

Soundings On

Welfare Reform

the dread of things to come

Edited by Sally Davison & Jonathan Rutherford

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and Sally Davison

The contributions to this short ebook have been written in the moment of political campaigning. They bear witness, employ argument and offer statistical evidence to challenge the way both Labour and the Coalition governments have designed and implemented welfare reforms.

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Welfare reform

The dread of things to come

This short ebook is a collection of essays previously published in *Soundings* (www.lwbooks.co.uk/journals/soundings/contents.html) and written in the moment of political campaigning. Their task is to bear witness and to employ argument and statistical evidence to challenge the way both Labour and the Coalition governments have designed and implemented welfare reforms. They expose the impact these reforms are having on the most vulnerable in society. Steve Griffiths describes them as a 'social policy disaster'. The essays are written by people who have spent years campaigning for disabled people's rights and more recently against the Coalition's Welfare Reform Bill. As Peter Beresford argues in his essay, the disabled movement will carry on its campaigning after the Bill is passed into law.

My own involvement in campaigning around welfare reform began in 2006. I'd been asked by a psychoanalyst to take a look at the role of private companies in the provision of mental health care and I stumbled onto the issue by accident. At the time the broader left and progressive community were uninterested in the New Labour government's welfare reform. There appeared to be no disquiet about its trajectory, or about the intemperate language being employed against claimants by some Labour politicians. And yet it was clear that the reforms had the potential for causing a great deal of unnecessary suffering. Added to this, the business model of welfare proposed by Lord Freud would transform the welfare state by introducing large private companies to run the system for profit. In fact, the marketisation of welfare was already in evidence through the involvement of the giant US insurance company Unum Provident. I wrote an essay 'New Labour, the market state and the end of welfare' which is included in this ebook.

Like the 1834 Poor Law Amendment Act, the 2009 Welfare Reform Act had been provoked by a moral panic about the feckless poor, and the rising cost of welfare payments. The Labour government had not recognised how wages for the bottom half of the working population were being squeezed. Far from globalisation and the

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economic boom trickling wealth down, income and wealth were spiralling upward to a small elite. Rising living standards for lower paid families were being sustained only by private borrowing and the growth in women's jobs. The result was growing indebtedness and increasing pressure on individuals and domestic life. A popular resentment toward people on benefits was being stoked by apocryphal stories in the right-wing press of a growing dependency culture of welfare cheats. Rising immigration fuelled feelings of unfairness and resentment toward the political class and fed into the clamour against benefit scroungers.

In this febrile culture of grievance, the Labour government identified a large number of what it termed the 'hidden unemployed' - people who were existing on Incapacity Benefit but were in fact capable of working. It put the number at 1 million, which helped to legitimise the call to radically cut welfare spending and reform the welfare system. In their essays, both Declan Gaffney and Steve Griffiths reveal the methodological flaws in the evidence base and statistical usage that underpinned this claim of 1 million hidden unemployed. They thereby raise major questions about the efficacy of the welfare reforms, not least their negative impact on hundreds of thousands of vulnerable people.

Like the Poor Law, the target of welfare reform was the able-bodied worker who was considered to be shirking his or her duty to work. As both Griffiths and Gaffney argue, the Labour and Coalition governments excluded the health dimension of the out of work problem. Neither the large number of people living with limiting long term illness in the population nor its impact on individuals and their employability was properly taken into account. Instead it was politically expedient to focus on the supposed moral failings of the individual claimant, and the assumption that, contrary to the evidence, very large numbers were simply avoiding work. Consequently the design of welfare reform was organised around increasing conditionality and introducing a sharper punitive element into the system. The problems of the lack of jobs, the inappropriate nature of many jobs for sick or disabled people, or the considerable employer resistance to taking on the mentally or physically unwell, were treated as secondary problems or ignored entirely. Like the poor law, welfare reform has ended up punishing the sick and disabled, a reality that is plainly told by Kaliya Franklin and Sue Marsh in their essay.

During the years of Labour's welfare reform, the only opposition came from small user groups who existed in a state of fear and intermittent illness and incapacity.

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The pioneering John Rogers of the Sheffield Welfare Action Network (SWAN) wrote presciently in 2006 of the 'dread of things to come'. The isolation of these campaigners briefly changed when Compass pressure group (www.compassonline.org.uk) joined with the Public and Commercial Services Union to campaign against what became Labour's Welfare Reform Act 2009. The campaign didn't go well. Compass and the PCS had very different styles of working, and did not build up a good enough relationship to weather the differences; and, while both these organisations opposed the Reform Bill outright, the NGOs and charities involved in the campaign had different priorities - supporting some aspects of the Bill while opposing others. The campaign petered out. It wasn't until the emergence of a new generation of campaigners employing social media that a different voice - that of users themselves - began to make itself heard.

Peter Beresford writes about the new generation of campaigners, beginning with the extraordinary success of the Spartacus report (www.ekklesia.co.uk/files/response_to_proposed_dla_reforms.pdf) in January 2012. A number of campaigns stand out: Carerwatch (<http://carerwatch.com/>), Diary of a Benefit Scrounger (<http://diaryofabenefitscrounger.blogspot.com/>), The Broken of Britain (<http://thebrokenofbritain.blogspot.com/>), and Act Now (<http://actnow01.web.officelive.com/default.aspx>). They have filled the vacuum left by the charities and larger NGOs, who in seeking roles in the new welfare system have partially lost their independence and power of advocacy.

Earlier this week I sat in the House of Lords listening to the debate on amendments to the Coalitions Welfare Reform Bill. Labour had already defeated the government in a series of amendments. It was about to do so again on the proposed benefit cap. But this success masked a problem. Labour suffered from a lack of a story about the kind of welfare system it stood for. Just as Lord Freud had moved his allegiance from Labour to the Conservatives, so too his version of welfare reform felt like it belonged to the Conservatives, even though Labour had been its architect. During the debate, it was two of Margaret Thatcher's former ministers, Norman Fowler and Tony Newton, who convinced with their clear sense of the kind of welfare system they wanted. Labour peers sprung their litany of amendments but they lacked a shared ideological project about the kind of welfare system they wanted. There was concern for fairness and compassion, a heartfelt fear of the impact on children, and awareness of the spectre of homelessness. But what did

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Labour want? It seemed to boil down to the Conservatives' system but a bit nicer here and there.

This ebook is about the struggle now for decency and dignity and a modicum of fairness for those who are sick and disabled. The larger questions about the future of our welfare state remain. Labour will need to rethink its approach to welfare or risk being sucked into the political slipstream of the Conservatives, and will find itself assenting to measures and then qualifying its assent. It has a political problem because it is viewed by many as being soft on welfare, but it can never resolve this problem in the longer term by trying to out-nasty the Tories. Does it want to rebuild the model of the liberal welfare state or try something different? The question needs serious consideration. Beveridge's legacy does not look politically robust today. It is not succeeding in protecting the most vulnerable. It risks being undermined by profit-seeking companies. Its safety net is mean and tattered. Who wants the impoverishment of the Job Seekers Allowance or the humiliation and fear of the Work Capability Assessment? Unlike the NHS, the welfare system lacks public support: in hard times and over longer periods of time, large fractions of the 80 per cent lose their sense of obligation toward paying for the needs of the twenty per cent.

In the coming period of austerity, welfare will be a critical political issue. The challenges of labour market volatility, of the soaring cost of pensions and an aging population, of a tax system in need of redesign, and of restructuring capitalism for wealth creation and jobs, might be better met with a reciprocal, contribution-based system of social insurance which ensures protection and is more politically robust. But it must be one that hard-wires compassion into its structure for those who, through no fault of their own, are unable to contribute. It would involve a massive change, perhaps one that is politically impossible given the welfare traditions in this country. But the present system is failing and the political prize for changing it would be enduring and historical. The call belongs to Labour.

Jonathan Rutherford, 27 January 2012.

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Kaliya Franklin and Sue Marsh

The government is withdrawing the support that enables disabled people to work, while simultaneously arguing that more of them should be working.

Despite significant progress in earlier decades towards enshrining legal rights and protection for disabled people, beginning with Lord Morris's Chronically Sick and Disabled Person's Act (1970), the future of the disabled community now appears uncertain. The drive towards independent living, and efforts to establish rights to access businesses, services, transport, education and employment through the Disability Discrimination Act (now Equalities Act), are now being thwarted by the proposed cuts. Prior to the 2010 election the outlook was already stormy, in the context of rising hate crimes and the demonisation of welfare claimants by a slaving media egged on by politicians - with one eye firmly on the welfare balance sheet and the other determinedly closed to the consequences of their actions.¹ Then, within months of their election, the Coalition government were championing and cheering on a round of cuts that are increasingly devastating in their impact upon disabled people. Because of this, a new generation of sick and disabled people have now been radicalised into activism.

Two perceptions of sickness and disability pervade mainstream thinking. On the one hand there are the lazy scrounging scum, perfectly able to work if they choose, draining resources from an already overburdened taxpayer; on the other there are the deserving claimants, pitiful creatures, who will be provided for with free cars, bungalows and holidays as compensation for their lot. Neither image reflects reality, but the former continues to be cemented in the public consciousness, fed by a diet of moral outrage based upon statistics that the DWP

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themselves have been forced to admit give a distorted picture.² As to the latter image - it is based on a misconception amongst the general public that, should they become sick or disabled, the state will step in and willingly provide all that is needed. The dominance of these contradictory and inaccurate ideas helps to explain why the savage cuts that are being championed in the name of reform are going largely unchallenged. It seems that, whilst most of the public can immediately understand the importance of saving forests for all our futures, an understanding of the importance of sickness and disability benefits and services tends to be confined to those who are directly affected.

However, the introduction of Disability Living Allowance (DLA) in 1992 was an acknowledgement that sickness and disability bring with them additional and unavoidable financial burdens. But Thatcher's drive towards community care during the 1980s - initially welcomed as a positive step by the disability rights movement - was never sufficiently funded, and this meant that part of the effect of the new DLA was to transfer to individuals funding that had previously gone to institutions, as people moved into independent living. Separated into two components, for mobility and care, DLA was an important part of the fledgling personalisation agenda. This perception has therefore always been something of a mixed blessing, but it did at least allow some people to live more independently.

Within months of their 1997 election victory New Labour had announced plans to dramatically curb eligibility to disability benefits, on the basis that spending had doubled and must be curbed. Charities greeted this announcement with outrage, and pointed to the legitimate reasons for the increases in costs, which were being ignored by government; these included medical advances, the costs of community care, and the success of efforts to encourage take-up of these benefits. One noteworthy protest involved people in wheelchairs chaining themselves to the Downing Street gates and throwing red paint around, to symbolise 'Blair's blood'.³ Soon after, the first plans for reforming disability benefits were quietly shelved.

During the following decade a new generation of disabled people - born with an expectation of their right to live independently - began to come of age, and they were joined by larger numbers of people who had recently become sick and disabled in the course of their working, tax-paying lives. Together they constituted a generation who had not known the horror of imprisonment in institutions. Having lived more freely for a while, disabled people were at first

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slow to recognise the threats being made to their independence. However, New Labour had not given up on their 'reforms' of welfare provision, and in October 2008, after a long period of preparing the ground, previous disability benefits were replaced by a new Employment Support Allowance (ESA), whose eligibility criteria seemed deliberately designed to exclude large numbers of people from benefits.

High unemployment throughout the 1980s had also undoubtedly contributed to the numbers of people claiming Incapacity Benefit (IB); this was because mostly male, older claimants, who were far more likely to have industrial injuries or sickness from their working years, had been deliberately directed towards incapacity benefit as a way of reducing unemployment figures.⁴ But this group were then seized upon by politicians as characterising the entire claimant group, and were used to justify major efforts to reduce the number of IB claimants, in the first instance in measures put forward by John Hutton. Then, during Peter Hain's stewardship, the Department of Work and Pensions used research carried out at Cardiff University, part-funded by the American private insurance company Unum, to move towards a 'biopsychological' model of sickness and disability.⁵ Deeply concerned by the rise in insurance claims for sickness and disability that lacked clear 'biological markers', the basic premise of the biopsychosocial model was to reclassify the concept of sickness preventing work: the argument was that in reality it was the individual's perception of their own sickness that was leading them to believe themselves unfit for work. They believed that this incorrect perception could be easily be corrected, and on this basis they would be able to reduce the number of successful claims - from both state and private insurance providers.

However, it was James Purnell's leadership at the DWP which first propelled this new group of sick and disabled claimants on their journey towards activism. The premise of ESA had initially seemed reasonable - that some people were so sick and disabled they should be supported unconditionally, whilst others might be capable of some work under the right conditions and with the right support. But the means by which people were to be assessed, and the widespread introduction of sanctions to this vulnerable group, soon revealed its true motives, which, fundamentally, were aimed at reducing the number of claimants, based on the false idea that substantial numbers of claims were fraudulent. By 2007 the benefit scrounger rhetoric was increasing, and campaigns such as 'no ifs, no buts, benefit fraud is a crime' were becoming popular. But the MPs' expenses scandal in 2009, which

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included the revelation of claims by Purnell for large sums of money for his grocery bills - which he claimed at a monthly rate higher than unemployment benefit levels - encapsulated the hypocrisy of New Labour thinking for sick and disabled people, and made Purnell a figure of fury as well as fear, thereby helping to sow the seeds of more recent activism.⁶

There is a distinct irony in current disability rights politics: determined to create his Big Society, David Cameron's only true step towards this has been to unify the disabled community, who traditionally have been concerned with emphasising the different needs and identities of each group. Unfortunately there are no political allies on the horizon. Betrayed, abandoned and enraged by the welfare policies of the New Labour years, disabled people already had our backs against the wall, and the savagery of the cuts outlined in the comprehensive spending review are pushing us over the edge. Respect for fellow members of our disabled community at one time meant that Cameron had an easier ride on disability issues, because of his personal experience as a son and father of a disabled person. But his willingness to use these experiences as a campaign tactic has backfired, creating a deep anger and visceral mistrust towards him personally.

The effects of deficit reduction on the disabled

Out of a total planned reduction in public spending of approximately £90 billion, the cuts initially outlined by George Osborne that affect sick and disabled people are estimated to total £9 billion: in other words, ten per cent of the overall cuts burden will fall upon the most vulnerable in society.⁷ These cuts are so wide ranging that it is impossible to provide a truly comprehensive list, particularly as sick and disabled people are more heavily reliant than most on NHS and local authority services; for the purposes of this article only those cuts directly affecting employment prospects will be considered.

Sick and disabled people feel that we are living in a horror story worthy of Poe, as more and more of the vital supports we rely upon for daily life are either removed or made significantly more difficult to access. Time and energy that is already limited by health conditions will now have to be spent upon increasingly fruitless applications for support, thus creating additional barriers to the possibility of employment.⁸ There has been no consideration of this conundrum in the

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government's current plan to transfer a million people from sickness and disability income replacement benefits into the totals for jobseeker allowance. If suitable accommodation, equipment and support were freely available, sick and disabled people would feel more confident about the potential of employment, but with that support being withdrawn from every direction, for many of us it feels as though we are in a pit, with the walls closing in upon us and no route of escape to be found. We are being simultaneously deprived of the support we need to be able to work and demonised for not working.

