected to be impressed by the unacceptable and spiralling numbers of claimants and to agree with bland generalisations about their conditions, but we are not presented (as would be the case in genuinely objective research) with the data from which to evaluate the conclusions drawn.

(2) Those on benefits are depicted as victims of the benefits system, so by implication passive, idle and helpless. This suggests that holding the 'status' of sickness on benefits is a doddle - 'something for nothing' according to the Secretary of State when contrasting his offer of 'something for something.' The actual experience of those with serious and long-term illness/disability could not be more different. With pain, weakness, exhaustion

and (often) sleeplessness, not to mention self reproach and huge anxiety and despair about the future, serious illness/disability calls for self management of a high order. Unless they are cared for by others (in which case they are providing employment) those in this situation have to expend more energy, time and money on maintaining themselves than people with no experience of illness can easily imagine. Normally taken-for-granted tasks of everyday life require advance planning and often substantial courage. Holidays, diversions and treats are usually out of the question. Shunned by others, including (quite often) partners and family, the long-term sick and disabled only survive through developing impressive inner resources.

(3) Claimants are depicted as a drag on the economy and money spent on them as good as poured into a black hole. But, like oaps, benefits recipients spend whatever money they get on goods and services, incidentally providing employment to the caring professions. At however humble a level, they are part of the (cash) economy. They also participate in what may be called the social economy. They run homes for themselves and often for others, look after children and other dependants, have friends and neighbours, contribute to charitable, voluntary, local and national organisations.

(4) For all its boasted solicitude towards them, the underlying philosophy of this reform in fact belittles sick and disabled people. By implying that they are parasites, it excludes them more insidiously from the body politic than the system it seeks to replace. The people in question, like the 19th-century poor, are not asked to speak for themselves about their health conditions and resulting problems and needs. For example, the study of early Pathways clients in *DWP Research Report 259* was only interested in their reactions to the service provided, so useful information that could have been

extracted from even this tiny sample was missed. In countless DWP-commissioned studies, the voices of sufferers are only heard through, and interpreted by, researchers and officials. (There is a partial exception in ***Moving between Sickness and Work. DWP Research Report 151. 2001***, which records first-hand comments, but it does not ask for people's actual experience of being ill).

Pathways to Work pilots

The system that is to replace Incapacity Benefit by the new **Employment and Support Allowance** takes its justification from the alleged success of the Pathways to Work pilot projects begun in three areas in October 2003, followed by another four in April 2004. From reports in *S/C Basis* and two *DWP Research Reports, Nos 259 and 278*, all of 2005, the Green Paper judges the pilots sufficiently successful to be extended nationwide by 2008, when they will be delivered mainly by the private and voluntary sectors, with 'payment by results'. From then, all new claimants, plus the over-fifties and single parents, will be given a Personal Adviser (PA). They will be required to attend a series of 6 monthly work-focused interviews (WFIs) and, in a 'tailored, active system that addresses each individual's capacity' (*Green Paper Ex.Summary 18*), agree an Action Plan for return to work, select from a menu of 'Choices' and participate in 'work-related activities'. If they refuse to co-operate or are deemed insufficiently co-operative, they will be subject to **sanctions** of two successive cuts in their benefit, bringing it down to the level of Jobseeker Allowance, which is some quarter to a third lower. Other elements of the package show traces of earlier lobbying by action groups, and the experience of various 'New Deals'. For instance, voluntary work, training and Condition Management Programmes (CMPs) can be included in Action Plans; the period when employment may be tried without detriment,

should it be necessary to return to benefits, is increased from one to two years; and a return to work credit will soften the ending of benefits. Established claimants are promised protection of their existing benefit level, but they will eventually be brought within the mandatory Pathways regime and have the frequency of their PCAs increased, as well as being subject to random spot checks.

Official evaluations of the Pathways to Work pilots

By August 2004, 58,000 people had entered the Pathways pilots, all of whom had been on IB at least 12 months. Some 10% came voluntarily from the existing stock. 'These take-up rates are higher than expected and much higher than the usual 3-6% achieved in previous social security pilot studies with this client group' (*S/C Basis p.154*). Much is made of the 'off-flow' rates - the numbers coming off benefits - in the pilot areas. A graph plotting these from April 2001 to June 2004 (*Fig.12, p.155, Green Paper Fig.2.3*) purports to show they were significantly higher in the pilots than the normal national rate. However, at the latter date Phase 1 pilots had only been running for four quarters, while Phase 2 pilots had only one quarter to show. In other words, intentionally or not, the graph is so designed as to exaggerate in favour of the pilots. In the Phase 1 areas, off-flow rates had evidently been higher than national average since 2001, though once the pilots began they rose from around 35% to around 40%. Phase 2 rates also exceeded the national average in the only quarter for which figures were available.

