For Whose Benefit?

Policy Exchange

Proposals to Reform Health and Disability Benefits & To Create a New Social Contract

Jean-André Prager, Sean Phillips and Alexander Tait

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About the Authors

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Endorsements

"This is an extremely timely report given that the government's own welfare reform paper is imminent. What is absolutely certain is that for the sake of individuals, our economy and the affordability of the system, radical and positive change is necessary.

Reflecting the experience of implementing the New Deal for the Young Unemployed from 1998, the recommendation that for the under 30s there should be some form of conditionality is well worth exploring. Not least with the staggering figure of around 70 % of those under 25 claiming sickness or disability benefit presenting with some form of mental ill health.

The change over time and the variation with older people of working age cannot be ignored.

So a combination of focused and improved support together with much clearer requirements on the individuals seeking help makes absolute common sense.

This is a useful contribution to the debate which will be both painful and vital to the overall health and wellbeing of the UK."

Rt Hon The Lord Blunkett PC FAcSS

Former Secretary of State for Work and Pensions; former Secretary of State for Education and Employment, former Home Secretary, former Shadow Health Secretary

"This report is a vital contribution to one of the biggest policy challenges facing the nation today. What is clear is that we need to fundamentally change our approach to health and disability benefits. Policy Exchange make a compelling philosophical and policy-driven case for reform which seeks a rebalancing of our benefits system so there is a focus on what people can do, rather than what they cannot."

Rt Hon. Lord Blencathra

Member of the Public Services Committee and Shadow Minister for Environment, Food and Rural Affairs

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Abbreviations

AA	Attendance Allowance
AP	Assessment Provider
AtW	Access to Work
DHSC	Department of Health & Social Care
DLA	Disability Living Allowance
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
HMCTS	His Majesty's Courts and Tribunal Service
HTP	Health Transformation Programme
LCW	Limited Capability for Work
LCWRA Activity	Limited Capability for Work and Work-Related
MR	Mandatory Reconsideration
PIP	Personal Independence Payment
SDG	Severe Disability Group
SREL	Special Rules for End of Life
SRTI	Special Rules for Terminal Illness
UC	Universal Credit
WCA	Work Capability Assessment

Key Terminology

- **Disability**: The Equality Act 2010 defines disability by stating that a person is considered to have a disability if they have a 'physical or mental impairment' that has 'substantial' and 'long-term adverse' effect on their ability to do normal daily activities.[1] The Disability Discrimination Act 1995 applies in Northern Ireland.[2] 'Long-term effect' means the condition has lasted at least 12 months; or where the total period for which it lasts, from the time of the first onset, is likely to be at least 12 months; or which is likely to last for the rest of the life of the person affected.[3]

- **Fluctuating Condition(s):** A health-related condition which remains present but varies in severity, frequency of flare-up, and sometimes symptoms. There is no definitive list of fluctuating conditions. Common examples of physical conditions include multiple sclerosis, asthma, or diabetes.[4]

- **Inactivity:** Defined by the Office for National Statistics (ONS) as "people not in employment who have not been seeking work within the last 4 weeks and/or are unable to start work within the next 2 weeks."

- **Reasonable Adjustment(s):** A legal duty for an employer (or prospective employer) to make reasonable adjustments, on request, where a provision, criterion and/or practice puts a disabled person at a substantial disadvantage in comparison with job applicants or workers who are not disabled; a physical feature of the premises occupied by an employer puts a disabled person at a substantial disadvantage in comparison with non-disabled job applicants or workers; or the lack of an auxiliary aid puts a disabled person at a substantial disadvantage in comparison with non-disabled job applicants and workers. The nature of the adjustment is not prescribed but could include allowing flexible working arrangements, buying specialist equipment or allowing job candidates more time to complete an exercise. [5]

1. Gov.UK, Family Resources Survey: financial year 2022 to 2023, 26 March 2024, [link]
2. Disability Discrimination Act 1995 [link]
3. Equality Act 2010 Guidance, *Office for Disability Issues*, link
4. Factsheet – Fluctuating and recurring conditions, *Business Disability Forum*, 11 September 2024, [link]
5. A. Morris, Reasonable Adjustments: *Employers' Guide, Davidson Morris*, 13 December 2024, [link]

What Are 'Health & Disability' Benefits?

In this report we discuss reforms to 'health and disability benefits', with a focus on those which support individuals who are of working age (from 16-64). We use this as a term to encompass (health-related) *incapacity* as well as *disability* benefits awarded by the Department for Work and Pensions (DWP). Table 1 below presents an overview of these benefits. Given the focus on working age benefits, we do not comment at length upon the Attendance Allowance (AA) or the Disability Living Allowance (DLA).

Table 1 – Health and Disability Benefits Under Discussion

Type	Name	Description	Claimant Volume
Incapacity	Employment and Support Allowance (ESA)	Benefit for individuals who cannot work due to sickness or disability and do not receive Statutory Sick Pay. Benefit is means and need tested.	1,584,000 (August 2023)
	Universal Credit (UC)	Out of work benefit: A benefit that you can claim if you have a health condition or disability. Benefit is means and need tested.	2,100,000 (UC health, March 2024)
Disability	Personal Independence Payment (PIP)	A tax-free benefit for people with long-term physical or mental health conditions or disabilities. Those both in and out of work are eligible. PIP has two components which determine basis of award: 'daily living' and 'mobility'. Benefit is needs-tested only.	3,115,000 (August 2023)
	Attendance Allowance (AA)	A benefit for people who are of State Pension age (or over) and require assistance with daily tasks or personal care. Benefit is needs-tested only.	1,662,000 (August 2023)
	Disability Living Allowance (DLA)	A benefit for children under the age of 16 with a disability. DLA has two components based on the level of assistance required. Benefit is needs-tested only.	1,240,000 (August 2023)

Preface

By Jean-André Prager

We believe in a safety net for people with long-term ill health and disabilities. The British public believe that protecting our most vulnerable is part of an unwritten social contract. Most if not all disabled people want a fulfilling life, to aspire, be engaged with society, work, and live as independently as possible. Our benefit system is intended to help enable disabled people to realise this goal. With forecasts now suggesting that we will be spending £100bn by 2029 on health and disability benefits – a price tag now commonly thought to be unsustainable – can we be sure the current approach will meet our expectations?

There is a reductive quality to our desire to protect, one which disabled people recognise and struggle to overcome. Protection is often manifest with infantilisation, and the enormous economic and creative potential of our disabled population is overlooked and undervalued. Disabled people are too often seen through a cost lens, rather than a consideration of their potential. This attitude is reinforced by our current benefits system, where support is determined by what an individual can't do; rather than what they are capable of doing.

