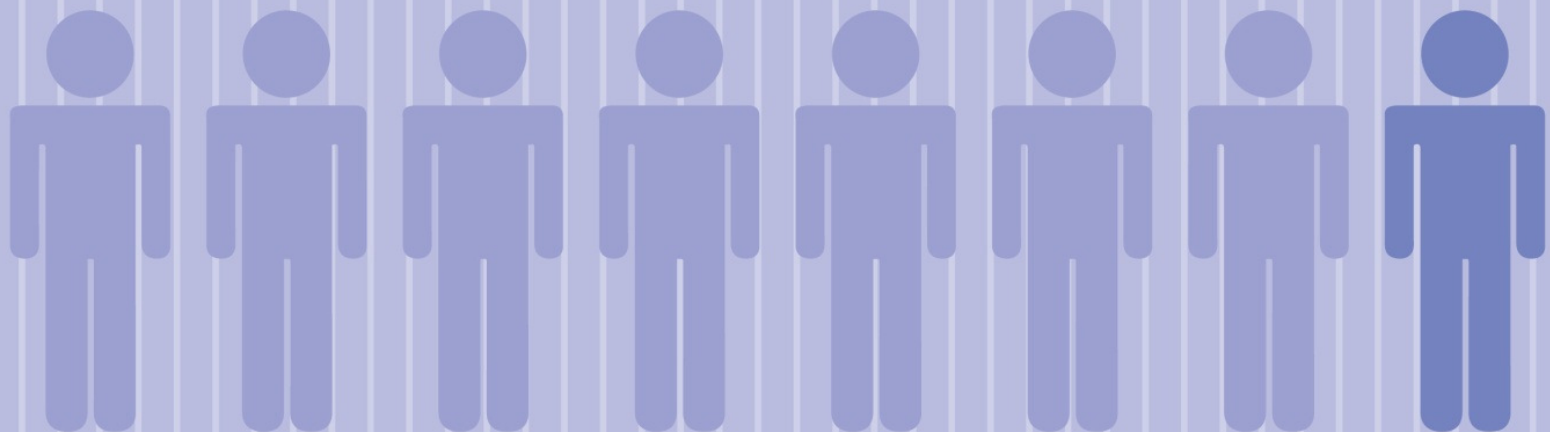


# The role of health interventions in reducing incapacity claimant numbers

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# **THE ROLE OF HEALTH INTERVENTIONS IN REDUCING INCAPACITY CLAIMANT NUMBERS**

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## Summary

This paper reviews the evidence on the role of health interventions in bringing down the large numbers out-of-work on incapacity benefits in the UK.

The increase in incapacity numbers in the 1980s and 90s, and in particular the high claimant rates in Britain's older industrial areas, point strongly to a shortfall in labour demand as the underlying cause. The failure of economic growth up to 2008 to make much impact on claimant numbers, however, points to the extent to which incapacity claimants have subsequently become marginalised. Welfare reform is now curbing eligibility for benefits without increasing in job opportunities.

Ill health or disability is not necessarily an absolute bar to working, but in difficult labour markets it is one of the great discriminators determining exactly which individuals are able to secure and maintain employment. Health problems also shape the way that most incapacity claimants see their prospects.

The Pathways to Work initiative, introduced in 2003, gave incapacity claimants the opportunity to opt in to a Condition Management Programme but a 2010 National Audit Office (NAO) report concluded that this had no additional employment impact.

The NAO's conclusions, however, appear seriously flawed. The survey evidence on which they were based suggests that conclusions about Pathways as a whole cannot be generalised to the Condition Management Programme in particular. In addition, the NAO's criticism of the value of health interventions is at odds with the evidence from schemes around the country.

In terms of health benefits, there is clear evidence that Condition Management Programmes do have positive effects on individuals' well-being and readiness to work. In terms of the employment impact the evidence is less clear-cut, but evidence from a health-led pilot scheme in County Durham, in particular, points to positive employment outcomes.

The paper concludes that at the present time, when the Condition Management Programme has been wound up and the Work Programme providers appear to be placing little emphasis on specialist health support, the benefits of health interventions are being neglected. But there are convincing reasons for a re-think and a different approach in future.

# THE ROLE OF HEALTH INTERVENTIONS IN REDUCING INCAPACITY CLAIMANT NUMBERS

## Introduction

The UK has exceptionally high numbers of men and women out-of-work on incapacity benefits. In 2012 the count stood at 2.5m, a full million more than the numbers out-of-work on unemployment benefits even in the wake of recession. Not surprisingly in the light of the substantial cost to the Exchequer, bringing down incapacity claimant numbers has become an important policy issue.

This paper looks at the role of health interventions in reducing incapacity claimant numbers. Oddly, given that successful claims for incapacity benefits require all claimants to demonstrate a degree of ill health or disability, the role of health interventions in bringing down claimant numbers is relatively unexplored. Instead, successive UK governments have generally regarded the large numbers on incapacity benefits as simply a variant of the unemployment problem. This view finds its clearest expression in statements from the Department for Work and Pensions (2006, 2008, 2010). The recent emphasis has been on tighter restrictions in eligibility for benefit and, for all but the most severely ill or disabled, requirements to attend 'work-focussed interviews' and engage in 'work-related activity'. This does not rule out addressing health problems at the same time, but it would be fair to say that medical issues are not centre-stage in policy thinking.