Accessible social housing is also woefully inadequate and poorly allocated, so that many disabled people are forced to rent homes which are not fully accessible in the more costly private sector (approximately 78,000 households in England that include a wheelchair user survive in premises that are not fully accessible).⁹ The planned introduction of provision for an additional bedroom for a non-resident carer is a welcome step, but this extra funding will not be awarded automatically, and will be time limited in most cases to a maximum of thirteen weeks; while claimants under 35 will receive the 'shared room' rate, with exemptions only for those in receipt of middle or higher rate DLA. And the proposal to scrap DLA makes it impossible to fully assess the impact of these changes. Meanwhile the reduction of Local Housing Allowance (housing benefit), which was previously payable at the level of median average rents, but now will only be payable at the level of the bottom third, will force disabled people to rent cheaper properties that are more likely to be inaccessible. Contradictions in policy mean that DLA recipients are exempt from the caps on housing benefit, but not from the lowering of the levels of rent payable, which will have far wider effects. Suitable accessible accommodation removes many of the barriers to daily living faced by disabled people, making them more confident in considering employment, but it will be even harder to obtain once all these changes to entitlement take effect.

Mobility is another area that will be affected by cuts. The proposal to remove entitlement to the higher rate mobility component of Disability Living Allowance from state funded care home residents caused such outrage that the government have temporarily postponed the decision. But cuts to various council funded community transport schemes mean that disabled people are likely to face cost increases of more than 65 per cent, and for vastly restricted travel services.¹⁰ Much of the current transport network is inaccessible to disabled people, so that reduced

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funding for alternatives will further restrict travel, and have an impact upon people's ability to travel to and from work.

The Coalition government also intend to scrap DLA altogether, and to replace it with Personal Independence Payment (PIP), which will involve reassessing all DLA recipients from 2013, even those with lifelong degenerative conditions - at vast cost, and with the aim of further reduction to entitlement, currently estimated at 20 per cent. There are many flaws in the proposed PIP, but for the purposes of this discussion the main impact will be felt in the removal of payments for the additional costs that dealing with disability requires, which will limit the ability of sick and disabled adults to remain in work, given that the funds they use to support these additional needs are to be withdrawn.

Social care is also affected - changes to its provision, people's entitlement and charges will be affected by a number of factors, including the scrapping of the Independent Living Fund, which matched funding from local authorities for those with the highest level of support needs. Furthermore, despite government insistence that cuts in funding to local authorities should not lead to any need to reduce social care provision, areas such as Birmingham are already planning to restrict support to those that meet a threshold of care that is higher than the four bands set out in the government's fair access to care services guidance; whilst most local authorities intend to increase charges.¹¹ Yet, without assistance in performing basic daily activities such as washing, dressing, shopping or eating, considering employment is impossible for many.

Access to Work is a government scheme that provides funding for disability-related equipment in order to assist working disabled people in carrying out their roles (for example it can pay for voice activated software or specialist chairs). It supported 37,000 disabled workers in 2009-10; worryingly but not surprisingly, the figure fell to 35,830 in 2010-11.¹² Now the Sayce Report, published in June 2011, is seeking to redefine what items it is 'reasonable' to expect an employer, rather than the government, to provide for disabled employees.¹³ However, these items are frequently extremely expensive, which means that expecting employers to pay for them is likely to see a further reduction in opportunities for disabled people at work.¹⁴ The proposed list of items that employers are now to be expected to pay for will make it significantly more expensive to hire a disabled employee. Reports of disabled employees being denied access to work support have already emerged,

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for example one application was refused because of a stipulation that if people are working in senior positions they should be funded by their employer regardless of their ability to bear the costs.¹⁵

The ESA labyrinth

When it was initially proposed, one of the ideas of the Employment Support Allowance was that disabled and sick people should be helped and supported to work if they wished to do so. This was a valid and popular idea. Many sick or disabled people would indeed love to work if there was work that they could do. But in its present form the ESA is failing: it simply presents the claimant with a series of dead ends, backed up by a whole raft of sanctions and means tests that negate any realistic chance of success. It takes little account of the limitations of individual conditions, or the barriers to work that someone with a fluctuating or mental health condition may face. The capability tests that are applied to claimants are simply unfit for purpose. Currently around 40 per cent of cases go to appeal, and of these 40 per cent succeed in overturning the original decision, a figure that rises to 70 per cent for those with representation.¹⁶

To qualify for ESA, an applicant must score fifteen points or more during a Work Capability Assessment (WCA). Anyone who scores less than 15 points will be found immediately 'fit for work' and moved onto Job Seekers Allowance (JSA). Leaving aside the limitations of the point system itself (which is dealt with below), there is an evident problem for those who score up to 14 points, and live with significant functional limitations, but whose score denies them the support and assistance of the Work Related Activity Group (WRAG). (The WRAG are those who are considered fit for work if support and preparation is provided. Only those receiving enough points to be allocated to the Support Group are not required to undertake work-related activity.) Those who fail to score 15 points must now compete with able-bodied applicants for work available through the Job Centre. If an applicant is then considered unfit for work by Jobcentre staff, they are passed backwards and forwards indefinitely, between JSA and unsuccessful ESA applications. These claimants are not tracked by the DWP, so no-one really knows how many go on to find work and how many simply fall through the cracks.

To compound this, the Work Capability Assessments and the descriptors they

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use are widely regarded as completely inadequate. They have been comprehensively criticised by a recent DWP report, as well as the professor who helped design the system, various charities and the Citizen's Advice Bureau.¹⁷ They are simply not capable of assessing ability to work in any meaningful way. This leaves thousands receiving the wrong assessment, forced immediately into a workplace that they may not be ready for. Currently, 39 per cent of overall claimants are found immediately fit for work. Many of these people will have been away from the workplace for a considerable length of time, and some will have lifelong conditions.

Those placed into the WRAG (currently around 30 per cent of existing claims, and just 18 per cent of new claims) face many of the same problems. The descriptors used in the points system take no account of pain or symptoms or fatigue; they simply take a snapshot of what a person may or may not be able to do on the particular day of their assessment. Those with fluctuating conditions, which is particularly the case for those with mental health conditions or learning difficulties, are unlikely to be fairly assessed under the present system.¹⁸

With the proposed introduction of a one year time limit for those in the WRAG, almost all of the positives of ESA have been removed: after one year, whether or not their condition has improved, a claimant will now lose contributory ESA. Yet when it was designed, ESA was supposed to give sick and disabled people in the WRAG support for as long as it might take for them to enter work. The time limit removes any pretence at supporting the vulnerable, and turns ESA into a benefit that only supports conditions from which one might expect to recover within one year.

This means that if those with incurable or long-term chronic conditions are not placed in the Support Group category, thereby qualifying for unconditional long-term support, those with working partners will after one year find themselves totally dependent on them, and with no independent financial support. Currently just 7 per cent of new claimants are placed in the Support Group, meaning that thousands are faced with work sanctions that they cannot meet.

A clearly failing system breeds fear and suspicion within the disabled community, making them less likely to successfully engage with the scheme. At the same time the well publicised numbers of those suffering from its sanctions feed into the widespread assumption that those who are unwell or disabled are too lazy to work or just haven't tried hard enough. In our experience, this could not be further from the truth.¹⁹ Removing security and support will simply exacerbate many conditions,

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creating further pressure on the NHS and local authorities. Most people who become unable to work have tried many different ways of re-engaging with the workplace, but find employers unwilling to give them a chance, hours that are too long, or too rigid, or simply have to give up if their conditions worsen.

The rigidity of the current benefit system is incredibly daunting. With the proposed six-month qualifying period for DLA (it is currently three months), and a lengthy application process for ESA, claimants live in fear of giving up benefits to take a job in case they lose everything if they subsequently become unable to work again. A fairer system would offer a basic level of support to those with diagnosed conditions with a clear pathology, which could be tapered off as work is undertaken, yet readily available again if work becomes impossible or simply not financially sustainable.

Furthermore, if the system is to be rolled out to nearly 2 million people, relying on the assumption that they will be supported into work, then we should be very sure that the work programmes that have been charged with supporting claimants are operating successfully. But this is currently not the case. Pathways to Work, the programme which until very recently was responsible for assisting those on IB and ESA into work, has been found to have hardly any greater a success rate than claimants who are trying to find work on their own. Hundreds of millions of pounds have been paid out to private companies to help the sick and disabled into work, but, as Richard Disney et al explain:

Preliminary evidence from the trial evaluations suggested that these programmes [i.e. Pathways] had a significant impact on the outflow from disability insurance [i.e. IB] in the first six months of the spell, but little effect thereafter, and that the effect was focused more on some work disability conditions (mostly physical) than others (mostly mental).²⁰

In other words, those with more temporary conditions are 'helped' into work that they would have been very likely to find otherwise, whilst those with longer-term illnesses or disabilities are overwhelmingly let down by the system.

The truth is that pain, fatigue, nausea, dizziness, diarrhoea and many other symptoms are debilitating and disabling in their own right. We simply cannot wave

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a magic wand and expect people with serious, long-term conditions to be able to work in the way that an able bodied person usually can. Currently, 1 in 4 people of working age have some kind of illness or disability, and 60 per cent of them are already in work.²¹

With the rise in auto-immune conditions and long-term variable illnesses, and increased survival rates for many with congenital disabilities, the numbers of people living with long-term severe disability have risen, along with the numbers claiming DLA, whilst those claiming ESA alone have fallen.²² People are living longer, but many are being kept alive with a host of complex and expensive medications and treatments that simply were not available three decades ago. Just as we face a crisis in elderly care and pension provision, we also face a crisis of increasing levels of people living with severe disability and long-term sickness - a trend seen throughout the wealthy world. Closing our eyes to these problems won't make them go away.

Alternative ways of contributing

People living with the most severe conditions present us with an opportunity to look in a new way at the very nature of 'work' and 'contribution'. People with long-term illnesses or disabilities need an entirely different set of solutions to those who are able-bodied. A system of fully flexible working hours would potentially allow the individual to dip in and out of work as and when they were able to. The hard and fast division between 'full-time' and 'part-time' is simply too limiting. However, a system could be designed whereby this flexible work could be underpinned by a contract allowing pro-rata payments, possibly with government working in partnership with employers. Such a scheme could only operate on the basis of reliability and security when someone attempts to leave benefits and enter the workplace. It would also need to be large enough to be truly viable on a national level. At the same time, we could do much more in today's technological age to enable those with long term illnesses or disabilities to work from home in pockets of time that suit their limitations.

Those who become too ill to continue their chosen careers may be able to re-train or study for new qualifications, allowing their employer to continue employing them in different roles. However, unless this kind of support is available at the point

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when an illness or disability becomes too debilitating, many will simply lose their jobs, and then they will find it many times more difficult to get another one when the particular crisis has passed, or re-education has been completed. But as I write, education for sick and disabled people is being reduced, not extended.²³

A further option for many sick or disabled people would be to develop a hobby or small business idea into paid employment, which they would be more likely to have the confidence to do with a little support. Help to start and develop a small business, or even local business co-operatives, could remove much of the fear of failure that is inherent in starting any business, particularly when the entrepreneur is often unwell or unable to work.

Finally, government needs to engage with business, finding ways that those currently excluded from the workplace may again be included. They would do well to consider how the money already spent on welfare might be better targeted in the cases of those who wish to work but also need some time off or support in order to be able to do so. Transferring some of the welfare bill towards employers who are prepared or able to accept people with more variable limitations might remove some of the concerns that people have about fiscal responsibility. Some countries - for example Germany - mandate employers to hire a specific percentage of sick or disabled workers. Whether Britain adopts a similar scheme, or focuses on tax incentives and grants, we must start to take more note of the practicalities of employing someone with an illness or disability, and look at ways of supporting employers to do so.

It is, however, vitally important to remember that many people simply will not be able to work, and that sanctions and penalties will not create any miracle cures. But this is not to say that sick and disabled people cannot contribute in other ways. Many already volunteer or engage with their local communities, as and when they are able to. It may be unrealistic to expect those who are seriously unwell or severely disabled to fit into a traditional working model, but it is unhelpful to ignore the great contribution they can and already do make to society.

Any system that truly aims to reward responsibility, or claims to be based on fairness, must adopt a holistic approach to the idea of contribution. Those that find themselves unable to be reliably financially productive may yet be productive in many other ways. This contribution should not be ignored or dismissed, but should be part of the overall assessment of what a person can or cannot do. Politicians are

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currently very keen on the ideas of contribution and responsibility, but if that is simply taken to mean an ability to bring in a financially viable wage, it will inevitably exclude a whole sector of society with different needs and abilities.

Kaliya Franklin is a disability rights campaigner, writer and blogger (www.benefitscroungingscum.blogspot.com). She is a co-founder of the non-partisan group The Broken of Britain (www.thebrokenofbritain.blogspot.com), who campaign against the punitive measures in the Welfare Reform Bill and for disability rights. **Sue Marsh** suffers from severe crohn's disease and campaigns to raise awareness of fluctuating conditions, and the effect that welfare reform has on sick and disabled people in the UK. She writes the blog, Diary of a Benefit Scrounger (diaryofabenefitscrounger.blogspot.com/), and is political strategist for the Broken of Britain. She also writes for *The Guardian* and prominent left-wing blogs such as Left Foot Forward, Labour List and Liberal Conspiracy.

Notes

1. See for example www.dailymail.co.uk/news/article-1353111/Disability-benefits-Half-claimants-asked-prove-eligibility.html.
2. For recent government statistics on DLA claimants see http://statistics.dwp.gov.uk/asd/asd1/adhoc_analysis/2011/DLA_Growth_in_Caseload_FINAL.pdf.
3. See BBC news reports: <http://news.bbc.co.uk/1/hi/uk/politics/33556.stm>; <http://news.bbc.co.uk/1/hi/uk/41746.stm>.
4. For more on the myth that there are one million people on benefits who are really fit for work, see Steve Griffiths and Declan Gaffney in this ebook.
5. For more on the biopsychosocial model, see Jonathan Rutherford's essay in this ebook.
6. 'Minister puts food bill on expenses', *Sunday Express*, 12.4.09.
7. See www.scope.org.uk/news/disabled-people-hit-by-welfare-cuts.
8. See for example my own story - Kaliya Franklin, 'Being turned down for an electric wheelchair has left me dejected', *Guardian*, 4.8.11: www.guardian.

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co.uk/society/joepublic/2011/aug/04/denied-electric-wheelchair-nhs-criteria.