In order to determine eligibility for health and disability benefits, we use a *functional* test. This approach is theoretically sensible, linking financial support to the ability to fulfil tasks. But the reality is this: if you can't do something, your award is greater. Our benefit system should protect those who truly need protection – and therefore requires a robust assessment process to determine eligibility – but we must rethink and rebalance our approach so there is far greater weight on enabling disabled people to engage fully with society, to contribute to our economy and to live a fulfilling life. Our health and disability benefit system should be recalibrated to enable, support and latterly to protect.

With the increasing prevalence of mental ill-health and behavioural issues reflected in claimant growth, the number of people who feel they require support has risen dramatically, and our method of evaluation has been revealed as not sufficiently flexible or perspicacious. With greater awareness and reduced stigma around mental ill-health has come a huge rise and a younger cohort who are now claiming. For some, disappointment is confused with disability.

Make no mistake, the new cohort of claimants believe they are in need; the vast majority are not chancers or fraudsters, but they may not be the

group of people society originally conceived of needing to enable or protect through welfare payments. Not only do we need to rebalance how we weight protection versus enabling, we need to re-evaluate who our system should support.

This endeavour requires a national conversation and ultimately, a new social contract. It should not demonise a section of society, but must inspire people them to want to contribute to their life chances and to the wealth of the nation. This is a task, moreover, which could not be more urgent for the new Government to address.

Almost everyone who reads this report will either have first-hand experience of disability or a health condition, such as the author, or will – in one way or another – know somebody with them. Around 1 in 4 people report a disability in the UK. However, the perception of those with a disability or health condition remains superficial and unnuanced. In popular culture, disabled people are either seen as heroic, or as deserving of pity. Disabled people have the same hopes, dreams and aspirations as everyone else. They are taxpayers, parents, husbands, wives, pensioners, users of public services.

The greatest adversity faced by disabled people is not their disability but the attitudes of those who would prevent them from achieving their potential, reinforced by a system that encourages you "to be worse" in order to get more. We must change attitudes towards disabled people whilst recognising no two people are the same. People are able at different levels. People can achieve different things. Their capabilities and needs are unique to each person, like the capabilities and needs of all of us.

Disabled people should not fear reform of the system. Rather, they should fear the failure to reform an unsustainable system which is crippled by spiralling costs and that increasingly appears to be misaligned with public expectations for how it ought to function. A failure to act now will lead to only greater tension, and potentially much less considered change, in the years to come.

We need a new social contract that says we owe it to each other – and to ourselves – to create a better safety net. One that fundamentally realigns and rebalances the incentives in our system, encouraging engagement, creating aspiration and opening a world of opportunity while preserving the protective safety welfare function of the state.

That is the destination that this report seeks to move towards.

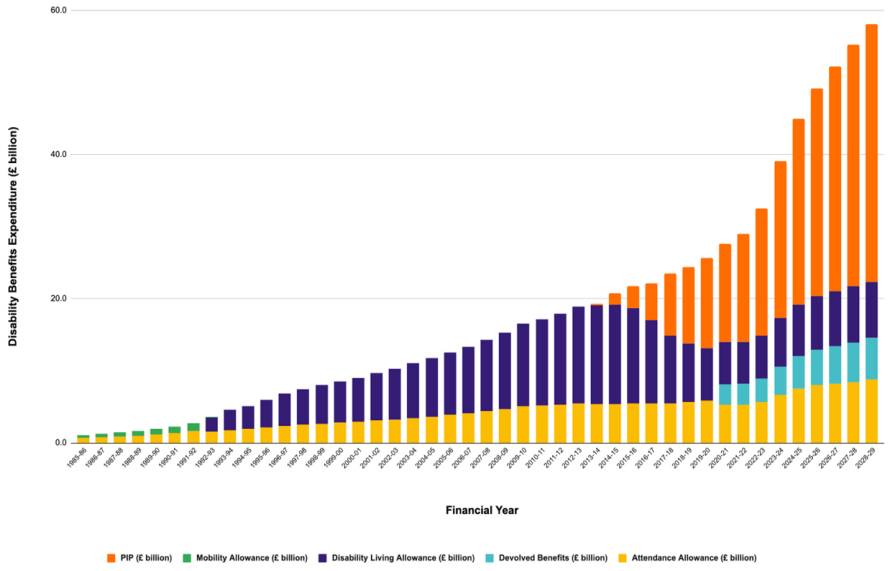
Executive Summary

Britain's approach to health and disability benefits for people of working age – isn't working: fiscally, technically or morally.[6]

One of the most urgent political issues facing the Government is the current fiscal implication and forecast for welfare spending. The cost of both disability benefits (supporting individuals with additional costs to manage a disability) and incapacity benefits (supporting those too ill to work) has risen 40% in real terms since 2013 and is forecast to reach £100 billion by 2029-30.[7] In this scenario, £1 in every £4 of income tax will be spent on health and disability benefits, equivalent to almost £1500 per year per person across the UK.[8] In the 2024/25 financial year, the 'welfare cap' was breached to the tune of £8.6 billion by the Department for Work and Pensions (DWP).[9] The emerging consensus that Britain will need to spend far more on defence makes this issue even more acute.

Spending on disability benefits alone has almost tripled over the past decade. Around 2.6 million people of working age are currently claiming the Personal Independence Payment (PIP) and the Disability Living Allowance (DLA), with 33,000 new awards now being made for PIP every month.[10] The Office for Budget Responsibility (OBR) meanwhile forecasts spending on disability benefits will represent c. 4% of total public spending (and 2% of GDP) by 2028/29.[11]

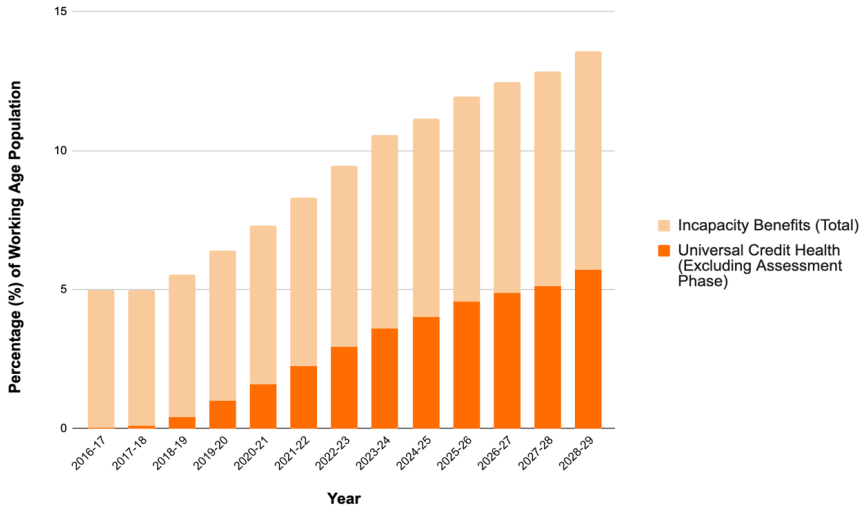
Figure 1 – Expenditure on Disability Benefits, 1985/86-2028/29 (forecast)