Quite properly, the text warns against jumping to conclusions on such sketchy data. In particular, it was not known how many from the 'off-flow' left benefits for jobs, nor how long any such jobs were sustained. Existing evidence of people with 'less severe health problems' who

had been ejected from IB and forced into Jobseeking, does not look encouraging: after 12-18 months over a third were back on IB, a quarter were relying on other benefits, and only 23% were in work (*S/C Basis p.97*).

In a similar vein, *S/C Basis* issues caveats against other elements of 'Pathways'. For example, before becoming mandatory, WFIs should be fully developed and proven, 'otherwise there is a real danger of imposing conditions that some claimants simply cannot meet without help, and further disadvantage those who are already most seriously disadvantaged' (*p.138*).

Likewise for the CMPs, the main tool of proactive self-management of illness, there is no direct evidence on 'the process, effectiveness or health-related outcomes' (*p.157*). They are based mainly on cognitive behavioural therapy, but 'are not formal psychological interventions and might be described better as advisory or "talking" therapies' (*p.149-50*). The CMP modules used in the Gateshead and S.Tyneside Pathways are held out as an example for others to follow (*Box 26 p.151*):

- Making sense of your condition
- overcoming stress and anxiety
- Learning to be assertive
- Promoting emotional/physical wellbeing
- living with fatigue
- living with pain.

For Pathways as a whole, 'preliminary results need to be confirmed on a national scale and over the longer term, with a particular focus on sustained work outcomes. Pathways is resource intensive and demands a high level of staff skills and competencies.... This would require major investment in staff recruitment and training. There must still be some question whether this can be delivered

effectively on a national scale. Although the Pathways package appears to be effective, there are still major questions about the effectiveness of different Condition Management Programmes, Employment Support interventions, and delivery models. This will involve detailed analysis of the pilot studies and further research and development over several years. All previous evidence suggests it is unlikely that Pathways will be as acceptable or effective with the existing stock, particularly those who are aged >50 years and/or have been on benefits for more than 1-2 years.... Extending Pathways on a mandatory basis to all suitable longer-term recipients raises a number of additional questions and challenges and would require considerable further research and development, and evidence of its effectiveness and cost-effectiveness' (p.159). In addition, 'supply side interventions (e.g. Pathways, benefit conditionality and making work pay) must be balanced by demand side interventions (e.g. job availability, stopping employer discrimination)' (p.160).

However, *S/C Basis* adds: 'despite all the caveats, it is important to recognise what has been achieved so far. These are very large-scale pilot studies covering a significant portion of the caseload and country. Very few social security interventions in the world have ever achieved such take-up rates, enthusiasm and labour market outcomes with this client group. These results stand in marked contrast to the long history of failed international efforts to address the problem of long-term incapacity' (p.160).

It is this optimistic assessment of the Pathways pilots that the DWP and the Green Paper choose to pick up on, while they pass over all the preceding caveats.

Two reports of early Pathways pilots in operation were

not, evidently, available to the authors of *S/C Basis. IB Reforms Pilot: Findings from a longitudinal panel of clients (DWP Research Report 259, 2005)* is a study of 24 new claimants from the first 3 pilots who volunteered to take part (with a small financial inducement) in one long face-to-face and two follow-up telephone interviews, over a period of 12 months (the limit of this 'longitudinal' study). All 24 were experiencing the new regime of Personal Advisers, the series of 6 monthly WFIs and the 'menu' of aids for progressing towards work, including CMPs and a variety of grants. Some of the sample had not been on the pilot as much as 12 months, and only 18 completed the full programme.

It is worth noting that 24 is less than half of 0.1% of the total number on Pathways by August 2004. It is also far too small a number for any meaningful statistical analysis. Nevertheless useful pointers might have been spotted - but were not - from the age/sex/health condition/housing/ &c data by which the sample had been drawn. Because they were so focused on this being a 'qualitative' study, the researchers resisted any numerical breakdowns even where these might have been illuminating (see 5.3.5). In the knowledge that those with exempt conditions were already screened out, they treated all 24 individuals as capable of work, sorting them into the 3 prescribed categories of work-readiness. They were unable to find clear, demonstrable improvement in people's health or prospects of return to work as a result of Pathways. They did establish that the WFIs were broadly acceptable to claimants and that those already predisposed towards work found the information and support offered both useful and welcome. Not surprisingly, the least progress was observed with those in Group 3, who would 'continue to pose a considerable challenge to the Pilot' (*para 5.3.5*).