Yet it would also be wrong to characterise incapacity benefit claims as primarily or even predominantly an issue of health or disability. In fact, there is substantial evidence that in the UK the large numbers claiming incapacity benefits reflect a shortage of jobs, especially in Britain's older industrial areas, and poor skills and qualifications among incapacity claimants, which mean they tend not to be employers' first choice (see Beatty and Fothergill 2013 for a review of this evidence).

A key purpose of the present paper is therefore to assess the merits of health interventions within the context of wider labour market trends in the UK. The paper draws on published evidence from socio-economic studies and from medical literature. It also combines insights from two social scientists<sup>1</sup> and two health professionals<sup>2</sup>.

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<sup>1</sup> Beatty and Fothergill, of the Centre for Regional Economic and Social Research

<sup>2</sup> Duncan and McLean, of the Centre for Health and Social Care Research

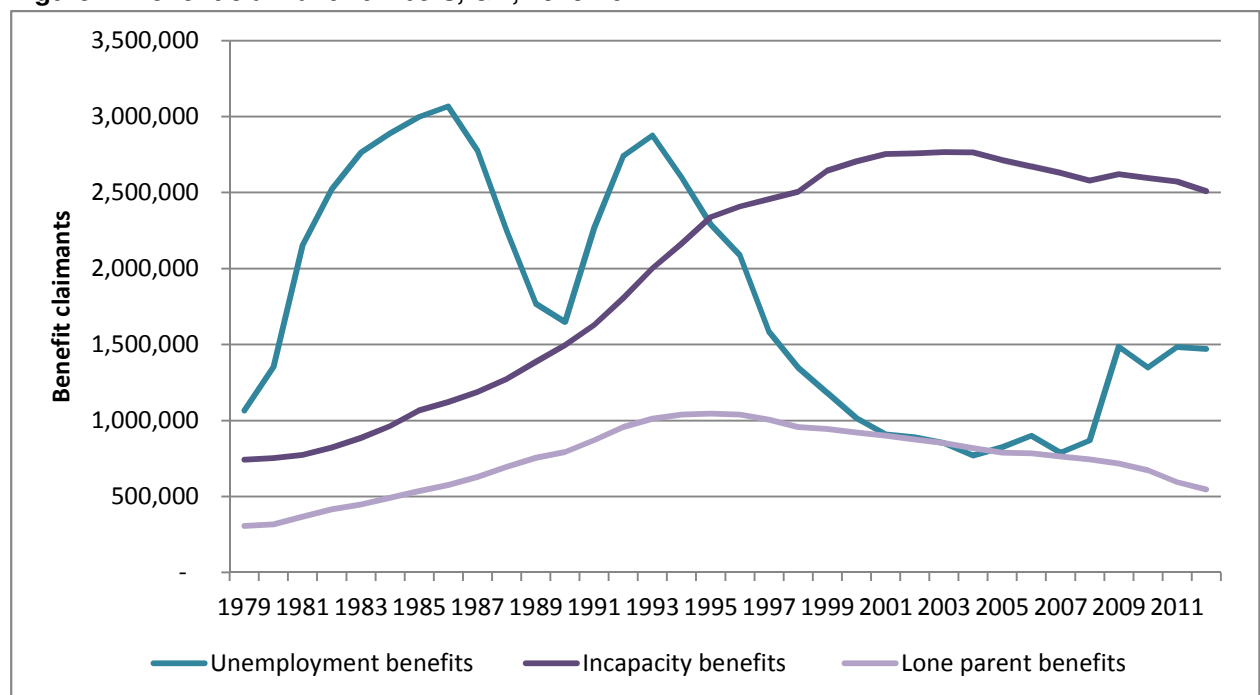
## The rise in incapacity claimant numbers

In the UK context, the term ‘incapacity benefits’ applies to a family of benefits comprising Incapacity Benefit itself, Income Support and National Insurance credits paid on the grounds of disability, Severe Disablement Allowance, and Employment and Support Allowance (ESA). Since 2008 a process of reform has been underway and the aim is that by 2015 all qualifying incapacity claimants will have moved onto ESA. The intention is also that by 2018 all ESA claimants who claim means-tested benefits will in turn have moved across onto Universal Credit, which is planned to replace most working-age benefits, though the rules applying to ESA claimants will stay unchanged so they will remain a distinct sub-group within the benefits system.

Figure 1 shows incapacity claimant numbers in Great Britain between 1979 and 2012, alongside the numbers claiming unemployment benefits and lone parent benefits. The diagram illustrates very well why incapacity benefits have become such a policy concern. Since the end of the 1970s, the numbers out-of-work on incapacity benefits have tripled. The numbers on unemployment benefits, by contrast, remain well below peak levels in the 1980s and early 1990s. The numbers claiming lone parent benefits have also halved since the mid-1990s.