6. We use the term 'health and disability benefits' throughout this report to refer to the main working-age, health-related incapacity and disability benefits currently administered by the Department for Work and Pensions. This includes the Personal Independence Payment, Disability Living Allowance, Employment and Support Allowance and Universal Credit.
7. The Benefit Trap, *Learning and Work Institute*, [link]
8. This is based upon OBR forecast that expenditure on health and disability benefits will grow to £90.9bn by 2028/29.
9. Response to Welfare Cap Breach, UK Parliament, 29 January 2025, [link]
10. Modernising support for independent living: the health and disability green paper, *Department for Work and Pensions*, 13 June 2024 [link]
11. Welfare spending: disability benefits, *Office for Budget Responsibility*, link

Source: 'Welfare spending: disability benefits', Office for Budget Responsibility [link]

Figure 2 – UC Health as a proportion of total incapacity benefit claimants, (%) of total working population



Source: 'Welfare spending: disability benefits', Office for Budget Responsibility [link]

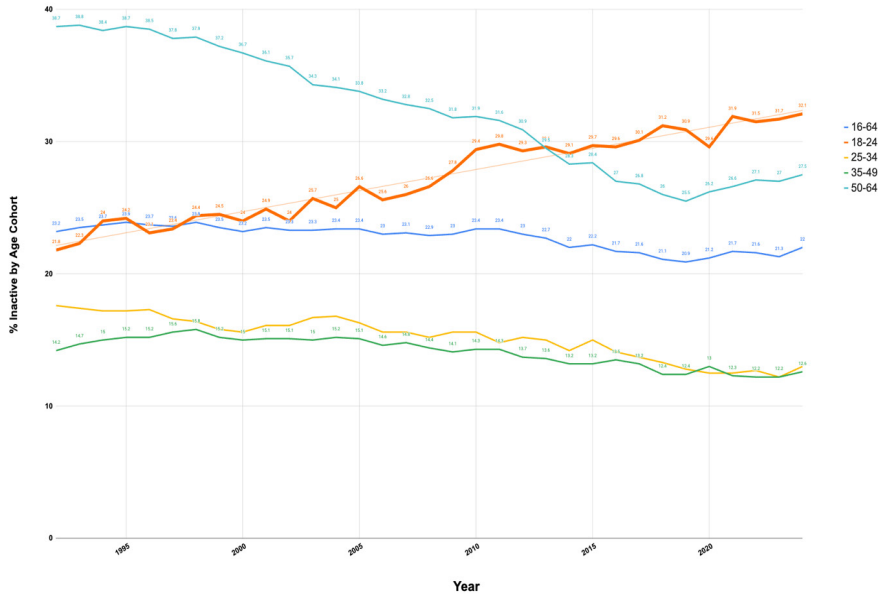
The number of working-age people in receipt of incapacity *and* disability benefits has grown significantly over the past five years with higher 'onflows' and fewer people 'coming off' benefits. Those in receipt of incapacity benefits – the Employment and Support Allowance (ESA) or Universal Credit (UC) with a health condition – increased from 2.6 million in 2019/2020 to 3.3 million in 2023/2024, a 27% increase.[12] The increase in those on UC and placed into the 'Limited Capability for Work and Work-Related Activity' (LCWRA) or those in the ESA 'Support Group' (claimant cohorts within these benefits where there is no obligation to seek work, or to prepare for work) over the past five years in particular is stark: increasing from 1.85 million to 2.5 million recipients – an increase of 35%.

There is an ever-increasing disparity between the generosity of incapacity benefits with unemployment benefits. This paper argues that the current system actively discourages the very behaviours we should be encouraging; it incentivises claimants to prove what they cannot do; assessments are a "tick-box exercise" and drive the wrong behaviours by claimants and assessors. The previous reforms tried to create a bespoke, flexible system focused on functionality, not condition, but ultimately this has not improved the outcomes in the system. Moreover, there is too little emphasis on ensuring that all claimants provide relevant medical evidence to support their claim. Currently, in roughly a third of PIP cases (we have heard anecdotally) and in twenty per cent of WCA assessments, none is provided.

12. Decomposition of growth in the number of claimants of Universal Credit with Limited Capability for Work and Work-Related Activity, or in the Employment and Support Allowance Support Group, *Department for Work and Pensions*, 29 January 2025, [link]

There has been significant growth in self-reported economic inactivity, owing to long term ill-health. Since 2020, 671,000 working-age adults (UK-wide) have left the labour market, citing a long-term health condition (or multiple conditions).[13] Today there are 10.2 million working-age Britons self-reporting a disability which restricts their daily activities. That represents 24% of all people of working age.[14] Meanwhile we have seen an inversion over the past thirty years, with the proportion of over 50s inactive declining (to 2019), whilst those aged 18-24 and inactive now growing significantly, with ill-health a key driver. (See Fig. 3, below)

Figure 3 – Employment, unemployment and economic inactivity by age group (seasonally adjusted)



Source: 'Employment, unemployment and economic inactivity by age group (seasonally adjusted)', Office for National Statistics, 18 February 2025 [link]

There is, therefore, a disconnect between the Office for Budget Responsibility (OBR) analysis and Government messaging and current policy prescription regarding economic inactivity. The Government has linked a rise in working-age inactivity to waiting times for NHS services, but the OBR have stated that it is "probably wrong to assume that even transformative improvements in people's health have anything like as large (in terms of the number of people affected) effects on economic activity" with there being a "28 per cent chance that working-age people in ill health who get better (or who are prevented from becoming ill) will move into (stay in) the labour force, relative to if they remained in or moved into in ill health".[15] "Declining health," moreover, the Learning & Work Institute state, "can't explain" the rest of the rise in incapacity benefit claimants. "Trends in population health don't match changes in the number of …

13. 'Stemming the tide: Healthier jobs to tackle economic inactivity', *Work Foundation*, 5 December 2024 [link]
14. 'Family Resources Survey: financial year 2022 to 2023', *Gov.uk*, 26 March 2024 [link]
15. 'How much could reducing the NHS waiting list contribute to falling inactivity in our upside scenario?', *Office for Budget Responsibility*, July 2023, [link]

claimants".[16] As a consequence, we have likely, insufficiently focused on the underlying incentives and structure of our benefits system as a factor in driving claimant behaviours – and demand.