9. See www.disabledgo.com/blog/2010/08/solutions-to-housing-shortage-are-not-complicated/.

10. For an example of local cuts to community transport see www.sunderlandecho.com/news/local/end_of_the_line_for_shoppers_bus_1_2849126.

11. See www.communitycare.co.uk/Articles/2010/12/02/115939/storm-of-protest-greets-birminghams-super-critical-threshold.htm; and www.communitycare.co.uk/Articles/2010/07/01/114824/care-charges-set-to-soar-for-users-in-warwickshire.htm.

12. www.candocango.com/government-ignores-alarm-bells-as-access-to-work-figures-slump/.

13. www.dwp.gov.uk/docs/sayce-report.pdf.

14. For examples of exclusions see www.abilitymagazine.org.uk/Articles/Article-108-3.aspx.

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16. http://www.legislation.gov.uk/ukxi/2011/228/pdfs/ukxi_20110228_en.pdf

17. See www.publications.parliament.uk/pa/cm201012/cmselect/cmworpen/1015/101505.htm; www.guardian.co.uk/commentisfree/2010/jul/06/osborne-haste-undermine-incapacity-benefit-reform; www.guardian.co.uk/politics/2011/mar/09/welfare-bill-cancer-patients; www.citizensadvice.org.uk/press_20100323.

18. See Malcolm Harrington, *An independent review of the work capability assessment*, HMSO 2010, www.dwp.gov.uk/docs/wca-review-2010.pdf.

19. <http://diaryofabenefitscrounger.blogspot.com/2011/05/welfare-for-people-by-people.html>.

20. R. Disney et al, 'The baby-boomers at fifty...', in P. Gregg and J. Wadsworth (eds) *The Labour market in winter: the state of working Britain*, Oxford 2011, p67.

The benefits scandal

21. 'Baby-boomers at fifty', see note 20.

22. See Declan Gaffney in this ebook.

24. www.disabledgo.com/blog/2011/08/government-could-face-new-high-court-challenge-over-cuts/

‘Dependency’ and disability: how to misread the evidence on social security

Declan Gaffney

Contemporary narratives on ‘welfare dependency’ turn on airbrushing long-term disability out of the evidence.

Both left and right have a tendency to treat out-of-work benefit receipt as a symptom of broad societal malaise - whether this is seen in terms of the failures of capitalism, or of moral decline, or (increasingly, on both sides) of both. But neither of these perspectives is appropriate for the purposes of discussing a system that mainly deals with situations which would need to be addressed by any functioning welfare state, under any plausible economic circumstances or social values: i.e., assistance in periods of temporary unemployment or sickness, and for longer periods of severe and long-term disabling conditions and caring responsibilities.

The sort of grandstanding references to ‘six million people on welfare’ that dominate political debate in this area involve airbrushing out of the picture these routine functions of the benefits system, in favour of shadowy social archetypes: families where ‘no one has worked for generations’, communities where ‘no one works around here’, ‘the underclass’.¹ The conflation of social security and social

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dysfunction is one of the dominant tropes of current debate on welfare on all sides. Will Hutton, on the centre left, could declare last year that 'the welfare state was not set up to support vast families or single mothers in intergenerational welfare dependency' - the question of whether it was to any significant extent doing anything of the kind was not even posed.²

It is well known that social security systems can have intended and unintended effects that go well beyond their function of managing social risks. However, the extent to which any system does have negative effects is essentially an empirical issue rather than a matter for intuition; but the sort of accusations that have been levelled against the UK system by commentators on left and right have rarely been supported with relevant, up-to-date data on who claims out-of-work benefits, why, and, crucially, for how long. Indeed most assertions on 'welfare dependency' turn on an implicit and quite erroneous assumption that benefit claims are overwhelmingly long-term in nature.

This article looks at the area of the benefits system that is most relevant to discussions that present long-term benefit receipt as a symptom or a cause of societal problems - i.e. those in receipt of incapacity and disability benefits, which now account for some 81 per cent of all long-term out-of-work claims (claims running for five years or over). To understand the underlying trends within this group we begin with the history of economic inactivity and benefit receipt from the early 1980s to the mid-1990s, since this history continues to influence contemporary anxieties about social security.³ We then look at the period from 1997 to the present, and in particular at contrasting developments in the 'incapacity' and 'disability' caseloads. We show that the idea that Labour failed to reduce the Incapacity Benefit (IB) caseload - a dominant theme in the party's post-election autopsy - is largely a myth, and is based on misconceptions about the geography, age and gender patterns of benefit receipt. In fact IB receipt fell substantially during this period, and fell most for age groups and areas with the highest levels of receipt. On the other hand disability benefit receipt rose during this period (albeit not as much as incapacity benefit receipt fell), partly because of demographic factors, but also because of increases in claims associated with mental health and learning difficulties. On the other hand there was no rise in disability benefit claims associated with physical conditions.

The key point here is that long-term out of work benefit receipt is increasingly

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dominated by people living with more severe disabling conditions, and by people caring for the disabled. And neither the flaws of contemporary capitalism nor changes in social values have much of a role in explaining these trends or indicating promising policy directions.

'Incapacity and disability' benefits in the UK fall into two groups. The first group consists of income replacement benefits, whether contributions-based or income-based: Incapacity Benefit (IB), or, for those who do not meet the contributions conditions, income support for reason of sickness or disability. For new claimants, these benefits have been replaced since October 2008 with Employment Support Allowance (ESA), and existing IB claimants are currently being transferred to the new benefit. In most statistical discussion, those in receipt of any income replacement benefit for reasons of sickness or disability are classed together as 'IB/ESA' claimants. We depart from this practice to make a distinction within the IB/ESA caseload, based on whether or not someone is in receipt of Disability Living Allowance.⁴

Disability Living Allowance (hereafter DLA), introduced in 1992, is a non-means tested benefit for people with disabilities which lead to specific mobility and care requirements. Eligibility conditions and administration are completely separate from those for the income replacement benefits (although some DLA entitlements affect entitlements to these and other benefits). It is paid at a variety of rates depending on the nature of the claimant's impairments, and a large proportion of awards are 'indefinite', i.e. claimants' conditions are not expected to improve over time. DLA is *not* an out-of-work benefit, and about a fifth of working age DLA recipients are not receiving an income replacement benefit.

This article focuses on the differences in trends between those receiving IB/ESA and those who receive DLA, most of whom also receive IB/ESA, in order to give a rounded picture of trends in incapacity and disability benefit receipt.⁵

Thirty years of incapacity and disability benefits

The historical labour market data of the 1980s and early 1990s documents a period of labour market trauma. At the time attention was largely focused on the return of unemployment at levels that had not seen for generations, but for our purposes there is particular significance in the accompanying major build-up of economic inactivity (i.e. those neither working nor looking for work) among people of

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working age, which was to prove one of the most persistent legacies of the Thatcher era. The scale and rapidity of the changes can be illustrated by the fact that activity for men in the 55-59 age band fell from 91 per cent in 1980 to 80 per cent by 1987, and to 74 per cent by 1994. These changes did not contribute to the unemployment figures, as these former workers were not actively seeking work: many either took early retirement or were diverted on to incapacity and disability benefits. By 1995, of the 424,000 men aged 55-59 in receipt of benefits, some 71 per cent were receiving a sickness or disability benefit.⁶

The experience of rapid falls in economic activity for older men was international, affecting most western economies in the 1980s. While the scale and timing varied from country to country, common factors included the felt need on the part of employers to shed less 'productive' workers in the face of increased international competition, and a tendency towards labour rationing on the part of governments committed to employment-constraining deflationary policies - if the economy could no longer provide full employment, better if the jobs went to those with young families to support.⁷

This logic did not always extend to female parents. The UK saw rapid increases in employment for women in couples during the 1980s, but for the growing number of female lone parents the experience was the opposite, with employment falling from 63 per cent in 1980 to 44 per cent by 1995: again, this represented a growth in inactivity rather than unemployment, and, as with older men, the benefit system played a role in diverting claimants into inactivity, as lone parents were placed on income support rather than unemployment-related benefits.⁸

By the late 1990s benefits caseloads were dominated by economic inactivity rather than unemployment, and of these incapacity benefit (2.6 million) and income support for lone parents (995,000) were the most important elements.⁹ There were also major disparities in IB receipt between areas, reflecting the geographical pattern of deindustrialisation and the collapse of mining, and substantial gender differences, especially among older claimants. Thus in Wales and the North East, IB claims for men aged 55-59 were equivalent to some 29 per cent of the population by 1999, compared to a national average for men in this age band of 19 per cent and for women of 15 per cent. More than a million IB claims had been running for five years or more. This was, broadly, the situation that Labour inherited in 1997.

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So far we have followed the standard story on the rise in incapacity benefit receipt: however it is clear that there was more going on during this period than government exploitation of the benefits system to manage deindustrialisation and slack labour demand. It has long been recognised in the academic literature that the prevalence of disability, as measured by survey data, did in fact increase from the 1970s to the mid-1990s. Richard Berthoud found that the percentage of the population reporting a long-standing limiting illness rose from 14 per cent in 1975 to 18 per cent in 1995.¹⁰ However, this rise in self-reported disability has often been interpreted, largely without evidence, as reflecting a greater willingness of people to define themselves as disabled, rather than any substantial change in the prevalence of disability within population: there was for a long time an informational vacuum due to lack of statistical evidence on the severity of disability among the growing self-reported disabled population. It was not until Berthoud's 2011 paper that evidence on disability trends at different levels of severity was brought into play; and this indicated that disability prevalence had risen at *all* levels of severity, and at a somewhat greater rate for the most severely impaired.

It now looks as if the rise in incapacity and disability benefit receipt up to the mid-1990s was underpinned by three broad processes, each with differing timings and tempos: there was a gradual rise in disability prevalence between the late 1970s and the mid 1990s; there was at the same time a steady deterioration of the employment chances of disabled people at all levels of severity; and there was a pronounced geographical variation in IB receipt, caused by the concentration in certain areas of the accumulated impacts of weak labour demand and deindustrialisation.¹¹ While it is likely that government policy played a role in making a worsening situation even worse, by diverting unemployed workers on to incapacity and disability benefits, there were clearly other factors at work in driving benefit caseloads to the high levels they had reached by the mid-1990s, and in maintaining these levels during Labour's period in office. However, by 1997 the assumption that the rise in incapacity and disability benefit receipt was entirely due to 'labour market' factors or 'welfare dependency' was thoroughly engrained. In 1999, Tony Blair roundly declared the IB was 'not a benefit which compensates those who have had to give up work because of long-term illness or sickness - it's an alternative to long-term unemployment or early retirement. That's why it must be reformed'.¹²

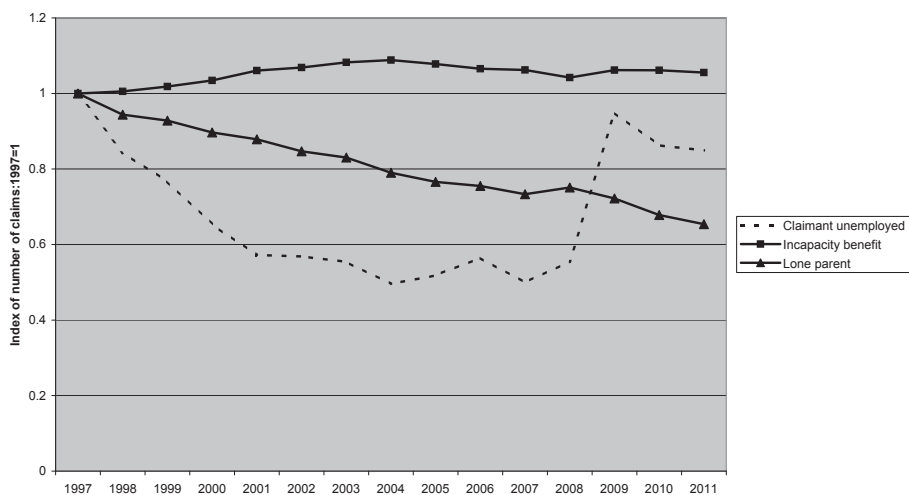
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From 1997 to 2002, Labour oversaw what was arguably the most radical period of social security reform since the foundation of the welfare state, with the introduction of the minimum wage, an unprecedented expansion of in-work financial support, important steps towards integration of the tax and benefit system, the establishment of Sure Start (later, Children's Centres), the introduction of a range of 'New Deals' for different categories of benefit claimant and the adoption of the target of eliminating child poverty by 2020. Contrary to what seems to be widely believed, Labour also reformed Incapacity Benefit in 1999, tightening contributions conditions.

The chart below summarises developments for the two main 'inactive' groups inherited from the previous administrations over Labour's period in office. The contrast between lone parents and IB claimants could hardly be more striking - or, as we shall see later, more deceptive. On the face of it, lone parent benefit receipt reduced dramatically, while the IB caseload remained largely unchanged. This stability was to become the major premise of those arguing the need for 'radical' reform of IB, which became something of a totemic issue for Blair towards the end of his period as prime minister.

There is, it must be said, something rather implausible about this picture. Under Labour, unemployment fell to its lowest level for a generation, and the combination of the minimum wage and tax credits should have improved the

Chart 1 Receipt of main out-of-work benefits 1997-2011 (1997=1)



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gains from working for the lower-skilled workers who dominated the IB caseload. That these changes should have had no effect whatsoever on IB receipt therefore strains credulity. And indeed, when we look at receipt by age, gender and geography, it becomes clear that IB receipt did fall, and it fell most where rates had been highest: in former industrial and mining areas, among older workers, and among men. A simple analysis of the caseload between 1999 and 2010 shows that falls in rates of receipt among men over this period equated to some 19 per cent of the 1999 caseload, but that this was offset by the effects of population ageing; these increased the total by the equivalent of 10 per cent, resulting in a net fall of only 9 per cent. Reductions in rates of receipt were concentrated in the North of England, Wales and Scotland, where rates had risen most during the 1980s and 1990s. Among women, whose rates of receipt were generally lower, there was a slight rise in overall receipt, and this was entirely explained by ageing. Unpicking these opposing influences shows that the immobility of the IB caseload was something of a myth. This becomes even more apparent when we look at compositional changes in the caseload in the next section.

An alternative perspective on benefit receipt

So far we have talked of ‘incapacity and disability’ benefits, ignoring the heterogeneity of situations that the benefits system needs to support. Many claimants experience relatively short-term episodes of work-limiting illness: others have severe conditions which will last for the rest of their lives; while yet others are in situations between the extremes of severity and duration. There is no single, objective methodology for partitioning the claimant population on criteria of severity and duration of conditions. However, we can exploit the fact that the UK has a separate and non-means tested benefit specifically for the more severely disabled to explore the composition of benefit caseloads.