That incapacity claimant numbers have increased so dramatically over the last thirty years cannot be explained by trends in health. The government’s General Household Survey, for example, shows that the proportion of men and women of working age who report a limiting long-standing illness has changed little since the beginning of the 1980s. Indeed, the increase in incapacity claimant numbers runs contrary to the gradual improvement in the

**Figure 1: Benefit claimant numbers, GB, 1979-2012**



Source: DWP

health of the working age population over the same period. Likewise, the ageing of the population and increasing eligibility for benefits, especially among women, offer little in the way of an explanation for such a large increase (Beatty et al 2009).

The most plausible explanation for the increase is the fall in labour demand that occurred across large parts of the country during the first half of the 1980s and again in the early 1990s. The exceptionally high incapacity claimant rates in older industrial Britain, where there was widespread job loss from mining and manufacturing, point to this process: there was always ill health and disability in these parts of the country but it was only *after* large-scale job loss that incapacity claimant numbers began to surge. In effect, the increase in incapacity numbers hid the true scale of unemployment (Beatty and Fothergill 2005). By contrast, in the parts of southern England where the labour market remained buoyant, incapacity claimant numbers barely increased and remain low at the present time.

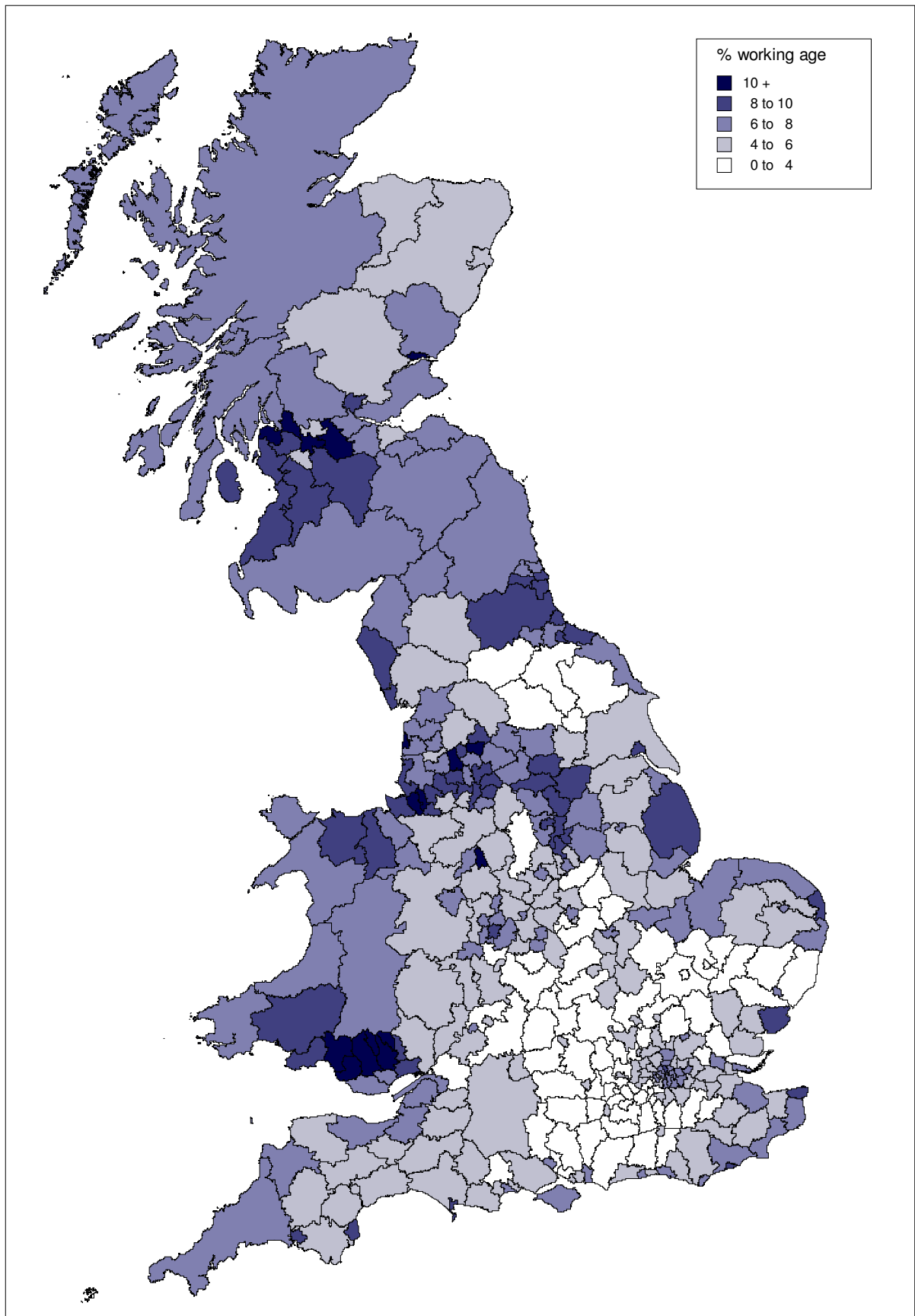
The big variation between areas in the incapacity claimant rate is illustrated in Figure 2 which maps the data by local authority district. For those familiar with the geography of Britain it will be immediately apparent that the highest claimant rates are nearly all found in Britain's older industrial areas – in the South Wales Valleys, in the North of England in places such as Merseyside, Lancashire, South Yorkshire, Teesside, Durham and Tyneside, and in the West of Scotland in and around Glasgow. These are the parts of Britain where large-scale industrial job losses occurred in the 1980s and early 1990s where there has been a continuing imbalance between labour demand and labour supply. A diversion onto incapacity benefits has absorbed much of the resulting labour market slack.