In the broadest sense, there is a 'cross-Government' need to enhance the quality and nuance of data collection and analysis in relation to work and health – to better understand impacts on inactivity, incapacity and disability. This is imperative if the DWP and DHSC are to secure longer-term support for programmes, targeting the young, inactive or disabled (or a combination of all three) from the Treasury. Part of the answer lies in improving data collection by the DWP so that coding in relation to health conditions is more accurate and nuanced across all programmes. There is a need for improving the volume and quality of evidence provided to inform the Labour Force Survey, conducted by the Office for National Statistics. But this effort will also require new partnerships between research organisations and workplaces; NHS services and universities to improve the overall evidence base. Moreover, there is a need to improve the objectivity of assessments. We believe that medical evidence provided separately to the formal assessment process should accompany every claim for health and disability benefits.

There has been a particularly striking growth in PIP claims (and awards) amongst people under 30 years of age. The latest figures show that almost one million (987,000) 16–24-year-olds are not in education, employment or training (NEET).[17] Whilst claim rates for PIP have increased across all age groups, for those aged 16-19, rates have tripled since 2019. PIP awards where the primary condition is a 'psychiatric condition' (which includes common mental disorders, including anxiety and depressive disorders) grew from an average of 2,600 per month in 2019 to 5,700 by January 2024. Around a third of all claims for PIP are currently for mental or behavioural conditions, but this figure rises to 70% for those under 25.[18]

This significant growth in demand (and spending) on health and disability benefits has been subject to considerable scrutiny, with much debate in recent months about the multitude of factors which have created this seemingly unique phenomenon. Is it the case that the population is simply more ill? Are incentives in the benefit assessment process misaligned – where the focus is too heavily weighted toward one's incapability to perform certain tasks? How significant is the changing nature of employment and of the structure of the economy overall contributing to these outcomes? If it is a combination of the above, what is the respective weighting of the above factors?

From our perspective, each of these factors plays a role, but the current function – and underlying incentives – of our benefit system have been underweighted in the public policy debate. As the Learning & Work Institute have recently contended, "only one third of the rise [of incapacity benefit claimants] can be explained by the rising state pension age (meaning more older people who are more likely to have health problems are still expected to work), an aging population, and the rollout

16. S. Evans, 'The benefit trap Better support for disabled people and people with long-term health conditions', *Learning and Work Institute*, February 2025, p.4 [link]
17. 'Young people not in education, employment or training (NEET), UK: February 2025', *Office for National Statistics* [link]
18. The number of new PIP claimants has doubled in a year, *Disability Rights UK*, [link]

of Universal Credit (which brings people who would previously have received other benefits into the system)."[19]

We are failing people with ill-health and disability by disincentivising positive behaviour(s). This paper argues that the current system actively discourages the very behaviours we should be encouraging; it incentivises claimants to prove what they cannot do, rather than what they can. For too many individuals, broader social issues are now being parked in our welfare system, where our response is to make a fiscal transfer and hope this support suffices. The benefits system has arguably been a front-stop, rather than a backstop for too many people. As a result, the system is becoming unaffordable, delivers poor outcomes and creates a 'helpless state' for both claimants and policymakers alike. The previous reforms tried to create a bespoke, flexible system focused on functionality, not condition, but ultimately this has not improved the outcomes in the system.

This is creating a crisis of confidence in the benefits system. Recent polling from YouGov shows that just 9% of Britons believe that all or almost all users of the benefits system are genuinely in need. Less than half the public (49%) even believe that *most* people on benefits genuinely need help. Almost four in ten (39%) believe that half or more of welfare recipients are not in genuine need.[20]

All governments are confronted by unpalatable political choices – perhaps none more so than in welfare policy. In the late 1990s, Tony Blair asked the late Frank Field to "think the unthinkable" on welfare.[21] The political saliency of the issue today is clearly recognised by the Government. Writing recently in *The Sun*, the Chancellor has vowed that she would "not hesitate to act" to drive down Britain's benefits bill.[22] "Radical reforms", the Work and Pensions Secretary states, are required.[23]

The Autumn Budget and a White Paper focused on tackling fraud and reforming Jobcentres, but measures to reform health and disability benefits are yet to emerge. The Government proposes to outline reforms in a Green Paper, due for publication "in Spring". There has been considerable briefing over recent weeks over may be contained, including introducing a "duty to engage" with employment services; for the Work Capability Assessment (WCA) to be abolished; for the UC LCWRA category to be removed; and for prospective changes to PIP criteria and thresholds.[24]

So what reforms do we believe are necessary? Defining who ought to be eligible for support is the key challenge of Government. We need to rebalance our welfare system – and the incentives underlying it – so it becomes a more proactive, engaging and connected system of support, where we place greater expectations on claimants, but in turn we expect the state to provide more appropriate – and assertive support.

This can be achieved by a radical evolution of the system. Whilst there are fundamental challenges, constant changes have led to a policy hyperactivity – particularly initiatives to support disabled or the inactive into work. We should put our political and policy weight behind those schemes which have demonstrated positive effects to date, back them and

19. S. Evans, 'The benefit trap Better support for disabled people and people with long-term health conditions', *Learning and Work Institute*, February 2025, p.4, [link]
20. D. Difford, 'How do Britons feel about benefits and welfare recipients?', *YouGov*, 12 December 2024, [link]
21. G. Cordon, 'Frank Field: the political maverick appointed to think the unthinkable', *The Standard*, 24 April 2024, [link]
22. R. Reeves, 'We cannot keep footing the bill for jobless Britain – so I will bring forward a plan to cut sickness benefits in weeks', *The Sun*, 25 January 2025, [link]
23. C. Smyth, 'Half of claims for most expensive incapacity benefits are approved', *The Times*, 30 January 2025, [link]
24. C. Smyth, M. Kendix & O. Wright, 'Long-term sick will need to look for jobs in benefits overhaul', *The Times*, 31 January 2025, [link]

continue to monitor their performance.