To explain: many benefit claimants are in receipt of more than one benefit, and in order to avoid double counting of claimants, official data on benefit receipt from the Department of Work and Pensions and the Office for National Statistics conventionally groups claims for different combinations of benefits into statistical groups (jobseekers, lone parents, disabled, etc) according to a hierarchy in which certain benefits and reasons for claiming take precedence over others in deciding

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which group a claimant will be allocated to. Importantly for our purposes, a DLA recipient who is in receipt of IB/ESA will be allocated to the 'ESA and incapacity benefits' group rather than to the 'disabled' group. The official 'disabled' statistical group includes only the (growing) minority of DLA recipients who are not receiving an income replacement benefit.

In this section we use an alternative grouping, in which DLA receipt takes precedence over IB/ESA receipt in allocating recipients to groups. In other words, we are more interested here in whether people are receiving DLA - an indicator of the severity of their impairment - than in whether or not they are receiving an income replacement benefit. The totals for incapacity and disability benefits (table 2, right hand column) confirm that our alternative grouping uses the same underlying data as the DWP groups and does not lead to double counting or undercounting of claimants.

This is not, it should be stressed, an attempt to distinguish 'disabled' from 'non-disabled' benefit recipients. In particular, it is not the case that DLA receipt marks out a group which is unable to work, because many DLA recipients are working, while not all work-limiting conditions will necessarily lead to DLA eligibility. Evidence on claim durations suggests that a substantial minority of IB recipients who are not receiving DLA have long-term conditions, but nevertheless IB recipients who are also receiving DLA are far more likely to be long-term claimants.

It is worth dwelling on this point, given that the pattern of claim duration for IB recipients is the subject of considerable confusion. Statements to the effect that the great majority of IB claims are long-term in duration are common, and are often used to suggest that IB has a quasi-magical power to induce long-term benefit dependency. In fact, the arithmetic of stocks and flows means that at any point in time, long-term claims (i.e. longer than five years) form a clear majority of the IB caseload. In the same way, a census of in-patients in a hospital ward would show a preponderance of older patients with longer lengths of stay. However, if we wanted to calculate the average length of stay for all in-patient admissions, we would not count patients at a single point in time, as this would give us an upwardly biased estimate: we would look at all admissions over an extended period. The same applies to benefit caseloads.

This point is illustrated in Table 1 below, using data from 2003-2008. The point-in-time estimate for 2008 shows that a majority (61 per cent) of IB claims in payment had run for five years or more. Over five years, however, this percentage is

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Table 1 Distribution of incapacity benefit claims by claim duration (approximate)¹⁴

All IB claims	<1 year	<2 years	<5 years	5 years +	
2008	13.4	21.5	38.8	61.2	
2003-2008	37.8	47.8	62.8	37.2	
All IB claims excluding DLA combinations	<1 year	<2 years	<5 years	5 years +	
2008	23.7	35.3	56.2	43.8	
All IB claims excluding DLA combinations	2003-2008	50.8	62.4	77.3	22.7
IB/DLA combinations	<1 year	<2 years	<5 years	5 years +	
2008	4.1	4.9	14.0	76.9	
IB/DLA combinations	2003-2008	7.7	6.3	15.1	70.9

Source: DWP benefit flows tabulation tool (flows); WPLS (stock).¹⁴

37 per cent. When we exclude claims which include DLA, the point-in-time share of long term cases falls to 44 per cent, while the five-year estimate is 23 per cent. This is a substantial minority of non-DLA IB claims, but it is clear that long-term claims for this group were the exception, not the rule, over this period. Half of claims ended within a year and 62 per cent within two years. For claims which include DLA, however, 71 per cent lasted five years or more.

This striking difference in the pattern of claim durations shows how important it is to take account of DLA in looking at trends in IB receipt. It is well known that the amount of time people spend on IB was a more important driver of growth in caseload numbers than any changes in the number of people coming on to IB. An increase in the share of DLA-entitled recipients of IB, other things being equal, implies an increase in the share of long-term claims, with a greater impact on overall caseload numbers over the longer term than an equivalent increase for other types of claimant, who are much more likely to leave the benefit within a relatively short period. Figures on long-term benefit receipt in particular should be contextualised in terms of DLA, to avoid the risk of misleading inferences - for example, that IB/ESA taken on its own tends to encourage long-term benefit receipt.¹³

Comparison with the DWP groups shows the point of our regrouping of the data (Table 2). Our 'disability' group based on DLA receipt is more than four times the size of the DWP 'disability' group in 2010, while our 'ESA/IB' group, which excludes DLA claimants, is just half the size of the DWP group. In 2010, our 'disability' group is considerably larger than our 'ESA/IB' group, while the DWP 'IB/ESA' statistical group is some six times the size of the corresponding disabled group. The alternative grouping brings out what is surely one of the more important aspects of contemporary benefit receipt: a clear majority of all incapacity and disability benefit recipients have conditions severe enough to entitle them to DLA - something which is obscured by the precedence given to IB/ESA receipt in the DWP's grouping.

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Table 2 DWP and alternative groupings of incapacity and disability benefit claims

	Year	ESA and Incapacity Benefits	Disability
DWP statistical groups	2002	2,765,220	256,230
Alternative grouping*	2002	1,601,280	1,420,190
DWP statistical groups	2010	2,576,240	398,880
Alternative grouping*	2010	1,279,450	1,695,700
DWP statistical groups	numerical change 2002-2010	-188,980	142,650
Alternative grouping*	numerical change 2002-2010	-321,830	275,510
DWP statistical groups	% change 2002-2010	-6.8	55.7
Alternative grouping*	% change 2002-2010	-20.1	19.4
Decomposition of change by age band 2002-2010			
Alternative grouping		ESA and Incapacity Benefits	Disability
	% change due to demography	5.2	6.6
	% change due to rate of receipt	-25.3	12.8
	% change	-20.1	19.4

** In the 'alternative grouping', 'disability' includes all receiving DLA, while ESA and IB excludes those in receipt of DLA; for the DWP, the ESA and IB group at Source: Work and Pensions Longitudinal Study

The alternative grouping also offers a different perspective on changes in benefit receipt over time. Both groupings show numerical falls in the 'ESA/IB' group and rises in the 'disabled' group between 2002 and 2010, but the scale of these changes is almost doubled in the alternative grouping.

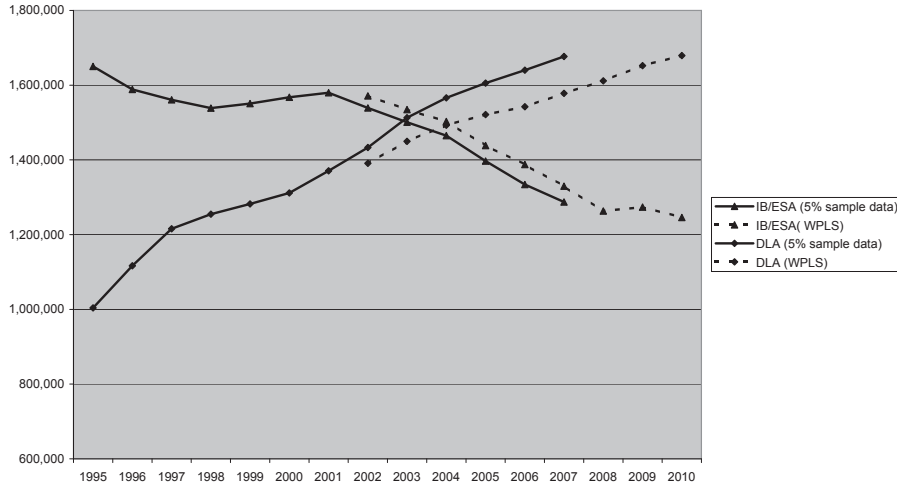
The long-term development of the incapacity and disability caseload using our alternative grouping is shown in chart 2, which combines data from two DWP datasets covering different timeframes (as can be seen from the overlap between the two from 2002 to 2007, they give broadly consistent results). Disability benefit claims have risen more or less continuously since the introduction of DLA, and have exceeded IB-only claims since 2004. Note that these figures include people who are only receiving DLA, many of whom will be working; this group, while it forms a minority of DLA claims, has in fact shown by far the strongest growth since 2002. IB/ESA-only claims have been falling since 2002, but this then levelled out with the onset of recession. Some of these changes of course reflect transfers between the two groups, but in the absence of published longitudinal data tracking individual claimants over time, we are unable to quantify this.

We can however separate out the demographic component of these changes, as we did earlier for IB/ESA totals. In fact the 20.1 per cent fall in the IB/ESA-only caseload is composed of a 25 per cent reduction due to falling rates of receipt by age and gender, offset by a 5 per cent increase due to population changes. (For men the reduction by rates of receipt is some 31 per cent of the 2002 caseload, offset by a 7 per cent increase due to population. For women demographic change raised the caseload by 3 per cent while reduced receipt lowered it by 18 per cent.)

Thus the IB/ESA grouping as a whole, which is on average less severely

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Chart 2 Incapacity and disability benefit receipt 1995-2010



impaired than the group in receipt of DLA, has seen a quite dramatic numerical reduction since 2002, especially among men, but this has been partially offset by demographic change. This contrasts with the upward trend for the 'disabled group', where demographic change explains only about a third of the increase. However, among those who are in receipt of both DLA and IB/ESA, demographic change has increased numbers of recipients by 6.5 per cent, compared to 5 per cent due to rising rates of receipt. In other words, demography alone explains more than half the increase in out-of-work DLA claims.

How should these contrasting trends be interpreted? Just over half the fall in IB/ESA-only receipt among men is accounted for by those aged 55-64: the retirement or death of those workers who shouldered the burden of the massive employment dislocations of earlier decades may be an important part of the overall change, but it is still only a part. Strong labour market performance up to the recession, coupled with policy changes (tax credits, minimum wage), are likely to be the main factors: the expected effect would be that those with less severe conditions would return to employment more quickly in tighter labour markets, gradually bringing down caseload numbers.¹⁵ For women, the fall in caseload is more evenly spread over the age range, suggesting that changes affecting specific cohorts are less important than among men. Labour's third term reforms are not central to these changes, as most of the fall took place before 2008.

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As we have seen, more than half the rise in out-of-work DLA receipt is explained simply by demographic change: for those receiving DLA alone this explains only about 14 per cent. The extent to which we should see the remainder of the increase in DLA as an indication of a wider prevalence of disability - as an effect of the maturing of the DLA system (i.e. people being more likely to claim) or as a side effect of policies of deinstitutionalisation - remains an open question. Two things are clear, however. The rises in DLA receipt over this period are not due to increased flows of claimants on to the benefit (these have fallen), but to the gradual build-up of claims of long duration.¹⁶ And once we adjust for demographic change, there has been no increase in DLA receipt associated with physical conditions: the diagnostic groups which account for the increase are learning difficulties and mental health.¹⁷ Any explanation of the rise in DLA is therefore likely to turn on changes in the way people with mental health problems and learning difficulties are supported, rather than on some general factor such as 'welfare dependency' or 'hidden unemployment'.

Conclusion

Bringing demographic change and severity of impairment into the picture in this way raises obvious questions about the aggressive benefit caseload reduction aims adopted by both the current and previous governments ('a million off IB'). If the IB/ESA-only group has already fallen by a quarter (controlling for demography), and by nearly a third among men, one has to ask how much further this part of the caseload can be expected to be reduced if the system is to continue to provide social protection for those experiencing short and medium term incapacity for work. Changes to work incentives through tried and tested welfare reform interventions are likely to yield diminishing returns given the current composition of the caseload, which reflects in part the success of previous social security reform. Rather, the focus needs to be on a realistic assessment of employment chances for people with more severe conditions, and long-term effort to improve these chances, involving all relevant policy instruments. The current moralising and grievance-laden discourse of welfare is a formidable barrier to any such positive developments.

This article has tried to give a sense of the out-of-work benefit system we have as opposed to the largely symbolic construction which dominates current debate.

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This is a system which is primarily engaged in dealing with spells of work-limiting illness and unemployment, and with longer term periods of severe disability and caring responsibilities. While it is far from perfect, this system is unrecognisable as the ‘road to dependency’ of left and right welfare reform rhetoric; and, for the time being at least, it is in much better condition than it was in the aftermath of the deindustrialisation waves of the 1980s and early 1990s.

Notes

1. For a rigorous account exposing the lack of realism in claims that there are significant numbers of ‘intergenerationally workless’ families see L. Macmillan, ‘Measuring the intergenerational correlation of worklessness’, *CMPO Bulletin*, University of Bristol, September 2011; see also D. Gaffney, ‘The myth of the intergenerational workless household’, *Left Foot Forward*, 21.9.10: www.leftfootforward.org/2010/09/the-myth-of-the-intergenerational-workless-household/.
2. www.guardian.co.uk/commentisfree/2010/oct/10/fair-society-cameron-osborne.
3. We follow Ruth Lister in eschewing the term ‘welfare’, and for the same reasons. See her ‘Our social security system must guarantee real welfare’ *Guardian*, Comment is Free, 28.8.11: www.guardian.co.uk/commentisfree/2011/aug/28/robin-hood-poor-welfare.
4. Severe Disablement Allowance, an income replacement benefit for disabled people, was closed to new claimants in 2000. Our figures for both ‘sickness’ and ‘disability’ benefits include SDA claims. SDA claims are allocated to the ‘disabled’ group when combined with DLA.
5. Consistent data on DLA is generally only available from 2002 on, although we have devised a broadly consistent time series back to 1995. Much of the analysis therefore focuses on the period 2002-2010, which by coincidence saw major changes in incapacity and disability benefit caseloads.
6. DWP benefits 5 per cent sample data.
7. See European Commission, *Study of compilation of disability statistical data*

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from the administrative registers of member states, 2007, esp. p.17, p.25; see also I. Mares, 'Firms and the welfare state: when, why and how does social policy matter to employers?', in Hall and Soskice (eds.), *Varieties of capitalism*, Oxford 2001; and T. Iversen, *Capitalism, democracy and welfare*, Cambridge 2005.

8. Data on lone parent employment from R. Blundell, A. Bozio and G. Laroque, *Extensive and intensive margins of labour supply: working hours in the US, UK and France*, Institute for Fiscal Studies Working Paper, 01.11; male economic activity figures from International Labour Organisation, *Economically Active Population Estimates and Projections* (EAPEP) dataset.

9. Data for third quarter 1999 from Work and Pensions Longitudinal Study.

10. R. Berthoud, *The employment rates of disabled people*, DWP Research report No 298, 2006.

11. I am grateful to Ben Baumberg for advice on interpreting disability trends. Responsibility for the interpretation offered here rests with the author of course.