That neither the short-lived economic boom in the second half of the 1980s nor the first stages of recovery from the early 90s recession resulted in falling incapacity numbers is not surprising. Labour markets take time to adjust fully in response to job loss. The rising numbers on incapacity benefits in the 1980s and 90s were made up of not just those who had made been redundant from mining and manufacturing but also those in poor health who subsequently lost out in the normal competition for jobs. Where jobs are in short supply, men and women with health problems are one of the prime groups that lose out. In a period of economic recovery the numbers on unemployment benefits also fall more quickly because the claimant unemployed, unlike their counterparts on incapacity benefits, are required to stay in touch with the labour market.

The experience of the 2000s is more disturbing. Between 1993 and 2008 the UK economy saw continuous growth and employment increased by around 3 million. But having peaked in 2003 at around 2.7m, incapacity claimant numbers then fell by only a couple of hundred thousand. The decline in incapacity numbers continued again after 2009, despite recession, but it is difficult not to attribute this more recent fall to tightening eligibility criteria, in particular the introduction of a new Work Capability Assessment to replace the previous medical test.

What the experience of the 2000s tells us is that there are formidable obstacles to re-engaging incapacity claimants with the labour market. Indeed, the detailed figures for flows on and off benefit show that the reduction in the number of incapacity claimants after 2003 was entirely the result of a reduction in *on-flows*: fewer men and women were being pushed out of work and onto incapacity benefits in a stronger labour market.

Figure 2: Incapacity benefit claimant rate, local authorities in Great Britain, August 2012



Sources: DWP, ONS

By contrast, the *off-flow* of claimants from incapacity benefits remained virtually unchanged (National Audit Office 2010). The consequence was continuing high numbers on incapacity benefits alongside growing labour shortages in some sectors and places, and high levels of international in-migration to fill expanding UK job opportunities.

## **Welfare reform**

Rising incapacity claimant numbers were first recognised as a problem in the mid-1990s, when initial medical certification by GPs was supplemented by a further medical check, around six months into a claim, by doctors working on behalf of the Department for Work and Pensions. For new claimants, Incapacity Benefit also became taxable and there were no longer supplementary payments for dependants. Further reform in the late 1990s introduced new qualification rules on National Insurance contributions and, from 2003 onwards, a requirement on most new claimants to participate in work-focused interviews.

The current round of reforms began in 2008 with the introduction of Employment and Support Allowance and a new medical test, initially only for new claimants. The application of the new medical test to existing claimants was introduced in pilot areas in late 2010 and subsequently rolled out nationally in 2011 with the aim of completing the re-testing by 2015. DWP statistics indicate that around 30 per cent of existing claimants will fail to qualify for ESA.

Within ESA, a distinction has been introduced between the 'Support Group', deemed sufficiently ill or disabled to be not expected to work again, and the 'Work-Related Activity Group', for whom activities to prepare for a return to work – such as training, rehabilitation or voluntary work – are now mandatory.

From 2012, entitlement to the non-means tested version of ESA has also been time limited to one year for claimants in the Work-Related Activity Group. The consequence is that claimants with other sources of household income – a partner in work for example – or with significant savings will find that their benefit entitlement is reduced or eliminated. The official estimate is that 40 per cent of those in the Work-Related Activity Group whose ESA is non-means tested will lose entitlement (Department for Work and Pensions 2011). Because the process of transfer onto ESA is still underway, relatively few claimants have so far been affected by the loss of non-means tested entitlement but their numbers can be expected to grow sharply.

Welfare reform is therefore reducing the numbers receiving incapacity benefits, irrespective of whether there is a corresponding increase in employment. One effect, however, is to push some claimants with ill health or disability onto unemployment benefits instead. Another effect is to push some claimants out of the benefits system altogether, which will be the case where other household income or savings rule out entitlement not only to means-tested ESA but also to means-tested unemployment benefits.



### III health or disability as a barrier to employment

The government's Labour Force Survey for 2012 identifies 8.3m adults of working age who are disabled (in terms of the Disability Discrimination Act) or report a work-limiting illness or disability – around one-in-five of the whole working age population. Of these, 4.1m, or 49 per cent, are in employment. This is well below the employment rate among men and women without health problems or disabilities (76 per cent) but it illustrates the point that ill health or disability is not necessarily always an insurmountable obstacle to holding down a job.