If we want to create long-term sustainability, we need to take a series of measures to shore up the current system. These reforms are urgent, necessary and will provide the space for the Government to determine if they are sufficient. We advocate the following:

We suggest that The Personal Independence Payment (PIP) becomes a conditional benefit for those aged 16-30. Reforms should proceed with those aged 18-21 to begin with (mirroring the cohort who will be targeted by the Government's 'Youth Guarantee'). Reform should also be based on the principles which underpinned the New Deal for Young People, first introduced in 1998, which compelled engagement via full-time education, voluntary work or formal employment. The Government should refresh these concepts for the modern day.

This is a clear departure from the current purpose of PIP whose purpose is to meet some of the extra costs incurred by disabled people. However, given the rising claimant numbers – especially among young people with mental health challenges – we think this is a necessary step to encourage improved engagement with society. We suggest that DWP is still be able to opt individuals out of conditionality based on the severity of their condition. Coupled with this change, we would change the age where you can claim PIP to 18 (increasing it from 16) to better align with support provided.

Creating a more dynamic and less adversarial assessment oriented to finding the right type of support. Currently assessments are binary: determining eligibility for a financial award or not. Such an approach creates an adversarial nature to the benefits process, whilst not actually maximising the capability of the assessor, or the opportunity of the assessment process itself. Healthcare professionals employed by Assessment Providers (APs) to deliver PIP and the Work Capability Assessment (WCA) should have the ability to signpost and to refer claimants to other DWP support as part of/during the assessment process (e.g. to Access to Work). We begin by trying to nudge people to other support and see how this impacts other services, but this option could be escalated, and there could be a requirement introduced for engagement with the services an assessor refers a claimant to. Over time this approach could be expanded to include a wider range of voluntary-sector and NHS services, including social prescribing.

Every claim for health and disability benefits should be backed by medical evidence to support claims. Currently, too many claims lack appropriate external input**.** A 'Health Impact Record' should be introduced and should be mandatory for every claimant of health and disability benefits.

We believe that Parliament should play a greater role in scrutinising (and ultimately voting upon changes to health and disability benefits). Such an approach will be reliant upon creating a more dynamic approach to amending the qualifying criteria**.** We propose that future reforms should be made through primary legislation. To ensure there is expert

input into proposed changes to the assessment criteria, a 'Health Panel' should be appointed, given direction by DWP ministers (emulating the Joint Committee on Vaccination and Immunisation (JCVI)) and should advise on changes to the assessment criteria (and the points attached to that criteria), upon request. Ministers would then be able to decide to put these changes to Parliamentary vote(s).

Access to Work (AtW) – a programme which offers practical support for disabled people to move into or to remain in work – requires significant reform so it is reimagined for the 21st century. An online 'marketplace of support' of self-service specialist aids and equipment should be created, underpinned by a set of more standardised support packages derived from a granular understanding of the types of individuals claiming AtW. This would improve the claimant experience by improving upon current waiting times, whilst achieving efficiencies for disabled people through bulk-purchasing and achieving improved economies of scale. However, DWP faces an immediate challenge. The current trajectory of spending risks AtW becoming unsustainable for DWP to administer. There is a need to address the fact that growth is predominantly for the 'Support Worker' category, with the scheme overwhelmingly used by public sector organisations and large businesses. The DWP should therefore look to expand cost-sharing agreements (with employers), whilst ensuring that greater use of medical evidence is used to determine eligibility for support through 'Support Worker(s)'.

Ultimately, our national conversation around ill-health and disability needs to become more aspirational, resulting in a new social contract. The incentives in our current benefit system are misaligned with the outcomes that we are trying to achieve. They discourage positive behaviours, diminish potential and create a negative feedback loop. This report seeks to address this current imbalance – and builds on recent output from Policy Exchange which has made the case for improved workplace health provision (via occupational health and vocational rehabilitation) to improve retention-at-work and rates of return-to-work. It also follows our recent proposals to reform the 'fit note' and approaches at assessing fitness to work so that it becomes a more dynamic tool and can enable professionals to direct people to the most appropriate support available.[25]

Summary of Recommendations

1. **For those aged 16 to 30, The Personal Independence Payment (PIP) should become a conditional benefit, creating an age-defined approach.**
    a. The Government should proceed by introducing reforms to the benefit for individuals aged 18-21, linked to wider proposals for a 'Youth Guarantee', but should expand the programme over the coming months.
    b. The Government should seek to improve the alignment of PIP claims with Education, Health and Care Plans, starting by

25. S. Phillips & S. Carroll, None of Our Business? How Places of Work Can Help to Improve the Health of the Nation, *Policy Exchange*, 28 February 2024, [link] and S. Phillips & S. Carroll, Not Fit for Purpose: An Appraisal of the 'Fit Note' and Assessments of Fitness for Work, *Policy Exchange*, 13 April 2024, [link]

changing the age you can first claim to 18 – and prospectively raising this to 25 over time.

c. In exceptional circumstances, the DWP should be able to opt individuals out of this proposed conditionality based on severity of condition, or where individuals have a terminal condition.

2. **The Government should evaluate the criteria and descriptors for health and disability benefits more routinely and Parliament should play a more active role in scrutinising and voting upon changes.**
   a. Currently, given much of the criteria for PIP and the Work Capability Assessment (WCA) is in regulations (secondary legislation), it has been subject to increasingly widening scope and legal challenge.
   b. Primary legislation should be introduced for future reform(s) as a means of returning greater (and more routine) Parliamentary scrutiny and oversight.
   c. To ensure expert input in changes to qualifying criteria, Ministers should appoint a 'Health Panel', akin to the Joint Committee on Vaccination and Immunisation (JCVI), who would receive Ministerial instruction(s) to propose changes to qualifying criteria on a regular basis. Based on an advisory opinion from the Panel, Ministers these suggestions should be put to Parliament for a vote.

3. **To create a more dynamic and joined-up system of support, Assessors for PIP and the Work Capability Assessment (WCA) should have the ability to signpost and to refer claimants to other DWP support as part of/during the assessment process (e.g. to Access to Work).**
   a. Currently assessments are binary: determining eligibility for a financial award, or not. Such an approach creates an adversarial nature to the process, whilst not in fact maximising the professional capability of the assessor, nor making the most of the opportunity presented by the assessment process to join up support.
   b. DWP should begin with their own programmes (e.g. Connect to Work, Access to Work), but over time this could be expanded to clinical services, social prescribing programmes. The aim of these measures is to encourage speedier access to support – which is a key predictor of the likelihood of a return to work.