12. See Steve Griffiths in this ebook.

13. The hypothesised causal process here runs from underlying conditions to work-limiting impairment to long-term non-employment and therefore long-term IB receipt combined with DLA. In the alternative hypothesis, put forward by Beatty, Fothergill and Platts-Fowler (*DLA claimants: a new assessment*, DWP Research report no. 585, 2009) the process runs from long-term IB receipt to eventual DLA claims 'as further source of financial support': in other words, whatever drives IB-only receipt (primarily labour market factors, on this account) also drives IB/DLA receipt; and DLA is essentially an 'adjunct' to IB. Given the quite different eligibility conditions for DLA compared to IB, and the evidence on the differences between the IB/ESA-only and DLA caseloads, we think that much stronger evidence than has been offered thus far would be needed to displace the naive reading that care and mobility needs are the dominant explanatory factors for DLA receipt.

14. 'Claims' are calculated as the sum of off-flows over the period by duration and benefit combination at off-flow, and the stock of claims (by duration and combination) at the end of the period. Percentages should be taken as illustrative only. To avoid spurious precision, rather than summing quarterly flows over the entire period we have simply multiplied the 2007-8 flows by

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five. Note that the benefit combinations are recorded at the point of off-flow or the end of the period: claimants will not necessarily have been on these particular combinations throughout the claim duration. Because these figures relate to the period 2003-2008, they are not affected by Labour's third term reforms to Incapacity Benefit. Flows data for DLA-only claims (the remainder of our 'disability' group absent from these figures) are not published.

15. For a similar interpretation of the overall fall in IB/ESA see D. McVicar, 'Local level incapacity benefit rolls in Britain: correlates and convergences', Queen's University School of Management, working paper, December 2009.

16. See D. Gaffney, 'The "inexplicable" rise of Disability Allowance explained', *Left Foot Forward*, 14.2.11: www.leftfootforward.org/2011/02/rise-in-disability-living-allowance-explained/.

17. See D. Gaffney, 'Clause 52 of the Welfare Reform Bill' (September 2011): <http://lartsocial.org/pdf/Clause52oftheWelfareReformBill.pdf>.

The misuse of evidence in incapacity benefit reform

Steve Griffiths

The use and misuse of evidence in the benefits debate

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

During the years of reform, this lack of engagement with critical discourse has adversely affected several hundred thousand people with severe and chronic health problems. The scale of this failure, and the airbrushing out by the media

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and political establishment of a stream of evidence that would, if taken on board, undermine their whole approach, should properly be seen as a democratic deficit - and one that has had a disproportionate effect on a particularly vulnerable section of our population. Such denial of the evidence will need to be confronted if there is to be a progressive realignment in our politics.

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

Background

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

not a benefit which compensates those who have had to give up work because of long-term illness or sickness - it's an alternative to long-term unemployment or early retirement. That's why it must be reformed.²

This approach informed Labour's Welfare to Work policies throughout its period of government, and has been carried forward by the Coalition government. A

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succession of Green Papers, White Papers and legislation, too numerous to list here, led us to the Pathways to Work scheme, followed by a new Work Capability Assessment, which acts as the gateway to Employment and Support Allowance (initially only applied to new claimants from 2009). This new regime was developed from a 2007 'Independent Report' by David Freud, an investment banker and deal-broker, brought in to advise the DWP by Secretary of State John Hutton.³ Freud, having been subsequently ejected by Peter Hain, was brought back by James Purnell, became an adviser to the Tories, was ennobled, and is now Minister for Welfare Reform for the coalition. His report accepts uncritically the New Labour aim of reducing the number of Incapacity Benefit recipients by a million. (A critique of the research basis for this figure is outlined below.)

Freud's Independent Report concludes that:

while there is no conclusive evidence that the private sector outperforms the public sector on current programmes, there are clear potential gains from contesting services, bringing in innovation with a different skill set, and from the potential to engage with groups who are often beyond the reach of the welfare state.

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

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

We support the emphasis of the new Work Capacity Assessment towards what

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individuals can do rather than what they cannot, although this will require assessors to be fully competent to judge the impact of a mental disorder on an individual's capacity to work in both the short and long term.⁵

Once the new scheme was underway it became easier to make an informed judgement of its effects. Claims for Employment and Support Allowance (ESA), as in earlier sickness benefit regimes, have to be supported by medical evidence that the claimant is unfit to work. If in work, the claimant will already have been getting Statutory Sick Pay, sometimes contractual sick pay, for twenty-eight weeks, supported by medical certificates. If the claimant is in receipt of Jobseeker's Allowance (JSA), ESA can be claimed after two weeks of sickness. After thirteen weeks of claiming ESA at the JSA rate of £65.45, supported by GP certificates, claimants then become subject to the new Work Capability Assessment (WCA).⁶ The WCA is administered by Atos, a large French/Dutch company. It divides claimants into three categories: the Support Group, who are not required to undertake work-related activity, and are entitled to £96.85 per week after the assessment phase at the JSA rate; the ESA Work Related Activity Group, who are deemed fit for work with support and preparation, and receive £91.40 per week after an assessment phase at the JSA rate; and the 'Fit for Work' group, who are transferred back to Jobseeker's Allowance. The first WCA Official Statistics for ESA were released by the DWP in April 2010. In the first eight months to August 2009, Atos assessments broke down as follows:

- Support Group - 9%
- Suitable for the ESA Work Related Activity Group - 23%
- Fit for Work, so transferred to Jobseeker's Allowance - 68%.

The assessment made is usually endorsed by a DWP officer - and with an ease that has been criticised by the House of Commons Work and Pensions Committee:

We note widespread concerns that decision makers appear to give excessive weight to the conclusions of DWP medical assessments over other evidence claimants may provide. If a claimant is able to provide statements from specialists, who have regular contact with them, this evidence should be given due consideration.⁷

In March 2010, Citizens' Advice published a report on the WCA, endorsed by eighteen disability, mental health, poverty and carers' charities. The main findings

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were that: seriously ill people were inappropriately subjected to the Work Capability Assessment; the assessment did not effectively measure fitness for work; and that application of the assessment was producing inappropriate outcomes.⁸ The Disability Alliance has come to similar conclusions, and has set out exhaustive evidence for their case.⁹

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

- Effective implementation of the programme was hampered by a flawed process of piloting and evaluation, which gave too positive a view of how well Pathways could be expected to perform.
- There is a lack of robust information on what happens to those claimants who fail to participate in Pathways.
- The controls in place are insufficient to manage the risk of providers submitting inaccurate contract payment claims.
- The Department lacks the information it needs to understand the supply chain for employment support, which conflicts with its objective of ensuring a healthy market ...
- As ESA is extended to all existing claimants, there is a risk that some of those who are re-assessed and found fit to work will not receive the employment support they need.
- Early evidence shows that the new medical assessment, introduced with ESA, will deliver a significant reduction in the number of incapacity benefits claimants. The Department should evaluate the accuracy of the new medical assessment robustly to evaluate that it is fit for purpose.
- Many existing incapacity benefit claimants ... will move on to Jobseeker's Allowance. The Department has no information on claimants who are refused incapacity benefits. It should monitor them to know how many move onto JSA. The Department has also not yet fully evaluated its capacity to support large numbers of people who transfer in this way. It should undertake such an assessment and put in place the additional support required before the medical assessment is rolled out.

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The hidden unemployed: the 'evidence' base

The arguments underpinning this new regime can be traced back to reports by the Centre for Regional Economic and Social Research (CRESR) at Sheffield Hallam University, from 1997 onwards, which appear to have had a major impact on the direction taken by New Labour. Alistair Darling as Work and Pensions Secretary was an early pioneer: his 'one million disabled people say that they want to work but are not being given the chance' (1998) echoed early findings of CRESR. By 2005, David Blunkett, when he was Work and Pensions Secretary, was saying 'about half of the 2.7 million people "on the sick" are capable of working'.

CRESR's 1999 report 'Incapacity Benefit and Unemployment', the second in a series of three, estimated that there were 'around three-quarters of a million "hidden unemployed" men on Incapacity Benefit', and that 'over ten years the number of male ICB claimants might be reduced by half a million; and ... a similar proportional reduction among women would reduce the number of claimants by a further quarter of a million'.¹¹ Further reports had by 2005 led to a more ambitious estimate, which may be seen as uncannily prophetic of the Atos findings in their administration of the Work Capability Assessment:

If our survey data on self-reported health limitations is any guide, then in the context of 2.7m on incapacity benefits no more than perhaps 0.7m would be eligible for the new, higher benefit. Moreover, because there is always a flow on and off incapacity benefits among those with less severe problems, the appropriate share of new claimants finding their way onto the higher benefit might be as low as one in ten.¹²

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

On closer examination it can readily be seen that the hypotheses on which the report's projections were based were deeply flawed. The 1999 report adopts three main types of projection in order to arrive at possible totals of 'hidden unemployed'. The first of these - the 'real unemployment' indicator - at least makes some attempt to take account of health data. As a guide to what is achievable in a fully employed

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economy, it uses the rate of 'permanent sickness' among men of working age in the South East of England, as recorded by the 1991 Census. Basing itself on this data sample, it concludes: 'Therefore levels of sickness in excess of this level - 3.4 per cent of the male working age population - should be regarded as hidden unemployment'. The most obvious criticism here - though there are many others - is that this projection completely disregards regional health inequality, and generalises on the basis of benchmark figures from the least deprived region in England. And its optimism is particularly misplaced given the widening of the gap in life expectancy between 1972-77 and 2002-2005.¹³

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

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

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

In an attempt to remedy this overlooking of health factors, I did some research on the relationship between two contemporary health indicators - mortality rates and emergency admissions to hospital - and the spread of incapacity benefit and

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unemployment in the male population across 326 English local authorities in 2004. In focusing on the male population I was looking at the same group as the Sheffield Hallam report. However, it should be noted that a key factor in the overall increase in incapacity benefit claimants is the steep rise in numbers of women receiving incapacity benefit as a result of their growing participation in the workforce. Between 1979 and 1997, the number of men receiving incapacity benefit tripled, while the number of women increased seven and a half times. In 1997-2004, while the number of men receiving incapacity benefit fell by 7 per cent, the number of women increased by 18 per cent.¹⁵ This reason for the increase in IB recipients is one that is rarely highlighted.

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

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

Trends in long-term illness and health inequality

As the NHS Next Stage Review Interim Report put it in 2007:

There are currently over 15 million people in England with a long term condition and who are proportionately far higher users of health services. They account for 55% of GP appointments, 68% of outpatient and A&E attendances and 77% of inpatient bed days.

The total apparently derives from the General Lifestyle Survey (GLS). Looking at people of working age, the 2008 GLS finds 1.96 million people aged 16-44

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with a long-term limiting illness; and 3.15 million aged 45-64. The existence of 2 million people unfit for work, many of them suffering from the very conditions so central to the Department of Health agenda, should be seen in this context. But the connection seems never to have been made between these two major government workstreams serving the same people. People on Incapacity Benefit die early - that is acknowledged by government. But it is as if, in benefit terms, they were just expected to drop off their perches. Instead what actually happens is that they continue to suffer chronic illness, dependent on a progressively vanishing 'security for those who cannot work'.¹⁷

The statistics on 'Trends in Limiting Long-term Illness' in the General Lifestyle Survey are informative. In the age group 16-44, the level of those suffering from LLTI rose by half from the 1975 baseline to 1995/1996; and it declined by a fifth from 1995/6 to 2004-8.¹⁸ In the 45-64 age band (much greater in number), the increase to 1995/6 from the 1975 baseline was nearly a quarter; and the fall from 1995/6 to 2004-8 was 13 per cent. This is surely one important factor in explaining the increase in claims for incapacity benefit. And a new report for the Institute for Social and Economic Research confirms the importance of these trends in the growth of incapacity benefit claims.¹⁹

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

... in the early 1970s, the mortality rate among men of working age was almost twice as high for those in class V (unskilled) as for those in class I (professional). By the early 1990s, it was almost three times higher.²¹

The Marmot review, in February 2010, found that:

People in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability ... even excluding the poorest five percent and the richest five percent the gap in

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life expectancy between low and high income is six years, and in disability-free life expectancy thirteen years.²²

This is in the context of a *mean* Disability-free Life Expectancy in the UK in 2005/7 of 62.5 years in men, and 63.7 in women. If that is the mean, clearly many people will become disabled much earlier.²³

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

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

'Work is good for you'

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

According to Waddell and Burton:

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

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

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

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

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

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

Thomas went on to criticise inadequacies in social security decision-making, and to chastise officials, stating they must make much more effort to reduce the number

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of successful appeals made against them:

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

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

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

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

Notes

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

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2. Tony Blair, *Observer*, 23.5.99.
3. David Freud, *Reducing dependency, increasing opportunity: options for the future of welfare to work: An independent report to the DWP*, Department for Work and Pensions 2007.
4. Organisation for Economic Co-operation and Development, *Transforming disability into ability, policies to promote work and income security for disabled people*, OECD 2003.
5. Mental Health Foundation response, White Paper, *Raising Expectations and increasing support: reforming welfare for the future*, Appendix A - Responses to the public consultation, DWP, December 2008.
6. Current (2010/11) benefit rates are given throughout.
7. House of Commons Work and Pensions Committee, *Decision making and appeals in the benefits system*, 2010.
8. *Not Working - CAB evidence on the ESA work capability assessment*, CAB Briefing, in association with Mind, March 2010: www.citizensadvice.org.uk/index/campaigns/policy_campaign_publications/evidence_reports/er_benefitsandtaxcredits/not_working
9. See particularly the Disability Alliance response to DWP's Call for Evidence on The Work Capability Assessment, September 2010: www.disabilityalliance.org/r66.pdf.
10. Public Accounts Committee - First Report: *Support to incapacity benefits claimants through Pathways to Work*, House of Commons, September 2010.
11. Christina Beattie and Stephen Fothergill, *Incapacity Benefit and Unemployment*, CRESR, Sheffield Hallam University 1999.
12. CRESR, *Memorandum to the House of Commons Work and Pensions Committee Inquiry into Pathways to Work*, 2005.
13. Michael Marmot (Chair), *Fair Society, Healthy Lives*, Strategic Review of Health Inequalities in England post-2010, The Marmot Review, 2010.
14. Sir Donald Acheson (Chair), *Independent Inquiry into Inequalities in Health*, The Stationery Office 1998.
15. DWP statistics; author's calculations.

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16. A fuller account of evidence to support this case is available on www.informedcompassion.com.
17. 'A new contract for welfare - principles into practice', DSS 1998.
18. The frequency of General Household/Lifestyle Surveys increased greatly after 1997, so means were calculated for 1995/6, 1998/2003 and 2004/2008, in order to maintain some regularity of comparison.
19. www.iser.essex.ac.uk/publications/working-papers/iser/2011-03.
20. Richard Wilkinson and Kate Pickett, *The Spirit Level - Why Equality is better for everyone*, Allen Lane 2009.
21. Acheson report, op cit.
22. Marmot report, op cit.
23. Office for National Statistics.
24. Steve Griffiths, *Spotlight on Social Exclusion*, London Borough of Waltham Forest 2000.
25. Gordon Waddell and Kim Burton, *Is Work Good for your Health and Wellbeing?*, The Stationery Office 2006.