However, where there is an imbalance between labour demand and labour supply, ill health or disability is one of the great discriminators determining exactly which individuals are able to secure and maintain employment. Other things being equal, employers prefer the fit and healthy. Poor qualifications, low skills, low-grade work experience, advancing age and low motivation tend to be the other discriminators. Where a claimant faces more than one of these obstacles – which can often be the case with incapacity claimants – their chances of finding work can be slim.

According to DWP data for 2012, the primary reason for entitlement to ESA for 43 per cent of claimants is 'mental or behavioural problems'. This is a broad category, spanning stress and depression through to much more tightly-defined psychological problems such as schizophrenia. The category also includes drug and alcohol problems. The second most numerous category, accounting for 15 per cent of ESA claimants, covers those with 'musculoskeletal problems'. Over the years, the proportion of incapacity claimants recorded as having mental or behavioural problems has risen while the proportion with musculoskeletal problems has declined. The changing balance partly reflects a generational shift: a group of men made redundant from heavy industry in the 1980s and 90s, who had often picked up physical injuries over the course of the working lives, have been passing out of the figures into retirement to be replaced by a more diverse group of both men and women with different work histories.

Beyond the two big groups of 'mental or behavioural' and 'musculoskeletal', other specific illnesses or disabilities account for much smaller numbers, generally less than 5 per cent of ESA claimants. The DWP's statistics, which record the primary medical reason for the benefit claim, do however provide only a partial picture. In fact, a great many incapacity claimants report more than one health problem or disability (Kemp and Davidson 2010).

Survey evidence on more than 3,500 incapacity claimants across eight local areas around Britain (Beatty et al 2009) confirms the importance of health in the narrative of individuals and in perceptions about their labour market options. Illness or injury is cited by more than 70 per cent of incapacity claimants as the principal reason for their last job coming to an end. Around 60 per cent report that their health problems or disabilities were less severe while in their last job. For many incapacity claimants a specific event (such as injury) or a deterioration in health has triggered job loss and they have subsequently been unable or unwilling to return to work.

The survey evidence shows that only around a quarter of incapacity claimants say they 'can't do any work' but that the remainder nearly all report some health limitations on their ability to

work. Typically, there are certain types of work that claimants no longer feel able to do (heavy labour for example) or limitations on how much work they feel able to undertake. Around half expect their health problems or disabilities to get worse; only 5 per cent expect to get better.

It is therefore not surprising that health problems shape the way that incapacity claimants see their future prospects. The survey data shows that only around a third would like a job, now or further into the future. In more than 90 per cent of cases the reason given for not wanting a job is that their health is not good enough. Likewise even among those would like a job, 90 per cent cite ill health, injury or disability as an obstacle to finding work, and three-quarters say they think employers would regard them as 'too ill or disabled' or 'too big a risk'.

This is persuasive evidence that, whatever the reality of conditions in the labour market, ill health or disability has become entrenched in the minds of most incapacity claimants as the reason for their marginalisation from the world of work. Ill health was the reason why they lost their job; ill health is the reason why they won't or can't consider returning to work; and ill health is the reason why employers would not want them anyway. These attitudes have often been reinforced by health service professionals who have emphasised the activities that claimants are unfit to undertake (Beatty et al 2009).

Here, indeed, lies the explanation for the paradox that rising job opportunities in the years up to 2008 made so little impact on incapacity claimant numbers. The vast majority of incapacity claimants had become disengaged from the labour market and saw their ill health or disabilities as a largely insurmountable obstacle to working again. As the duration of their incapacity claim extended, this in itself created another obstacle in the eyes of employers who prefer men and women with recent work experience. Add in poor qualifications, low-grade work experience and advancing years, all of which the survey evidence shows apply to many incapacity claimants, and the cocktail is lethal for aspirations and job prospects.

In the reforms that began in 2008, the Labour government of the day and (since 2010) its Coalition successor have chosen the simplest routes to reduce claimant numbers. The eligibility for benefit is being reduced by a new medical test and by the extension of means testing. These will have the desired effect in reducing headline numbers and in saving the Treasury large sums of money. But it is also clear that these reforms do not address the underlying problems facing claimants. The reforms will shift men and women with health problems or disabilities – all be it of the less severe kind if the medical test is working properly – from one part of the benefit system to another or out of the system altogether.

By reducing or eliminating benefit entitlement, the welfare reforms do incentivise a substantial group of incapacity claimants to look for work but they fail to equip claimants any better to actually find work. Their realistic chances of re-entering employment will not necessarily be any higher. A quite different approach would be to address the health problems that are so clearly perceived as an obstacle by claimants themselves.

## The Pathways to Work initiative

Addressing the health concerns of incapacity claimants would not be entirely new. In 2003 the then Labour government introduced the Pathways to Work initiative, initially in seven local areas but later elsewhere across Britain so that by 2008 the whole country was covered. Pathways to Work consisted of a number of elements: compulsory work-focussed interviews in the first year of an incapacity claim, the offer of training or employment support through the New Deal for Disabled People, a back-to-work credit worth £40 a week for the first year for those entering low-paid employment, and the opportunity to take part in a Condition Management Programme. Existing incapacity claimants could also 'opt in' to Pathways support on a voluntary basis.