4. **The health assessment process should be simplified through the creation of a Single Assessment.**
   a. As has been suggested by both the Labour Government and the Conservatives (when they were in Government). The

Work Capability Assessment should be abolished. In its place, a Single Assessment should be introduced for claimants of all health and disability benefits – to reduce waiting times and to embed the joined-up approach advocated in our recommendations above.

b. Through this reform, the DWP should embed an expectation of more regular reassessment.

c. Transition from the Disability Living Allowance (DLA) to PIP should be simplified for those with the most severe conditions through the provision of evidence provided by a healthcare professional which proves (or suggests) their condition will not change. We also think that for a small group of individuals with severe, or terminal conditions, we should streamline the assessment process and reduce the requirement for further assessments.

5. **Every claim for health and disability benefits should be backed by medical evidence to support claims. A 'Health Impact Record' should be introduced and should be mandatory for every claimant.**

   a. Every claimant of a health-related benefit should provide medical evidence to support eligibility of their claim;

   b. Improved information sharing between NHS organisations (particularly general practice) and the DWP will be required to achieve this objective.

6. **The DWP should boost transparency over the Key Performance Indicators (KPIs) and outcomes upon which their contracts with Assessment Providers (for benefit assessments) are based.**

   a. This is to improve public understanding of the requirements upon Assessment Providers – and to reduce incentives in the system which may act against the policy objectives of the benefit.

   b. There should – for instance – be quarterly publication by the DWP of outcomes of assessments by modality (e.g. paper-based, face-to-face, video or telephone).

7. **A Rapid Response Model should be developed (and delivered through NHS GP services) which is targeted at individuals of working-age who have recently fallen ill and dropped out of employment, or are likely to be absent for more than 21 days.**

   a. Every individual who is 'in work' and issued with a 'fit note' or who is likely to be absent for longer than 21 days, for reasons other than short-term illness, fractures or terminal conditions, should be 'flagged' for further assessment (for instance, via occupational health offered by employers) and offered wrap-around support.

8. **Measures should be introduced to create formal qualification(s) for Functional Assessors – as part of a broader approach to improve recruitment and retention and to create a clearer career structure.**
    a. Reforms to health and disability benefits should be regarded as an opportunity to enhance career progression and professional autonomy for healthcare professionals who conduct medical and/or functional assessments for Assessment Providers (or for the DWP itself).
    b. The DWP should work closely with the Society of Occupational Medicine (and its Special Interest Group for Functional Assessment Medicine) alongside the Faculty of Occupational Medicine, Faculty of Occupational Health Nursing and other relevant organisations to design and develop Diploma(s) in Functional Assessment.

9. **Significant reforms should be introduced to Access to Work (AtW) to ensure swifter access to support and to ensure greater financial sustainability.**
    a. An online 'marketplace of support' should be created by the DWP with the aim of developing 'packages' of tools, specialist aids and equipment, based upon the requirements of existing AtW claimant cohorts. The purpose is to improve overall levels of support and to maximise the advantages of 'bulk buying' target items.
    b. The DWP should expand the use of cost sharing agreements (with employers) through by extending standard rate contributions. This should be introduced for the 'Support Worker' category as a priority.
    c. Reforms should be introduced to ensure that 'short-term' conditions (e.g. fractures) are ineligible for the benefit.
    d. Greater use of medical evidence should be introduced to determine eligibility for the 'Support Worker' category.
    e. An approved supplier list should be introduced to ensure improved quality for Support Worker(s)
    f. Improved capture and coding of individual and groupings of health conditions should be required – and this should be aligned to the coding of conditions for other health and disability benefits to ensure greater consistency and comparison of demand for support by medical condition.

10. **There is a cross-Government need to enhance the quality and nuance of data collection and analysis in relation to economic inactivity, incapacity and disability.**
    a. Individuals who are unemployed owing to ill-health or due to a health condition should be counted in official unemployment figures produced by the Office for National Statistics (ONS).

b. The DWP should develop more nuanced and consistent coding of medical conditions which form part of the eligibility for health and disability benefits – to enable improved understanding of the changing nature of conditions amongst claimants.

Introduction

To govern is to choose. The shrinking fiscal headroom, coupled with growing spending pressures – especially expectations to meet the "generational" challenge posed to European security – makes this oft-repeated phrase particularly pertinent. Ultimately, some principles are more sacrosanct than others; some decisions are more urgent than others.

The urgency in tackling our ever-increasing expenditure on health and disability benefits is plain. Current expectations and demands for welfare are unsustainable. By way of example, those in receipt of the Employment and Support Allowance (ESA) or Universal Credit (UC) with a health condition (incapacity benefits) increased from 2.6 million in 2019/2020 to 3.3 million in 2023/2024 – a 27% increase.[26]

Reform is therefore not only a fiscal imperative, but has significant technical and moral implications also. It is therefore one of the most significant public policy challenges facing the Government today. We know some broad contours about the Government's plans for health and disability benefits. The Labour Manifesto stated that the Work Capability Assessment (WCA) needs to be "reformed or replaced".[27] In the short term, they intend to enact the same level of savings that were outlined by the Conservatives through reform to the WCA, but ultimately, to bring forward their own proposals to do so (through a renewed consultation on the WCA descriptors alongside a Health and Disability Green Paper due in Spring 2025).

The Government has suggested that they "will fix the broken benefits system" but to achieve that objective, the Government must first ask some fundamental questions about the current assessment model, the eligibility criteria, whether the support offered should be more diversified and tailored to individual needs, and the importance of greater alignment with other services.[28] This will inevitably result in politically difficult but fundamental questions.

How to define this eligible group is the key challenge of government – and of any reform. These choices require the Government to know the desired endpoint of their policy and the trade-offs required to achieve it. It should be underpinned by a philosophical Lode Star. Labour has been comfortable talking about a "revolution" in helping those with ill-health and disabilities to get back into work, firmly emphasising the need to improve the effectiveness of the support offered. This is their current philosophical Lode Star. However, there is a need and desire to deliver savings. (A very similar challenge to that facing the Coalition Government in 2010). While both these aims are possible to achieve, the emphasis and

26. 'Decomposition of growth in the number of claimants of Universal Credit with Limited Capability for Work and Work-Related Activity, or in the Employment and Support Allowance Support Group', *Department for Work and Pensions*, 29 January 2025, [link]
27. Labour Party Manifesto 2024 [link]
28. M. Savage, 'Labour to 'fix benefit system to get people back into work'., *The Guardian*, 8 February 2025 [link]

the relationship between these aims will define the Government's policy on welfare overall over the course of the Parliament.

There are a series of philosophical questions that should underpin this debate and thinking – and how you answer these questions shapes the reforms you design. We have grouped these questions based on 1) eligibility and 2) generosity of the support provided.