New Labour, the market state, and the end of welfare

Jonathan Rutherford

Jonathan Rutherford looks at the connections between government and the insurance business in their joint project to reduce eligibility for sickness benefits.

In November 2001 a conference assembled at Woodstock, near Oxford. Its subject was 'Malingering and Illness Deception'. The topic was a familiar one to the insurance industry, but it was now becoming a major political issue as New Labour committed itself to reducing the 2.6 million who were claiming Incapacity Benefit (IB). Amongst the 39 participants was Malcolm Wicks, then Parliamentary Under Secretary of State for Work, and Mansel Aylward, his Chief Medical Officer at the Department of Work and Pensions (DWP). Fraud - which amounts to less than 0.4 per cent of IB claims - was not the issue. The experts and academics present were the theorists and ideologues of welfare to work. What linked many of them together, including Aylward, was their association with the giant US income protection company UnumProvident, represented at the conference by John LoCascio. The goal was the transformation of the welfare system. The cultural meaning of illness would be redefined; growing numbers of claimants would be declared capable of work and 'motivated' into jobs. A new work ethic would transform IB recipients into entrepreneurs helping themselves out of poverty and into self-reliance. Five years later these goals would take a tangible form in New Labour's 2006 Welfare Reform Bill.

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Between 1979 and 2005 the numbers of working age individuals claiming IB increased from 0.7m to 2.7m. In 1995, 21 per cent were recorded as having a mental health problem; by 2005 the proportion had risen to 39 per cent, or just under 1 million people. The 2000 Psychiatric Morbidity Survey identified one in six adults as suffering from a mental health problem: of these only 9 per cent were receiving some form of talking therapy. The Health and Safety Executive estimate that 10 million working days are lost each year due to stress, depression and anxiety, the biggest loss occurring in what was once the heartland of New Labour's electoral support, the professional occupations and the public sector. Despite these statistics, Britain has one of the highest work participation rates of OECD countries; while benefit levels are amongst the lowest in Western Europe and benefit claims are on a par with other countries.¹ The system is not in crisis, and this is not the motivation for the proposed changes. New Labour's politics of welfare reform has subordinated concern for the sick and disabled to the creation of a new kind of market state: claimants will become customers exercising their free rational choice, government services will be outsourced to the private sector, and the welfare system will become a new source of revenue, profitability and economic growth.

The road to welfare reform

In 1993 Richard Berthaud of the Policy Studies Institute identified the causes of the continuing rise in IB claimants.² In the period of growing unemployment under the Conservative government a fairly constant number of people left work because of ill health, only to find it increasingly difficult to re-enter the labour market. As unemployment began to fall the numbers on IB continued to accumulate. The problem lay not, as the right-wing press insisted, with malingering claimants and collusive GPs, but with the economy and with the hiring and firing practices of employers. Berthaud concluded: 'The increase has not been caused by excessive ease of entry to the system, but by difficulty of exit.' The Conservative government had its own agenda, however, and Peter Lilley, Secretary of State for Social Security in the 1992 administration, pointed the finger at claimants and the way their illnesses were diagnosed by GPs. According to Lilley: 'sickness and invalidity benefits were originally intended for those people who, "by reason of some specific disease or bodily or mental disablement" were unable to undertake work.' Social and

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psychological causes of illness were now being taken into account and as a result, 'the rules have been progressively widened and complicated'. The definition of incapacity had become 'fuzzy' (quoted in Kennedy & Wilson).

The 1994 Social Security (Incapacity for Work) Act was designed to end the 'fuzziness'. The Act introduced Incapacity Benefit and a number of key reforms to reduce the inflow of new claimants. Lilley hired John LoCascio to advise on 'claims management'. LoCascio was at that time second vice president of Unum, the leading US disability insurance company. He joined the 'medical evaluation group' that was set up to design more stringent medical tests. Another key figure in the group was Mansel Aylward. A new All Work Test was introduced in 1997. Instead of focusing on whether or not an individual was able to do their job, it would assess their general 'capacity to work' through a series of descriptors, for example 'Is unable to cope with changes in daily routine', 'Is frightened to go out alone'. Decisions on eligibility for benefit would be decided by Department of Social Security (DSS) non-medical adjudication officers advised by a newly recruited corps of DSS doctors trained by LoCascio. The new test, and the marginalising of claimants' own doctors, brought the rise in IB claimants to a halt.

Unum's influence was now at the heart of the system of managing disability claims. In April 1997, when the new All Work Test was introduced, the company launched an expensive campaign. One ad ran:

April 13, unlucky for some. Because tomorrow the new rules on state incapacity benefit announced in the 1993 autumn budget come into effect. Which means that if you fall ill and have to rely on state incapacity benefit, you could be in serious trouble.

LoCascio replied in the negative when *Private Eye* asked if he was not concerned about the conflict of interest involved in his company's advertising campaign, which sought to gain from benefit cuts that he had helped to institute. However Unum Chairman Ward E. Graffam did acknowledge the 'exciting developments' in Britain. Unum's influence in government was helping to boost the private insurance market: 'The impending changes to the State ill-health benefits system will create unique sales opportunities across the entire disability market and we will be launching a concerted effort to harness the potential in these.'³

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Despite Graffam's upbeat comments, however, the company was in financial difficulties. In the 1980s Unum - along with the two other major life and accident insurance companies, Provident and Paul Revere - had been doing well from providing 'own occupation' income protection schemes for mainly upper income professionals. Insurance against loss of earnings caused by accident or sickness was seen as a lucrative market with strong growth potential. Profit for insurance companies mainly lies in the revenue generated by investing the monthly insurance premiums, and interest rates were high so the companies enjoyed high levels of profitability; they monopolised the sector by sharing a similar disability income policy that offered liberal terms. Two factors threatened future profits however. The first was falling interest rates, and the second was the growth in new kinds of 'subjective illnesses', for which diagnostic tests were disputable. The old industrial injuries were giving way to illnesses with no clear biological markers - Myalgic Encephalomyelitis (ME) or Chronic Fatigue Syndrome (CFS), Fibromyalgia, Chronic Pain, Multiple Sclerosis, Lyme Disease. In the early 1990s the new kinds of claims began to rise just as interest rates fell: profits were threatened. Unum's 1995 'Chronic Fatigue Syndrome Management Plan' sounded the alarm: 'Unum stands to lose millions if we do not move quickly to address this increasing problem'.⁴

It was actually Provident that was quickest off the mark, introducing an aggressive system of 'claims management' that would become the industry norm. It could not influence interest rates, but it could reduce the number of successful claims it paid out. Its Independent Medical Examination (IME) was skewed in favour of the company through the work undertaken by its claims adjusters and in-house doctors. Illnesses were characterised as 'self-reported' and so thrown into question. Only 'objective' test results were accepted. Some disabling conditions were labelled as 'psychological', which made them ineligible for insurance cover beyond 24 months. Doctors were pressured to use the 'subjective nature' of 'mental' and 'nervous' claims to the company's advantage.⁵ Specific illnesses were targeted in order to discredit the legitimacy of claims. The industry drew on the work of two of the Woodstock conference participants, Professor Simon Wessely of King's College and Professor Michael Sharpe of Edinburgh University, in an attempt to reclassify ME/CFS as a psychiatric disorder.⁶ Success would allow payouts to be restricted to the 24 month limit for psychological claims and save millions of dollars. By 1997 Provident had restructured its organisation to focus on disability income insurance as its main

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business. It acquired Paul Revere, and then in 1999 merged with Unum under the name UnumProvident.

That year New Labour introduced the Welfare Reform Act. It was heralded as an answer to Frank Field's call for an end to a culture of welfare dependency, and to Tony Blair's misleading anxieties about levels of spending on social security. All new claimants now had to attend a compulsory work-focused interview. This was partly because the All Work Test introduced by the Tories had failed to reduce the inflow of claimants with mental health disorders. The gateway to benefits therefore needed tightening up. Mansel Aylward, now Chief Medical Officer of the DWP, thus replaced the All Work Test with the Personal Capability Assessment (PCA). The emphasis would no longer be on benefit entitlement but on what a person was able to do and the action needed to support them in work. The task of administering the PCA was contracted out to SchlumbergerSema, which was then taken over (along with its DWP assets) by the US corporation Atos Origin; and in 2005 Atos Origin won a further £500m contract. Claims for benefit were assessed by Atos employees with no medical training, using a computer system called Logical Integrated Medical Assessment (LIMA). Unsurprisingly, these computerised evaluations, coupled with clearance time targets for Atos staff, made the PCA unreliable, particularly for those suffering mental health problems. Fifty per cent of IB appeals against the refusal of claims found in favour of the claimant. In 80 per cent of these the problem was poor assessment of mental health problems.⁷ While the new Act had succeeded in further restricting the gateway to benefits, it had failed to deliver Blair's promised revolution in welfare. The reform process would go on.

'Active Welfare'

In 2003 the DWP launched its *Pathways to Work* pilot projects. These were forerunners of the kind of 'active welfare' system that had been promoted by UnumProvident and the Woodstock academics. In the pilot projects all new 'customers' to IB undertake a work-focused interview (WFI) with an IB Personal Adviser (IBPA). The Personal Capability Assessments of the 70 per cent who are not screened out by the WFI are fast-tracked, and these claimants (who are deemed not to have severe functional limitations), go on to attend a further series of mandatory, monthly interviews. The role of the IBPAs is to actively encourage customers to

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consider a return to work, as well as discussing work-focused activity. Customers are offered a 'Choices' package of interventions to support a return to work. For claimants suffering mental illness, a Condition Management Programme is available, developed jointly between Jobcentre Plus and the NHS. A Return to Work credit of £40 per week is payable for twelve months to customers if their new job is not less than sixteen hours, and earns less than £16000. At the Labour Party conference in this same year UnumProvident organised a fringe meeting with employment minister Andrew Smith and health minister Rosie Winterton. Joanne Hindle, corporate services director for UnumProvident, spelt out the future direction of *Pathways to Work*:

Although we can say that we are 90 per cent of the way there in policy terms, the real challenge is delivery - in particular the role of the intermediary. We believe that it is absolutely vital that all employment brokers are properly incentivised to move disabled people along the journey into work and that there are enough of them to do the job. The next step therefore is for private sector to work alongside government to achieve delivery, focus and capacity building within the system.⁸

UnumProvident was building its influence. In 2001 it had launched New Beginnings, a public private partnership that acted as a pressure group, drawing in charities and NGOs and enabling the extension of the company's influence in shaping the policy making environment, particularly in relation to *Pathways to Work*. Its annual symposium had been attended by government ministers, with Woodstock academics providing intellectual input. Then in July 2004, it opened its £1.6m UnumProvident Centre for Psychosocial and Disability Research at Cardiff University. The company appointed Mansel Aylward as Director following his retirement from the DWP in April. Professor Peter Halligan, who had forged the partnership with UnumProvident, was ambitious: 'Within the next five years, the work will hopefully facilitate a significant re-orientation in current medical practice in the UK'.⁹ The two men were joined at the centre by Gordon Waddell, an orthopaedic surgeon turned academic and another Woodstock participant. The launch event was attended by Liberal MP Archie Kirkwood, recently appointed Chair of the House of Commons Select Committee on Work and Pensions. Malcolm Wicks, Minister of State in the

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DWP, gave a speech praising the partnership between industry and the university.¹⁰ UnumProvident could now capitalise on its academic respectability as well as its close government connections. It understood the importance of ideas. Words do not merely describe the world, they enact it. To transform welfare into workfare would involve an ideological battle around language and culture.

Culture of sickness

In 2005 the centre produced a monograph, *The Scientific & Conceptual Basis of Incapacity Benefits* (TSO, 2005), written by Waddell and Aylward and published by the DWP. In their declarations of interest at the beginning of the text neither man cites their association with UnumProvident. This matters, because the monograph provides the unacknowledged intellectual framework for the 2006 Welfare Reform Bill. And the methodology used by Waddell and Aylward is the same one that informs the work of UnumProvident.

In a memorandum submitted to the House of Commons Select Committee on Work and Pensions, UnumProvident define their method of working: 'Our extended experience ... has shown us that the correct model to apply when helping people to return to work is a bio-psychosocial one'.¹¹ The bio-psychosocial model is explained by Peter Halligan, and Derek Wade of Oxford University (another Woodstock academic), in the *British Medical Journal*: 'The old biomedical model of illness, which has dominated health care for the past century, cannot fully explain many forms of illness.'¹² This old model assumes a causal relation between disease and illness, and fails to take into account how cultural attitudes and psychological and social factors shape illness behaviour. In other words it allows someone to report symptoms of illness, and for society to accept him or her as sick, without their having a pathology. Waddell and Aylward adopt the same argument in their monograph: disease is the only objective, medically diagnosable pathology. Sickness is a temporary phenomenon. Illness is a behaviour - 'all the things people say and do that express and communicate their feelings of being unwell' (p39). The degree of illness behaviour is dependent not upon an underlying pathology but on 'individual attitudes and beliefs', as well as 'the social context and culture in which it occurs'. Halligan and Wade are more explicit: 'Personal choice plays an important part in the genesis or maintenance of illness'.

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Waddell and Aylward are exercised by the paradox of a society in which 'objective measures of health are improving' but in which numbers on IB remain 'stubbornly high'. They argue that this can be explained by adopting a bio-psychosocial model. IB trends are a social and cultural phenomenon rather than a health problem: 'Severe medical conditions only account for about a quarter of the current IB caseload. Most IB recipients now have less severe "common health problems"' (p172). The solution is not to cure the sick, but to transform the culture of welfare and tackle the 'personal and social/occupational factors [that] aggravate and perpetuate incapacity'. Adopting this model will lead to a 'fundamental transformation in the way society deals with sickness and disabilities' (p123). The goal and outcome of treatment is work: 'work itself is therapeutic, aids recovery and is the best form of rehabilitation'. For Waddell and Aylward, work is a virtue. But to make it so, they first abstract it from the material conditions of paid employment. Work becomes an idealised practice shorn of class and inequality and the reality of the large swathes of mundane and boring jobs people must endure. In contrast to their idealisation of work, the authors view worklessness as a serious risk to life. It is 'one of the greatest known risks to public health: the risk is equivalent to smoking 10 packets of cigarettes per day' (p17). No-one who is ill should have a straightforward right to Incapacity Benefit:

A person who is unwell may 'feel too ill' at present to consider returning to work, but that is not a valid basis for future, permanent incapacity. The argument that, even if they recovered, they could not 'risk' work because it might be 'harmful' to their health is invalid because of the generally beneficial effects of work and the ill effects of long term worklessness' (p91).

UnumProvident, in its memorandum to the Select Committee, pursued the same logic, arguing that even the most functionally disabled could be expected to work at some future point.