The Condition Management Programme (CMP) introduced for the first time a 'health' element to efforts to bring down incapacity claimant numbers. In the Pathways to Work pilot areas, and in the initial roll-out areas, the CMP was a venture run jointly by Jobcentre Plus and the National Health Service. In the rest of the country, as the initiative was rolled out, the Pathways initiative and the Condition Management Programme were both managed by private contractors working on behalf of the Department for Work and Pensions.

The Condition Management Programme was intended to help individuals manage their disability or health condition to permit a return to work. It was based on cognitive behavioural therapy principles designed to improve awareness of the approaches, such as exercise, that would assist in day-to-day activities. The Condition Management Programme was delivered over a 6-12 week period for each participant, often in group sessions in community venues.

The initial evidence on the Pathways initiative was that it was working well, increasing the rate at which incapacity claimants moved off benefit (Bewley et al 2007, 2008). The later evidence was much less encouraging. This led the National Audit Office (NAO), in its review of the Pathways initiative, to conclude that the initial positive results had been misleading, and that 80 per cent of the increase in the numbers moving off benefit was the result of bringing forward the medical assessment (National Audit Office 2010).

On other aspects of the Pathways initiative the NAO's conclusions are damning: *"The voluntary aspects of support offered through Pathways (including the Condition Management Programme and the Return-to-Work Credit) appear to have no additional employment impact."* So if the NAO's conclusions are taken at face value, addressing the health concerns of incapacity claimants through the Condition Management Programme has been a waste of time in terms of job outcomes.

It comes as no surprise therefore that Pathways to Work was wound down in 2011 and the Coalition government's successor to all welfare-to-work schemes, the Work Programme, makes no specific commitment to providing health support for incapacity claimants. The Work Programme is operated on a 'back box' basis by private contractors – it is up to them to decide what to deliver and they are paid by results – and the early evidence (Newton et al 2013) is that there has so far been little effort to deliver sophisticated or specialist services to participants, not least because contractors' budgets are so tight. Incapacity claimants have also been slow to be fed into the Work Programme, so little has been developed to address

their specific needs. When they find sustained employment they trigger larger payments, but the rate at which present and former incapacity claimant find work lags well behind the claimant unemployed (ERSA 2013).

The NAO's assessment of the value (or lack of it) of the Condition Management Programme is however not wholly convincing. One reason is the limited evidence on which the assessment is based. The Department for Work and Pensions commissioned a number of qualitative and quantitative evaluations of the Pathways programme. The NAO assessment was informed by those available at the time, but the most influential study appears to have been an assessment of the impact on employment, earnings and self-reported health in the areas where Pathways was introduced in April 2006 (Bewley et al 2009). It is this study, based on a large-scale telephone survey of claimants, that failed to identify statistically significant positive outcomes arising from the Pathways initiative.

The problem in generalising this negative conclusion from Pathways as a whole to the CMP in particular is that only a small minority of Pathways participants ever took part in the Condition Management Programme. In fact, DWP statistics show that of the grand total of 1,690,000 men and women starting Pathways over its full life to 2011, only 58,700 (or just 3.5 per cent) went on to start a Condition Management Programme. It is distinctly possible, therefore, that any positive impact of the CMP is obscured or swamped by the much larger number of non-participants. Indeed, of the 2,800 claimants surveyed in the April 2006 Pathways areas, in the study drawn on so heavily by the NAO, only around 100 might be expected to have been CMP participants. This is a narrow evidence base on which to condemn the programme.

The other reason why the NAO's assessment of the Condition Management Programme is not wholly convincing is that it is at odds with other evidence.

In particular, the evaluation of the Northern Way worklessness pilots, which operated in 10 local areas in Northern England between 2005 and 2008 and targeted a reduction in incapacity numbers, emphasises the value of a health-centred approach (ECOTEC Research and Consulting 2009). Participation in all the Northern Way pilots was on a voluntary basis, so the client group could be expected to be keen on a return to work. Nevertheless, the evaluation notes that several of the pilots that adopted an 'employment-focussed' approach felt with hindsight that they would have benefited from a more health-focussed delivery model.

The detailed evaluation of one of these pilots, in Easington district in County Durham (Frontline 2008), is especially interesting because this initiative, known as Aim High Routeback, deployed a 'health-first' approach and was run from within the local NHS Primary Care Trust. This pilot, working in an area with one of the very highest incapacity claimant rates in Britain, engaged 493 clients in all, of whom 164 – fully one-third – subsequently found work. The proportion of the Easington pilot's clients finding work was well above the average for the Northern Way pilots as a whole.

The significance of the Easington pilot is that it placed health at the centre of the delivery model. Health was used as the initial entry point, rather than a discussion about employment, which facilitated the engagement of clients. Once clients had started to

address their health concerns, the possibility of employment became more real. The focus was on practical condition management rather than 'cure'. The scheme offered something different to mainstream NHS provision and, according to the evaluation, was effective in supporting those who were "lost or forgotten" in the health system or for whom other alternatives had been exhausted.