Eligibility

1. **Severity v. Means:** Should we determine eligibility for health and disability benefits by the *severity* of an individual's condition or by the relative means at the disposal of the claimant?

   In layman's terms, this question concerns whether benefits should be means-tested. Our report starts from the premise that we should incentivize disabled people to be more active participants in society. We think means-testing would be counter-productive to that objective.

2. **Objectivity v. Subjectivity**: Should the assessments be more objective and/or more accurately reflect someone's direct needs and costs.

   The current burden of ill-health, with a greater prevalence of mental ill-health, inflammatory conditions – and co-morbidities overall has made diagnosis more challenging and there is now greater subjectivity in the assessment process as a result. How to achieve greater objectivity is, therefore a challenge. In principle, we believe that greater emphasis should be placed on ensuring the provision of medical evidence to support claims than is currently provided.

3. **Acceptable levels of ill-health or disability?** What is the level of ill-health we – as a society – accept does not require a cash transfer to support someone effectively?

   With a society where there is a greater overall burden of ill-health and with an ageing population, there will ultimately be a larger number of individuals overall who seek support. Accordingly, the benefit system must be sufficiently dynamic and adaptable so that it reflects and balances the needs and means of modern society.

Generosity

1. **'One size fits all' or a diversification of support?** Is the 'one size fits all' cash transfer model fit for the purpose, or do we need to rethink the model of support to better support individual needs? Should the type of support we offer to disabled people be diversified?

   Our current model of support is binary: either you receive a level of financial support,

or not. We believe this fundamentally needs to change to improve the lives of disabled people.

2. **A System of First or Final Resort?** Need-based approaches to welfare mean that other parts of the system accessed first with the welfare system a place of 'final resort'. Is this the case today and is this appropriate?

   Too often, we believe that the welfare state has become first port of call, rather than a backstop. Given the challenges that public services have faced, the state has often discharged its duty to people with health conditions or disabilities by providing financial support, rather than providing a more holistic and targeted offer.

3. **Therapeutic v Destructive?** Are there some claimants of welfare for whom cash transfers are in fact therapeutically harmful – or at least not in fact addressing the most salient issues in the case of the individual claimant?

   We believe that in some cases, the financial support we currently offer facilitates disengagement from employment services – and at times, wider society. This creates the wrong incentives and addressing this is fundamental to reform.

We aim to address these philosophical questions whilst also grounding our report in what we believe is feasible over this Parliament. One could imagine a future where there is a debate about the idea of centralised support vs a devolution model where, for instance, PIP is replaced with a Departmental Expenditure Limits (DEL) fund to deliver a localised model of support. Beyond the obvious challenge of creating a postcode lottery of support and the capacity of local authorities to deliver such a system, we also think it opens much wider questions about local government reform. Therefore, we have focused our recommendations on the assumption that – broadly speaking – the current functional system of assessments remains in place.

We focus primarily upon the administration of health and disability benefits for those who are of working age (18-65 years). Namely, the Personal Independence Payment (PIP) (which can be claimed from the age of 16) and those individuals in the 'Health Group' in receipt of Universal Credit (UC). We also assess the current use of Access to Work (AtW), a programme which seeks to provide targeted support for those with disabilities (e.g. support worker or transportation costs).[29]

Our report is structured as follows:

- **Chapter 1** considers the *Development, Design and Demand for Health and Disability Benefits Today*
- **Chapter 2** provides an *assessment of Health Assessments used to determine eligibility for health and disability benefits*

29. Access to Work, Gov.uk, [link]

- **Chapter 3** considers the recent history and current performance of schemes used to encourage greater rates of employment and support for those with health conditions or disabilities
- **Chapter 4** outlines a *package of reforms – with the aim of creating a new social contract.*

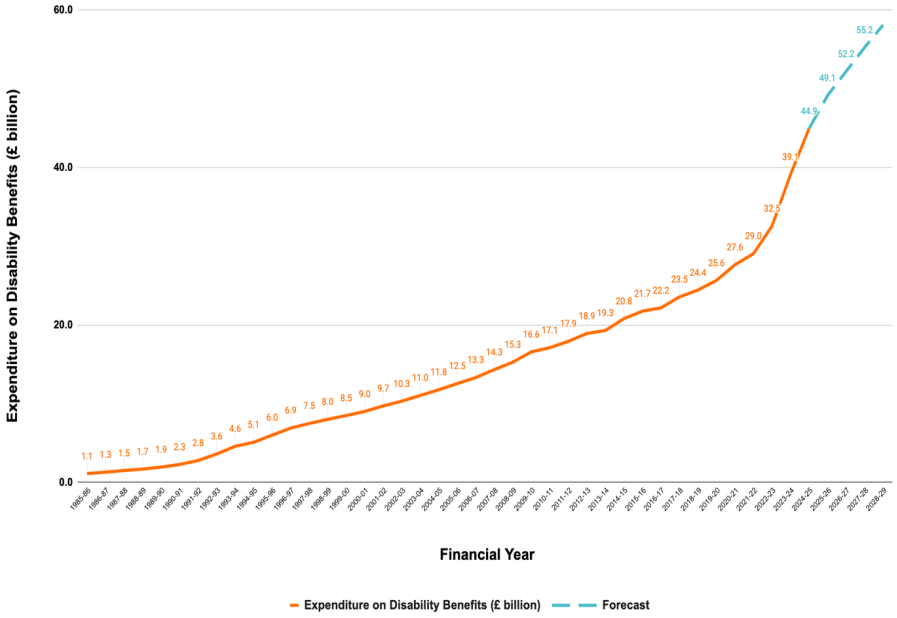
Table 2 – Key Facts

	The number of 'working-age' people who self-reported a disability was 10.2m in 2023 (24% of the total 42.3m people of working age) up from 6.6m in 2012/13. A growth of 54% in a decade. Compared to the figures for the year 2016-17, monthly onflows in 2022-23 had nearly doubled for disability benefits (up 97 per cent) and nearly tripled for incapacity benefits (up 180 per cent).
	2.1 million people were on UC health compared to 1.8 million a year earlier – up 22% from June 2023, and by 4% from the month of March 2024[30]
	Of these: • 259,000 (12%) had 'acceptable medical evidence of a restricted ability to work pre-WCA' • 362,000 (17%) were assessed as limited capability for work (LCW) • 1.5 million (71%) were assessed and placed into the limited capability for work and work-related activity (LCWRA) group of UC health [31]
	On average, 2.7 types of medical condition were recorded for each person in receipt of UC health • Coverage is incomplete, but mental and behavioural disorders are most likely medical condition to be recorded, followed by musculoskeletal conditions. • Proportion recorded as having mental and behavioural disorders is lower (53%) for claimants found capable for work, and higher for claimants found to have limited capability for work (90%)