The Waddell and Aylward monograph draws on the considerable knowledge of the authors, but employs a methodology that skews it towards moral authoritarianism and neo-liberal policy prescriptions. They rely on the much-critiqued and outdated systems theory of sociologist Talcott Parsons, in which the individual and society are assigned to discrete spheres of existence. Hence they

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acknowledge the social and cultural dimensions of illness, but fail to consider that these and other structural and economic forces might be the dynamic causes of genuine ill health. Instead the *problem* of illness is located in the individual, whose beliefs and behaviour then become the focus of moral judgment and action. As Halligan and Wade argue: 'Our model suggests that illness is a dysfunction of the person in his (or her) physical and social environment'. This follows Parsons's theory of the 'sick role', which he viewed as an individual's deviance from the social norm. He understood society as existing in a state of equilibrium, with individuals functioning in their allotted roles. The sick role upsets this equilibrium because it provides individuals with privileges and exempts them from normal social responsibilities. In order to restore balance society must recognise the sick role as an undesirable state and individuals must accept their moral obligation to recover as quickly as possible and return to work. Waddell and Aylward explain the high levels of IB claimants as arising from a breakdown in this conditionality. The sick role is now assumed to confer a 'right' to incapacity (p47). The solution is to change people's behaviour by transforming the language and culture of welfare, and by using sanctions as a 'motivational tool' to prise people out of their sick role (p166).

UnumProvident exposed

Meanwhile, in the US UnumProvident's business activities had been coming under increasing scrutiny. In 2003, the Insurance Commissioner of the State of California announced that the three big insurance companies had been conducting their business fraudulently. As a matter of ordinary practice and custom they had compelled claimants to either accept less than the amount due under the terms of the policies or resort to litigation. The following year a multistate review identified four areas of concern: an excessive reliance on in-house professionals; unfair construction of doctor's or IME reports; a failure to properly evaluate the totality of the claimants' medical condition; and an inappropriate burden on the claimant to justify eligibility for benefit.¹³ UnumProvident was forced to reopen hundreds of thousands of rejected insurance claims. Commissioner John Garamendi described UnumProvident as 'an outlaw company': 'It is a company that for years has operated in an illegal fashion.'¹⁴

To secure its financial position the company presented a public evaluation of the

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costs of the multi-state settlement. It estimated that there were potentially 25,000 long-term disability claims (out of a total of 275,000 claimants) that would qualify for re-examination. Between \$325m and \$415m was allocated to cover the likely costs. However this estimate did not include a further potential 14,000 claimants under the separate California settlement. And it was based on a deadline being imposed in early 2007 after which claimants would not be able to elect to have their claim re-examined. The company failed to make it public that this deadline had been nullified by pending multi-district claimants' class actions in Tennessee. This was misleading because there remains the possibility that many more of the 289,000 denied or terminated disability claimants may seek re-evaluation of their claims or litigation. Such potential future actions expose UnumProvident to a potentially ruinous financial outlay.¹⁵

In response to the outcry this caused the company has rebranded itself, and has now adopted the name Unum Group. There are reports that as the bad publicity is subsiding the company is returning to its aggressive claims management strategies in order to recover its profitability.¹⁶ In January 2007 a performance rating from Credit Suisse was low, but with an upside driven by higher than expected UK earnings and a lower than expected tax rate.¹⁷ Graffam's strategy has paid off. UnumProvident UK, with 2.3million covered by its insurance schemes and pre-tax profits of £109.8m, provides up to 25 per cent of the post-tax operating income of the UnumProvident group of companies. The company had also played an important role in shaping a workfare culture and policy strategy in the Department of Work and Pensions. In April 2007 UnumProvidentUK changed its name to Unum.

New Labour's Welfare Reform Act

In July 2006 the Government published its second Welfare Reform Bill (which was passed as an Act in May 2007). The aim was to radically reduce levels of worklessness amongst single parents, older citizens and those on Incapacity Benefit (IB), and a target was set of an 80 per cent employment rate amongst working age adults. *Pathways to Work* will be rolled out across the country by 2008. Current Secretary of State for Work and Pensions John Hutton praised the pilot schemes: 'The largely voluntary approach of *Pathways* has been a success'.¹⁸ But not successful enough. ¹⁹ To achieve its target the government will need to reduce the numbers on

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incapacity benefit by one million, and persuade into work one million more older people, and 300,000 extra lone parents. Employers, particularly in the public sector, will be helped to create more effective management of sickness absence, and benefits will not be given on the basis of a certain disability or illness but on an assessment of the capacity to work. In 2003 the OECD reported that Britain's benefits gateway was 'one of the toughest in the world'.²⁰ But it was not tough enough, and still more stringent policing was required. The new Act offers GPs and primary care staff rewards for taking active steps to get individuals back into work. 'Employment advisers' will be attached to surgeries to help in 'bringing about a cultural change in the way work is viewed by families and individuals'. The PCA will be redesigned by two technical working groups, one for mental health and one for physical disability. Both groups involve representatives from UnumProvident and Atos Origin.

In 2008, IB will be replaced by a two-tier Employment and Support Allowance. Minister of State for Employment and Welfare Reform Jim Murphy, in a Parliamentary written answer, emphasised that the new allowance will 'focus on how we can help people into work and will not automatically assume that because a person has a specific health condition or disability they are incapable of work'.²¹ Apart from those with the most severe disabilities (around 15-20 per cent, who will qualify for a higher rate of benefit) 'customers' who fail to participate in work-focused interviews or to engage in work related activity will be subjected to a 'motivational tool', as suggested by Waddell and Aylward. Current levels of IB average £6500 per annum, but claimants unable to manage or refusing the motivation could lose as much as £10.93 a week, rising to £21.8 for a second refusal of work.²² There is no evidence to suggest that impoverishing people who are ill will prompt them into longer-term employment, and this is particularly true for those with mental health problems. In 2006 the DWP published a report on the impact of the *Pathways to Work* pilots on people with mental health problems. It concluded that: 'the estimated impact of the policy on the outcomes of interest for those who report having a mental illness (as a single health condition) is never statistically different from zero at conventional levels'.²³ The future looks bleak for those who have 'symptoms without diseases', or mental health conditions, and who cannot demonstrate that their illness has an 'objective medical pathology'. Jim Murphy was blunt: 'Work is the only way out of poverty ... the benefit system will never pay of itself [enough to lift people out of poverty] and I don't think it should.'²⁴

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The future of welfare

The Welfare Reform Act is short on detail, and secondary legislation delegates powers to the DWP minister to continue the reform process and tighten up rules. In 2006 Hutton commissioned David Freud, a senior banker at UBS AG, to conduct a review of New Labour's welfare to work policies. Published in March 2007, *Reducing dependency, Increasing opportunity: options for the future of welfare to work* quotes Waddell and Aylward's dictum that work is 'therapeutic' and provides a business model for workfare. Freud argues that the government target can be achieved by bringing in the private sector on long-term, outcome-based contracts. The contracts are central to the success of the scheme. A price per claimant is calculated on the savings in IB costs when the claimant moves back into work. Payments to providers would then be paid over a three-year period from when an individual client enters paid employment. The income generated by the outflow of people from IB would be the incentive driving business towards the government target. The contracting regime would set a minimum standard of service that all 'customers' would receive. However: 'beyond this there would be freedom between the provider and the individual to do what works for them'. Those claimants furthest away from the labour market - and who are most costly to the Exchequer - will command the highest rewards.

To carry out this transformation of welfare the DWP would need to establish a new kind of contracting system, which would open up public finance to private companies. According to Freud, the private sector is the only body capable of shouldering the financial risks and arranging the private finance that will reduce costs to the Exchequer. And using the private sector will bring in the banks, which will be able to fund the 'extremely large investments implied here'. Private companies would take the lead in the bidding process for contracts, and in building up consortia of groups in each of the regions and countries in Great Britain. This annual multi-billion pound market, and the creation of regional monopolies, 'would attract major players from around the world' (p62-3). As Freud concludes: 'The fiscal prize is considerable'. Hutton's public reaction was to describe the report as a 'compelling case for future reform'.²⁵

Welfare reform exemplifies the transformation of the old style nation state into a new kind of 'enabling' market state. Instead of providing social protection,

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the market state offers 'opportunities' and 'choice' to 'customers', who in return must shoulder a greater degree of responsibility for their individual predicament. Alongside this transformation in the nature of service provision is the blurring of the boundaries between public service and private business, not least in the revolving door that operates in the higher echelons of the state. The logic of welfare reform is to reduce costs by keeping claims to a minimum. To achieve this, New Labour has adopted the practices of a private insurance company whose claims management in the US has been described as 'illegal'. With the Freud Report it has opened the door for further privatisation.²⁶ The workfare system that is taking shape in this country is turning the logic of welfare onto its head. It is no longer a system that seeks to help people who are sick or disabled; instead it is increasingly asking them how they can help us. The demand for performativity in return for a meagre subsistence robs people of their autonomy - but New Labour dresses it up in the language of individual career development and dignity for the disabled. John Hutton describes workfare as a 'something for something' approach, and Tony Blair calls it 'mutual responsibility'. But the compact between the state and an individual whose life has been disrupted by disability or sickness is not an equal one.

The 'sick role' as an explanation for a person's actions and attitudes makes the individual who is incapacitated responsible for what are socially produced problems. The logic of the reforms serves the need of the market, attempting to turn the individual into an efficient, docile unit of consumption and productivity.

The Conservatives have now announced their own approach to welfare reform. Shadow Chancellor George Osborne argues that David Freud has not gone far enough: 'We should seriously consider a bold "no-win, no-fee" approach to getting people off benefits. Prime contractors, be they companies or charities, would be paid primarily if they get people back into work, and keep them there - in other words payment by results.' In return, more will be expected from those on employment related benefits, and tougher sanctions will be introduced against 'those who can work but refuse to take steps to get back into the labour market'.²⁷ The history of the British welfare system has always been one of grudging, paternalistic and sometimes punitive forms of social protection. But even measured against its own limited ambitions, the future of welfare looks bleak.

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Notes

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From 'vulnerable' to vanguard: challenging the Coalition

Peter Beresford

One of the main challenges to the government will come from the disabled people's and service user movements.

There can now be little question that the Coalition government's intention is to take us even further along the neoliberal road - to radical regressive redistribution, the residualisation of state support services and greatly increased social and political inequality. And equally, there is no doubt that it is poor, old and disabled people that the Coalition cuts are hurting most. But instead of lying down and dying, many of them are finding new ways of challenging the government - to such an extent that in the end they may turn out to be the key architects of its defeat.

This is epitomised by the Spartacus report, *Responsible Reform*, a major new challenge to the government's welfare reform proposals.¹ This report was entirely written, researched, funded and supported by sick and disabled people, their friends and carers. Its publication has gained high visibility and widespread support, ranging from *The Guardian* to the *Daily Mail*, which ran the headline, 'We're all desperate for welfare reform, Mr Cameron, but hiding the truth is not the way to achieve it'.² The report has already helped in the inflicting of several Lords defeats for the government's welfare bill. At the time of writing it remains to be seen whether there will be further successes

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in defeating the bill's proposed draconian attacks on the disabled and other groups.

Attacking the 'deserving poor'

When David Cameron committed the Coalition government to cutting the public deficit as his first priority, he promised that in doing so he would 'try to protect the poorest and the most vulnerable'. Indeed, 'protecting the vulnerable' became a leitmotif of the prime minister and his cabinet. Time and again official statements refer to 'vulnerable people', 'the most vulnerable citizens', 'society's most vulnerable'. Though jobs might be lost, and programmes and public services slashed, the Coalition government repeatedly committed itself to looking after 'the vulnerable'. It was not always clear who the vulnerable were, or how useful it was to redefine in this way those large adjectival groups of 'the old', 'the disabled', 'the poor', 'the long-term sick' and 'carers'. And there was some irony in the Coalition's framing of such groups in the same old paternalistic discourse for which the political right so frequently condemns the welfare state.

But there was nothing new or initially particularly disturbing about this residualist safety-net approach to social policy. 'The vulnerable' seemed merely the coalition code for the 'deserving' poor, those whom the state recognises that it has to support because the market certainly doesn't. If the government's reforms *had* actually protected 'the vulnerable', there would have been little to remark on. What has, however, been novel about the Coalition's social policy is its apparent ending even of the Victorian poor law distinction between the 'deserving' and 'undeserving' poor: those historically seen as unable to work and fend for themselves - disabled and older people, and those with chronic conditions - as opposed to the feckless and idle unemployed. If anything, the deserving poor seem to have become the Coalition government's particular target; there no longer seems to be such a thing as deserving poor. In this Cameron is very different from Thatcher - his rhetoric has very little relationship to his policies.

Politicians associated with the values of the political new right, from Mrs Thatcher, through New Labour to the Coalition, have for some years been wheeling on a range of powerless targets for scapegoating duties. These have included the so-called 'underclass', those denied citizenship (refugees and asylum seekers), lone

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parents, unemployed people and dissident or disruptive young people. But things have now gone a step further and reached 'the 'deserving poor', who have found that, rather than being collateral damage for the spending cuts that are aimed at the undeserving scapegoats, they have now themselves become the main target. For current spending cuts not only penalise the poor rather than the better off; more specifically, they particularly target disabled people.

Disabled people have been targeted in two ways - through benefits 'reform', and through the reduction in local authority services that many depend on. The government's benefits 'reform' campaign has directly affected many disabled people and service users - in its determination to reduce the numbers on benefits through imposing ceilings and time limits, and through its increasingly arbitrary and harsh assessment and review procedures. This campaign has also backed up the need for 'reform' with a highly hostile and stigmatising media campaign against disabled and long-term sick benefit claimants.

Meanwhile unprecedented local authority spending cuts and restructuring have also had a disproportionate impact on disabled people, because of their reliance on local authority provision of social care (which, unlike NHS services, is especially exposed to cuts and receives no protection from them). Moreover, disabled and older people are also more generally dependent on public services, because so many of them cannot afford to turn to the market for essential goods and services. No 'vulnerable' group seems safe from these attacks. Even people at end of their life and those receiving active and debilitating treatment for cancer are currently being pressured to get off benefits.

The result of this reshaping of social policy has been the creation of a pervasive culture of fear among disabled people and other long-term social care service users. Many talk of having suicidal thoughts, and there are already some reports of suicides. A consultation about social care with a diverse range of social care service users supported by the Joseph Rowntree Foundation carried out in November 2011, reported:

All service users consulted [thought] that welfare benefits reform is having serious and negative effects on disabled people and other service users, particularly on mental health service users. Such reform is not only having destructive material effects on people's

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individual lives, but it is also having a broader damaging effect through increasing people's anxiety and insecurity, undermining their confidence and wellbeing and increasing stigma and hostility against them as they are presented as 'scroungers' and malingers.³

A key concern of service users was their 'increasing sense of coming under attack, negatively stereotyped by politicians and media, increasingly marginalised and excluded' (pp7-8).