Incapacity Benefit reforms - the Personal Adviser role and practices: Stage Two (DWP Research Report 278, 2005) reports on the experience of 34 PAs delivering Pathways in the first 7 pilot areas. During their time in the post, which ranged from under 6 to over 12 months, their workloads had increased by up to 100%, and their daily total of WFIs from 6 to 8 or 10. They were given 'targets' for job entries and referrals to other agencies, which they felt were not always in the best interests of their 'customers' (as they termed clients) and they were not always sure which group to prioritise or what might legitimately count as 'progress' with clients who were clearly not fit enough to return to work. Their task was emotionally taxing - it is clear that some advisers were unprepared for the harrowing cases they met - and could lead to stress and 'compassion fatigue'. They felt inadequately prepared for dealing with complex medical issues, particularly of mental health. It comes across that advisers took their task seriously and performed it flexibly and humanely; but they felt a conflict between their role as enabler (for clients) and enforcer (for the DWP). There was a difference of opinion about **sanctions**, to which some were deeply opposed, as undermining the trust they were trying to build with clients, while a minority were in favour and some wanted an even more rigid sanction regime. 'Unsurprisingly, these opposing views were filtering into practice' (*DWP Research Report 278, p.57*). To date, sanctions have been used sparingly - only 370 across all pilot areas, according to ***Incapacity Benefit reforms - Pathways to Work Pilots performance analysis, DWP Working Paper 26, 2006***.

Pathways to Work: how effective and how affordable?

'Pathways' is to be the template of the new benefits system, so it is important to be sure what the pilots have in fact demonstrated. First, and importantly, the WFI regime

was found generally acceptable, although 'Failures to Attend' were reported to be 20%, and as much as 40% by some PAs (*DWP Research Report 278*). A year later *DWP Working Paper 26* gave a figure of 12.6%. But notwithstanding the Green Paper's claim of 'rigorous evaluation' and the doubtless large amounts spent on research, it is as yet far too soon for any reliable judgment of the pilots, and in particular to predict how well they will serve once they are mandatory for all claimants, old and new.

It is to be supposed that the pilots had, if not extra resources, at least a novelty factor that cannot be expected once they are universally applied. This extension of Pathways can hardly be other than costly - 'highly individualised solutions will be more effective but also more demanding in terms of time, effort and cost' (*Transforming Disability p.158*) - but extra funds for this so far announced in the press fall well short of £1m - surely far below what is needed. Simply delivering the 6 WFIs per new applicant (at an average of 8 a day) would require in excess of 2000 PAs - and this is not counting their caseload of existing claimants, the aim of staying in touch with people after returning to work, and the need to liaise with many different agencies and 'stakeholders'.

The personal adviser is pivotal to Pathways - and it should be remembered that most PAs will be working in private and voluntary agencies paid by results. To achieve customised Action Plans for people in multiply difficult circumstances they will need to be social workers-cum-counsellors endowed with the wisdom of Solomon. Even if they do manage this, they cannot conjure resources that are not there: crucially, jobs and employers (only 40% of whom are reported to be willing to take on long-term benefits claimants, especially when mental

illness is involved). Another crux is reliance on CMPs as a tool for coaxing people out of patterns of 'illness behaviour'. The Green Paper states that the DWP has invested heavily in these, but they depend for delivery on health authorities, not all of whom yet have any up and running. Typically, they are applied by health care professionals such as occupational and physio-therapists, who lack expert knowledge of the diseases clients may have. They make much use of watered-down cognitive behavioural therapy which, delivered inexpertly and in group situations, can add to the anxiety and guilt of people with serious conditions - for instance by suggesting that they are causing their own illnesses, when all along they are suffering from insufficiently understood but real diseases. To provide all those who would benefit with expertly delivered CBT would, in the opinion of Professor Sir Richard Layard, take an extra 10,000 trained therapists (*'PM'* 24.01.06).