The successful collaboration between Jobcentre Plus and the NHS found in Easington is echoed in other parts of Britain where the two collaborated in the delivery of the Condition Management Programme (Lindsay and Dutton 2010). Both sides recognised the value of practice-sharing, flexibility in the management of staff and resources, the stimulus to creativity in the work of individual professionals and, crucially, the credibility to clients of the expertise the NHS brings to bear.

From the clients' perspective too, the Jobcentre Plus/NHS partnership seems to have been well received. In the Pathways pilot areas for example, health practitioners reported pleasant surprise at responses to CMP provision, finding the majority of participants to be highly motivated despite often severe health problems. Few reported resistance to what was being offered (Barnes and Hudson 2006). Perceived impacts on health and well-being included a more positive outlook, social contact, changed perceptions of conditions and improvements in health (Secker et al 2011).

The later Pathways areas, managed by private contractors, lacked the close involvement of the NHS in the Condition Management Programme. The evaluation in this instance remains that CMP can help improve well-being and readiness for work, notably through building confidence and motivation, though moving directly into paid employment was not a common outcome (Nice and Davidson 2010).

More generally, survey data on Pathways to Work participants finds that the "overwhelmingly important" factor in determining whether incapacity claimants return to work is their perception of the state of their health (Becker et al 2010). Those whose trajectory of health is 'good or improving' are far more likely to return to work, and it is health problems that are most frequently cited as a barrier to moving into employment.

### **The evidence on what works**

The largest study of the effectiveness of health interventions for incapacity claimants covers more than 2,000 participants in the Condition Management Programme element of the Pathways initiative (Kellett et al 2010). As the study explains, CMPs do not attempt to treat health conditions but emphasise awareness, reassurance and advice. The CMPs evaluated here were delivered in seven 4-hour sessions, in a group context. The sessions deployed the cognitive behavioural therapy approach and focussed on problem solving, noticing and changing unhelpful thoughts, techniques to improve sleep and relaxation, goal setting, behaviour, and overcoming avoidance. Between-session tasks ("homework") were also part of the programme.

The results showed that 50 per cent of CMP participants experienced a reliable improvement in psychological well-being. At follow-up, 16 per cent had returned to work and a further 10

per cent had taken some steps towards work. Participants with a mental health condition were more likely to experience a reliable improvement in psychological well-being than those with physical health conditions. The results led the authors to conclude that “*participation in CMP may be helpful in facilitating more effective self-management of the health conditions contributing to unemployment*”.

The cognitive behavioural therapy approach does not receive such a strong endorsement in a second study (Winspear 2008). This covered 78 incapacity claimants with mild to moderate levels of anxiety or depression, all of whom wanted to return to work. The group was selected from outside the normal channels into the Condition Management Programme and was organised so that those who received the intervention could be compared with those who did not. The study found positive changes in psychological health and attitudes to work for those who completed the course. However, there was no increase in job-seeking behaviour compared to the control group.

Turning to incapacity claimants with musculoskeletal problems, a study of long-term unemployed men and women with lower back pain provides encouragement (Watson et al 2003). 86 participants underwent a pain management rehabilitation programme which also included vocational advice. The programme ran for 12 half days over 6 weeks, with additional individual counselling. It dealt specifically with identifying and addressing barriers to work, using a cognitive behavioural approach supported by physical activity and specific work advice. Six months after completing the course, 38 per cent of the participants were in employment and a further 23 per cent were in education, training or undertaking voluntary work.

The value of highly intensive interventions is demonstrated by the experience of incapacity claimants on a 24-week residential rehabilitation programme (Desouza 2006). These were all men and women with severe injuries, including brain injuries, so they are a somewhat unrepresentative group among incapacity claimants as a whole. Of the 94 who completed the course, 53 gained employment and a further 33 were deemed ‘work ready’ – an impressive success rate, though one that may have been boosted by the project’s location in Cambridgeshire, one of the parts of Britain with the very lowest incapacity claimant rates and a strong demand for labour.

Personalised support appears to deliver positive results, at least for some, as experience in North East England illustrates, where a ‘health-first’ case-management approach has been delivered to longer-term incapacity claimants (Warren et al 2013). This involved initial liaison on health, and on any other related matters (such as employment, housing and debt). Participants were then enrolled onto specially commissioned physiotherapy and counselling services, with the length of engagement varying according to the needs of the individual. A comparison group allowed the effects of the intervention to be assessed. Measures of health improved for participants with mental health problems; those with musculoskeletal problems, however, recorded no improvement compared to non-participants.

Finally, a wide-ranging literature review (Dibben et al 2012) arrives at mixed conclusions. This covers the effectiveness of interventions for people with common health conditions in enabling them to stay in or return to work, and as such extends well beyond just incapacity claimants. The review finds that there is a strong body of evidence, with positive effects, to

show that cognitive behavioural therapy and vocational rehabilitation work for lower back pain, and psychological interventions for depression. It also concludes that there are benefits to be gained from coordination between rehabilitation professionals and from a case-management approach.