Fear has become a default mental state for many disabled and older people. As one mental health service user, once active in her community and now driven into fearful anonymity, said to me:

The full-on assault by government with a complicit media (and how that has influenced public understanding - more than anything else in my view) is pretty much dismantling my life ... I can't comment on welfare issues without being anonymous because if you're critical of 'reforms' you can find yourself being questioned as to whether this is because you are too lazy to 'get better', fraudulent or work-shy by anyone with an axe to grind, anyone who's envious of others being on Disability Living Allowance or pissed at their own working conditions/salary. You have to be quite careful about who knows your circumstances now because sick/disabled people and anyone on benefits are viewed as public property to be grilled by 'the hard working tax payer'. [It] means being questioned and judged by ... complete strangers on the bus (if you have a travel pass), or by staff in community/council facilities. I'm scared going out, I don't feel able to do what I need and want to do, my paranoia has reached levels I never envisaged. I feel 'at risk' from everyone bar those people I know.

Speaking for ourselves: the collectivity of disabled people and service users

Where once powerless people could at least count on having others on their side, this no longer applies. There is a strong sense among those under attack that powerful

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people won't speak up for them. As one carer wrote to me: 'As no one famous or in an official position has put their head above the parapet and told the truth about the welfare reforms - we must do it ourselves'. The Labour Party is no longer the defender of the poor and oppressed, but instead it is the party that when in government began the calls to 'get a million people off incapacity benefits'. The large traditional charities seem to have become increasingly concerned with their own interests and advancement. While often piggybacking disabled people's own campaigns, they are anxious not to lose existing government contracts as service providers, or to secure new ones in welfare reform; PR exercises seem to be replacing active campaigning. Increasingly corporate and indistinguishable from other sectors, some big charities seem to be moving in the same direction as the large multinational corporations - seeing the marketing of a brand name as more important than actually doing much. Finally, while some trade unions are seeking to include those who are excluded by or outside the labour market, including older and disabled people, the primary concern of most remains their members and fellow workers. With few powerful allies in parliament, Whitehall, the media or the establishment, service users and disabled people have had to do things for themselves.

But this can also be seen as something positive - a welcome departure from having other people speaking on their behalf and drowning them out. In fact, though generally framed in terms of dependency by the Coalition government, disabled people and service users have a long modern history of collective action, going back as far as the late 1960s. Starting with the disabled people's movement, we have seen the development of movements of mental health service users/survivors, people with learning difficulties, older people and people living with HIV/AIDS. These have been based on the key principles of valuing people's own firsthand experience and experiential knowledge, and speaking and acting for themselves. As a result they did not approach state welfare or the welfare state with a rosy-glow view: for many of them it meant segregation, stigma, low income and restricted life opportunities. Equally, they were frequently critical of the market and the charitable sector. Often excluded from access to the goods and services of the market, they were held in a paternalistic relationship with traditional charities. Given that disabled people have always been significantly debarred from the labour market, their movement was as much concerned with gaining control over the ideology affecting them, as over the means of production, from which they were largely excluded. This meant that the disabled people's movement gave priority to

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developing its own theories and philosophies. Crucial among these have been the social model of disability and the philosophy of independent living.

The social model of disability represents a rejection of the paternalistic medicalised approach on which the old welfare state rested. It distinguishes between people's perceived physical, sensory and intellectual *impairments* and the negative social reaction to them, which is described as *disability*. From this flowed the philosophy of *independent living*, and an associated movement which spread rapidly through North America to the UK and Europe. The key principle of independent living is that disabled people and other service users should have the support they need, and access to mainstream opportunities, in order to live their lives on as equal terms as possible to non-disabled people.

The irony of Coalition policy is that on the one hand it talks about independence and attacking 'dependency', as we have seen, but on the other it is rooted in the same narrow medicalised understandings of disability as the old welfare state it purports to reject. The reality is that by attacking and cutting social policies which take forward the social model of disability and values of independent living, it is forcing more and more disabled people into unwanted dependence.

The ultimate logic of government policy is a downward spiral of increasingly intolerable conditions: for people with learning difficulties, the appalling abuse of Winterbourne View; for mental health service users, increasing medicalisation and reliance on drug regimes and restriction of rights; and for older people, the neglect and insecurity that go with the increasing inroads of private equity companies like Southern Cross. In the face of all this, the disabled people's and service user movements offer a beacon of emancipatory values, social models and liberation. Many disabled people and other social care service users, particularly the increasing number who are becoming familiar with liberatory aspirations to inclusion and equal opportunity, now reject their presentation as 'vulnerable' and instead see their own potential to be agents of change - both in their own life and in society more generally.

The emerging challenge to neoliberalism

A key concern of the liberatory movements of disabled people and other service users has been to democratise public policy and to gain an effective voice, over their own lives and in policies and services affecting them. Paradoxically,

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at the same time as these movements were emerging, the political new right's commitment to the market was being reflected in government's large-scale adoption of consumerist ideas such as 'user involvement' in public policy, particularly in health and social care. Similarities of language concealed fundamental differences between competing liberatory and consumerist intentions, but at first many service users welcomed the new rhetoric. Thus public and service user interest in having a greater say gave force to consumerist user involvement, while consumerist rhetoric provided a lever for service users' ambitions for empowerment and democratisation. This talk of user involvement continues unabated under the Coalition (for example in its NHS slogan, 'Nothing about me without me'). But it now has little meaning for patients and service users, who are seeing frontline services cut arbitrarily despite their protests and the hardship caused. Government calls for 'user involvement' are being met with increasing suspicion. There has always been some ambiguity about user involvement, as governments have talked up voice, choice and the consumer, while keeping a tight lid on the liberatory goals of service users and their social movements. But the unprecedented public spending cuts now being made in the name of the 'public deficit' have brought these contradictions into stark relief.

Over this period, service users have increasingly looked for other ways of influencing what is happening. The old paternalistic relationships of voluntarism and self-help are being challenged by a new participatory politics of opposition. Their collective action has begun to offer a much more viable avenue for change and has begun to involve many more people.

Stuart Hall has argued that:

Excluded social forces, whose consent has not been won, whose interests have not been taken into account, form the basis of counter-movements, resistance, alternative strategies and visions ... and the struggle over a hegemonic system starts anew.⁴

He also cites Raymond Williams's concept of 'emergent culture', where 'new meanings and values, new practices, new relationships and kinds of relationships are continually being created'. The disabled people and service users who are now challenging the Coalition government and its public policies can be seen as playing

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just such a role. (Though this doesn't mean that they necessarily see themselves as marginal or excluded.)

As Claire Glasman of Winvisible said to me:

WinVisible is a multi-racial self-help group of women with visible and invisible disabilities. Mums, pensioners, refugee and asylum-seeking women, women who are caring for relatives while they have their own health problems, are all part of our group. We don't consider ourselves 'marginalised' but mainstream, because what is happening to us affects so many people. As soon as you scratch the surface, practically everyone has been affected or has a close relative or friend who has. After a lifetime of work, pensioners are dying from neglect; people with cancer and mental health problems are being thrown off benefit; young children are having to care for disabled parents because there is no one else.

Faced with the loss of benefits, housing and services, service users are finding their voice in opposition, action and protests. Because they have physical and sensory impairments, because they are frail through age, or isolated through mental distress, traditional forms of involvement and campaigning may not be open to them, or may be unfamiliar or uncomfortable. But over the years they have developed new accessible forms of involvement, which now draw on new technologies and new forms of networking. They are creating new meanings for collectivity and community, direct action and protest. They work alone and together, with people with whom they share a similar experience as well as with allied causes. They operate locally and nationally and at all levels: practice, policy and politics. They use the law, lobbying, media and formal structures of representative democracy, at national and local levels.

Doug Paulley is a wheelchair user living in residential services who uses the law:

Information access as defined under various legislation has certainly been a key tool in fighting my personal corner ... Through its enforced frankness, it can disarm and cause institutions, statutory or otherwise, to rethink. If the Department for Work and Pensions suspects a benefits claimant of breaking the rules, they can insist on

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a Compliance Interview. A scary letter, without any details as to what has caused the suspicion etc. They have absolutely no information on their website. It can be sparked by malicious accusations, misunderstandings, genuine mistakes etc. I put in a Freedom of Information Request to find out the rules on this process. This has generated a huge amount of interest from people otherwise unable to find any useful information, left petrified and unprepared as a result. It's made a real difference to benefits claimants.

In the campaign to save the Independent Living Fund, and against organisations like the US insurance giant Unum, disabled activist Mo Stewart sees knowledge as power:

I have been doing research now for the last two years, health permitting. Any info I get from all that research is what works. What I do is DEEP research - and then report the evidence I have found, passing it on to as many people as possible via websites etc. Mandela is a hero of mine and whenever I have been tempted to stop I recall his famous quote, 'Never underestimate the power of persistence'.

Disabled student Jody McIntyre's complaint about excessive police force in dragging him along the road from his wheelchair when he was protesting against student tuition fees was upheld by the IPCC, highlighting the contradictions of police behaviour in relation to disabled people. More and more service users feature on radio phone-ins and TV vox pops, and 'the public' is beginning to hear and to listen. In a new digital age they offer the promise of a new and inclusive kind of revolution that politicians and their policies are increasingly having to address.

According to Stella Mpaka of the All African Women's Group:

Everything that they are now using on citizens was tested on asylum seekers ... How we managed to change things was, first to get women seeking asylum to speak out publicly on the things that are happening to us, and relating them to what is happening to citizens too, so that people could see that they were actually trying to enforce these kinds of laws not only on us, but on everyone.

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The group is seeking to change people's perceptions of asylum seekers at a local level by confronting media portrayals with 'face to face reality'. This is an uphill struggle, but Mpaka says that people have started listening.

York Faces is a typical local organisation for mental health service users, made up of people with that experience. Although it doesn't have great power, the group does what it can to resist cuts, including leafleting outside hospitals and working to make anti-cuts events accessible and inclusive of people with mental health problems and other 'hidden' impairments. Mad Pride, the mental health service users' group, organised a march to Downing Street last year against housing benefit reforms, following a 'one-day medication strike' against cuts. This was followed by a two-minute 'scream', in memory of those who have killed themselves and for others who may do so in the future, because of the benefit cuts. They demand a 'Stop to The Suicides, Hands Off Our Benefits'.

Service users are joining mainstream anti-cuts campaigns, linking up with them and forming their own. They are taking to the streets and to the blogosphere, and are a growing presence on social networking sites. While some service users are still excluded from the new digital and internet age, others are at the cutting edge. As one woman involved in an activist carers' organisation says:

Until a few years ago it was very rare I used a computer ... I had no idea back then about the world being so accessible at the click of a switch. I had so much experience of caring and the disabilities/illnesses of those I cared for, but we were in a little bubble, the outside world very rarely came in. Then the internet became a learning tool, each day brought new contacts from individuals, groups, charities, politicians and academics. My understanding of disability grew, how a person's life could be affected and how they dealt with it on a daily basis.

... most of the people will never meet face to face. Yet they build a network of trust, they learn who their friends are, same way they learn who their enemy is. When under attack they will unite as one. Their voices will grow louder. I am a wife/mother, sat in my dining room, and yet through the internet I have been privileged to have met in cyber space the most wonderful of people ... They are all as dear to me as my friends at home.

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These new progressive service-user pioneers are developing their own new forms of inclusive and accessible action and collectivity. Imogen May, another disabled activist, has set up a blog in the last few months that will eventually become a website called WellFairSystem (<http://wellfairsystem.dreamwidth.org/>), seeking to reach people in the disabled community:

Twitter has been a huge platform for us, simply because you have the ability to reach the corners of the world with just a few Tweets. Another platform that's blown up in the last five years is blogging ... There really is a sense of community ... to connect with people who understand what you're fighting for. That's a very powerful tool when ... many of us are unable to attend large meetings or demos or don't have the energy to blog.

Service users are blogging, vlogging, podcasting, tweeting and communing within their own Facebook groups. More and more they are both a physical and virtual presence, from flash mobs to pickets and demonstrations. These are not isolated instances but the vanguard of new kinds of activism and collective action. Check out Black Triangle, Carer Watch, the Broken of Britain, Diary of A Benefits Scrounger, the Hardest Hit Campaign. Then there is the Crutch Collective, who picketed Atos, protesting against their Employment and Support Allowance (ESA) reviews; and People First Lambeth, a group of people with learning difficulties who recently launched a judicial review against their local council for ending their funding. This is no cosy responding to official consultations, but engagement with the mainstream political process, and new forms of direct action. And as well as developing their own campaigns, service users and disabled people are a visible presence in broader struggles and demonstrations - whether against increasing student fees or among the tents of the Occupy movement.

As The Broken Of Britain warned in their new year's message, 'David Cameron and Iain Duncan Smith have picked the wrong fight'. And as Jaspal Dhani, chief executive of the United Kingdom Disabled People's Council said to me: 'If it wasn't for disabled people's energies to campaign and protest against Disability Living Allowance cuts for residential service users, the government wouldn't have done a u-turn on that policy'. User-led initiatives like the Spartacus report sum up this new development. Inspired by disabled people and service users, they have gained massive interest and powerful and celebrity supporters, and made an enormous impact through their effective use of social media.⁵

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Service users and their movements are opposing this government. But they are fighting against the welfare state past, as well as a beckoning neoliberal future. They are campaigning for something very different - a democratic society, which treats all forms of diversity with respect, including issues of age and impairment, rather than seeking to divide and rule. Such a society would be based on the values of the social model of disability and independent living, rather than one that assigns vulnerability or imposes dependence. Employment would at last be recognised and treated as a right, rather than a responsibility. Society would have finally come to understand that major demographic changes and medical advances mean that disabled people now make up a large and significant minority in our society, and that this - rather than some fraudulent mass malingering - is what accounts for disabled people's large and positive presence in our society and their increasing fightback. And a network of user-led and disabled people's organisations will be at the vanguard of making all this possible.

I would like to thank the many disabled people and carers who have helped me write this through emailing and speaking to me, some having to remain anonymous because of the stigma and fear they have been subjected to by government policy.

Notes

1. www.ekkklesia.co.uk/files/response_to_proposed_dla_reforms.pdf.
2. <http://www.guardian.co.uk/commentisfree/2012/jan/08/disabled-people-welfare-reform-sham>; and www.dailymail.co.uk/debate/article-2084706/David-Camersons-Welfare-Reform-Bill-Hiding-truth-way-achieve-it.html#ixzz1jd6gdRUL.
3. P. Beresford and E. Andrews, *Caring For Our Future: What service users say, a national consultation with service users*, Shaping Our Lives, London 2011.
4. Stuart Hall, 'March of the Neoliberals', *Guardian*, 12.11.11.
5. See Patrick Butler, 'How the Spartacus welfare cuts campaign went viral', www.guardian.co.uk/society/2012/jan/17/disability-spartacus-welfare-cuts-campaign-viral.

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