The personal adviser will have a worrying degree of power over the lives of people who are by definition vulnerable. GPs will no longer be looked to for independent, expert assessments. The medical certificate is to be revised 'to make it more user-friendly and to support GPs in providing more comprehensive and robust fitness-for-work advice' (*Green Paper* 2.43), and DWP employment advisers are to be placed in GP surgeries. On PAs will fall the responsibility for distinguishing between those who are and are not capable of return to work, and assessing whether or not the former are making enough effort to do so. Nobody pretends such a judgment can ever be easy, or exact. There is a wide, disputed area between the extremes, where inevitably people will be unfairly ascribed to one or the other category. Different degrees of toughness of PAs may give rise to inconsistencies of delivery that could eventually bring the

system into disrepute.

Incapacity Benefit reform: what savings? what outcomes?

On any realistic assessment, the overall savings to the country from the Green Paper proposals are likely to be few, if any. It is from hope rather than certainty that Pathways is predicted, by *S/C Basis*, to pay for itself by eventually getting 100,000 claimants a year off incapacity benefits (with another 100,000 from the over-fifties and 300,000 lone parents). But the Green Paper concedes it is 'difficult to model the precise impact of these measures. If, however, the Government, employers, local authorities and health professionals come together to tackle this challenge, we can aspire to reduce the number of incapacity benefits claimants by 1 million over the course of a decade' (2.19). Further gains would come from the taxes of those returned to work, who will, it is suggested, be better able to provide for themselves in retirement (though this could hardly apply to those only earning the minimum wage).

Any immediate savings on the incapacity bill can only come from postponing and making access more difficult for new claimants, and shaving the level of the benefit as indicated in the Green Paper, which summarily announces the end of youth-related and dependent-adult supplements. Existing claimants are assured that their current benefit levels will be protected, but technically it would not be difficult to adjust these once they enter the Pathways programme and become subject to sanctions if deemed unco-operative. There is also, despite assurances given against meanstesting, some obscurity in the Green Paper concerning the Employment and Support Allowance, which is sometimes referred to as income-related and has parts that are means-tested (2.93).

Things that seem to call for close scrutiny are a promised rise in present benefit levels for those with conditions severe enough to exempt them from the Pathways regime (*Exec.Summary 16*); revisions to the appeals process (2.73); and an undertaking to 'increase the level of support over time.... As support is increased, so will the level of conditionality for claimants' (*Exec.Summary 18*).

In general, however, it seems generally agreed that the reform is necessary and will save the country money. The lead-up to the Green Paper took place over several years, during which the DWP consulted widely, commissioned many reports, put various New Deals into operation and (at least in its own estimation) obtained reliable evidence from pilot Pathways. All this has apparently pre-empted any strong party-political or pressure group opposition, and the reformers were given an easy ride when the Green Paper was launched on 24 January 2006 to plaudits all round, including the media. There seems little doubt, therefore, that the new benefits system will be instituted - unlike the case in some countries, including the Netherlands and USA, where benefit cuts provoked such outcry that they had to be withdrawn (*S/C Basis p.165-6*). Rather than this, what might be expected is a slowly accumulating number of bad decisions and blatantly scandalous cases, eventually giving rise to a groundswell of unease - for, sadly, serious disease and disability cannot be glossed out of existence by platitudes like 'work is the best therapy', however well-intentioned. Their costs may be re-allocated but cannot be made to disappear, and there seems no reasonable way of predicting the national incapacity bill in two, five, or ten years' time.

To the degree that it is capable of implementation, the new system could prove beneficial for people whose conditions are of limited duration, and others who are genuinely borderline - that (in the last resort) unknowable

number with the much-invoked 'common health complaints'. But others, dependent on incapacity benefits either because this is their lifelong situation, or because they must have support while trying to recover from serious conditions, will not be well served. Concessions such as lengthening the permitted trial period of work and the menu of 'Choices' may be welcome, but they will come at a price. These people will not find comfort in the Government's refusal to acknowledge the medical reality of their conditions, or their own huge efforts to cope with these. The Green Paper could not even find a place for 'health', 'sickness' or 'disability' in its title.

In effect, though claiming to address the future, the DWP is turning the clock back, to a time before National Insurance when the cost of sickness was born by the individual and the family. In the long run, this reform will stand or fall by the correctness of its belief that two thirds of all claimants are well enough to compete as jobseekers in the labour market. If this is wrong, the cost to society of a system that forces people into jobs they cannot sustain, on threat of penury, might well outweigh any financial savings; while the cost, in stress, to those people and their families will be incalculable. Mean while, this ideologically driven policy of reform chooses not to look into the range of reasons - social, economic, environmental and medical - that are influencing the incidence, variety and patterns of disease, and what the future outcomes will be.

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