## **Assessment**

The balance of evidence suggests that the National Audit Office was wrong to dismiss the benefits of the Condition Management Programme.

In terms of health benefits to incapacity claimants, there is clear evidence that CMP and similar initiatives do have a positive effect on individuals' well-being and readiness for work. The health improvements are not universal – for some individuals the support provided through cognitive behavioural therapy may not be appropriate to their specific illness or disability. Nevertheless, there is real evidence of health gains for a substantial number and CMP appears to succeed in delivering support to many individuals who have been left behind by conventional health service provision.

In terms of the employment impact of CMP – which in fairness was the NAO's concern – the evidence is less clear-cut. The direct evidence on the extent to which the CMP, as opposed to the wider Pathways to Work initiative, raised employment rates is missing. But the CMP-like programme for incapacity claimants in Easington, County Durham, saw a high proportion of participants returning to work – higher, indeed, than the return-to-work rate in other parts of northern England where alternative back-to-work initiatives were piloted.

That said, the Condition Management Programme delivered by the Pathways initiative should not be regarded as the only possible model. There may be a case for more intensive intervention, or for more sustained support. There may be a case for more personalised support, tailored to the particular health problems or disabilities of the individual. There may be a case for the better integration of employment-related support directly alongside the health interventions.

But the National Audit Office conclusions about the Pathways initiative, flawed in detail as they may be, also provide a salutary warning about the limits of purely 'supply-side' interventions to lower the numbers out-of-work on incapacity benefits (or, with an eye to the consequences of welfare reform, to lower the number of men and women with ill health or disability who are parked on other benefits or pushed out of the benefits system). Welfare-to-work initiatives of all kinds are always likely to work best at the times and in the places where there is a strong demand for labour. Where there are plenty of jobs available, it is easier for benefit claimants to find work and when they do so they are less likely to displace other jobseekers, which would simply pass unemployment from one individual to another and have no impact on the overall numbers out-of-work.

One of the challenges in reducing the numbers out-of-work with ill health or disability is that these men and women are disproportionately concentrated in the weakest local economies across Britain – places such as North East England, Merseyside, the Welsh Valleys and Clydeside, where even conventional claimant unemployment (on Jobseeker's Allowance) is

high. The real solution to the labour market imbalance in these places is a sustained increase in job opportunities, which requires growth in the national economy and effective regional policies to promote development away from London and the South East.

So long as there remains a serious imbalance between labour demand and labour supply, employers can pick and choose who they recruit, or who they retain when they are shedding labour. Men and women with ill health or disability are unlikely to be their first choice. This is especially the case if they also have shortcomings in skills, qualifications or experience.

The 'queue for jobs' does not operate like a bus queue. Those at the front of the queue for jobs – the men and women who are fit and healthy, well qualified and have recent work experience – are generally the first to be taken on and their places at the front of the queue are constantly being filled by other healthy, qualified people leaving or losing their jobs as part of the normal process of churn in the labour market. Those at the back of the queue – including most incapacity claimants – stay at the back. Indeed, the longer they stay out-of-work the less attractive they become to employers and the lower their chances of re-employment. They move back, not forward, in the queue.

At a time of recession or low growth, and in the weakest local economies, the scope for supply-side measures to reduce the numbers on incapacity benefits is therefore somewhat limited. This underlines the tragedy of the missed opportunities in the years of sustained economic growth up to 2008, when shortages of labour in some sectors and some places co-existed with only a very modest fall in incapacity claimant numbers.

So what is the potential role of health interventions in bringing down incapacity numbers? The benefits are probably two-fold.

First, health interventions help *level up the chances of finding work*. Men and women with health problems or disabilities are amongst the most marginalised in the labour market. Health interventions can improve physical and mental well-being and, since poor health or disability is so often seen by the individuals themselves as the main obstacle to working again, successful interventions can at least lessen this obstacle, potentially allowing them to re-enter the labour market. Of course, health interventions should not be pursued in isolation from other measures, especially if there are other problems such as low skills that need addressing in order to raise an individual's chances of finding work. But at the very least health interventions can be justified because they promote greater equality of opportunity.

Second, health interventions have economic benefits by *raising labour supply*. In certain parts of Britain, especially southern England, additional labour market engagement would probably facilitate growth even in the wake of recession. But the real benefits of additional labour supply would kick in if there were to be an economic recovery. Above all, a repeat of experience in the years up to 2008 needs to be avoided. If labour supply can be raised by successful interventions targeted at men and women with ill health or disability, in a period of economic growth it should be possible to bring down claimant numbers, reduce the financial burden on the Exchequer, and rely less on migrant workers from outside the UK to satisfy employers' demand for labour.



At the present time, when the Condition Management Programme has been wound up and when Work Programme providers appear to be placing little emphasis on specialist health support for present and former incapacity claimants, the benefits of health interventions are being neglected. But there are convincing reasons for a re-think and a different approach in future.

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