30. Universal Credit Work Capability Assessment statistics, April 2019 to June 2024, *Department for Work & Pensions*, 12 September 2024, [link]

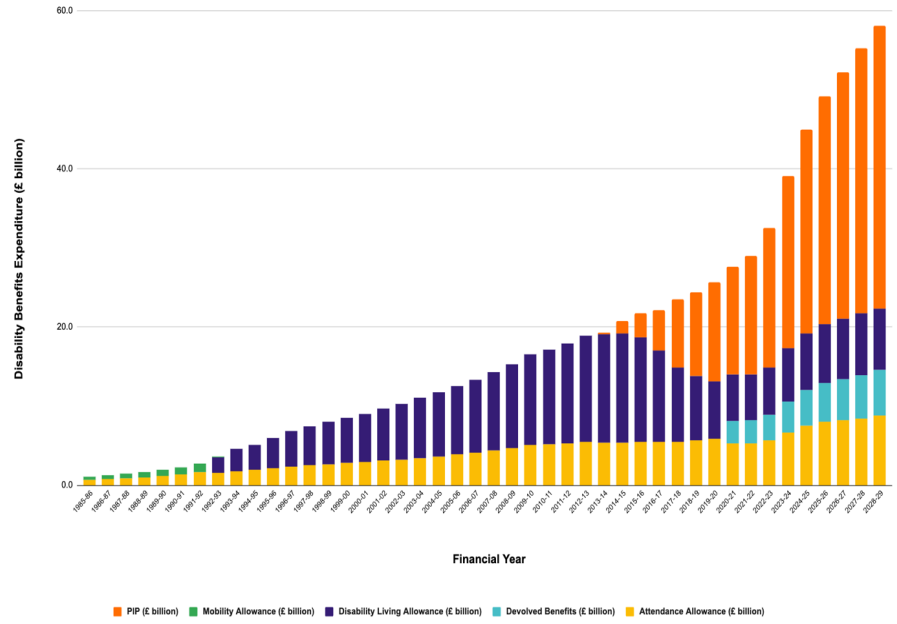
31. Ibid.

Figure 4 – Total Expenditure on Disability Benefits, 1985/6-2028/9 (forecast)



Source: 'Welfare spending: disability benefits', Office for Budget Responsibility [link]

Figure 5 – Expenditure on Disability Benefits (Segmented by Benefit), 1985/86-2028/29 (forecast)



Source: 'Welfare spending: disability benefits', Office for Budget Responsibility [link]

An Overview of Recent & Current Government Policy

> *"We will bring forward big reforms that help more people into work, protect the most vulnerable, and boost growth – while putting the benefits bill on a more sustainable footing."*[32]
>
> **Liz Kendall MP**, Secretary of State for Work and Pensions (February 2025)

There is little doubt that the Government recognise the political salience of the welfare challenge, although formal proposals to reform health and disability benefits are yet to emerge. Writing recently in *The Sun*, the Chancellor has vowed she would "not hesitate to act" to drive down Britain's benefits bill.[33] "Radical reforms", the Work and Pensions Secretary states, are required.[34] The Government has recently committed to making savings of £5.4bn from the welfare budget by 2029-30, with a Green Paper expected in March.[35]

Thus far, the Government have announced the following measures to address inactivity, owing to ill health and to address growing welfare spending:

At the Autumn Budget 2024, the Chancellor of the Exchequer announced:

1. **Measures in an Employment Rights Bill,** to "modernise the UK's employment rights framework in response to the changing world of work, including by making flexible working the default, establishing a new right to bereavement leave, and making paternity and parental leave available from day 1 of starting a new job".[36]
2. A crackdown on fraud through an **expansion of DWP's counter-fraud teams**, "using innovative new methods to prevent illegal activity".[37] (This will take the form of a Fraud, Error and Debt Bill, first announced by the Conservatives, to enhance DWP powers).
3. £115 million in funding throughout 202526 to deliver **Connect to Work**, a new supported employment programme matching people with disabilities or health conditions into vacancies and supporting them to succeed in their roles.
4. Commitment to **delivering savings of £1.3bn per year by 2028/9**, which the previous Government was seeking to deliver through reform to the Work Capability Assessment (WCA). (The Government has not yet confirmed the means by which these savings would be delivered.)

This was followed in November 2024 by the DWP White Paper, *Get Britain Working* which outlined the following proposals.[38]

5. **Reforming employment support:** in collaboration with mayoral authorities and the Welsh government to reduce economic

32. B. Davis, 'Benefits overhaul to make long-term sick look for work', *The Independent*, 1 February 2025, [link]
33. R. Reeves, 'We cannot keep footing the bill for jobless Britain – so I will bring forward a plan to cut sickness benefits in weeks', *The Sun*, 25 January 2025, [link]
34. C. Smyth, 'Half of claims for most expensive incapacity benefits are approved', *The Times*, 30 January 2025, [link]
35. C. Chaplain, 'Treasury documents reveal a £2bn black hole in Chancellor's benefits plans', *The I Paper*, 22 December 2024, [link]
36. Autumn Budget 2024, *HM Treasury*, 30 October 2024, [link]
37. Financial Statement and Budget Report Volume 755, 30 October 2024, [link]
38. Get Britain Working, *HM Government*, November 2024, [link]

inactivity

i. *Jobcentres to become a new national jobs and careers service*, focused on people's skills and careers instead of just monitoring and managing benefit claims;
ii. Staff at Jobcentres to be given more flexibility to offer personalised approach to jobseekers; *Coaching academies* to upskill jobcentre staff;

6. **Development of 'Connect to Work' to** provide voluntary employment offers to people with disabilities, health conditions or complex barriers to work and will support up to 100,000 people a year at full roll out;
7. **Introduction of a 'Youth Guarantee':** in eight areas to improve young people's access to education, training or employment.
8. ***Keep Britain Working* Review launched**: led by Sir Charlie Mayfield to investigate the role of employers in reducing health-related inactivity.
9. **Development of a 'disability panel'**
10. **Commitment to expand of NHS services which support return to work:**
    xi. Increased access to Individual Placement and Support (IPS) for severe mental illness, reaching 140,000 more people by 2028/29;
    xii. Funding for NHS 'accelerators' to stop people falling out of work completely due to ill health.[39]

The Government have also announced:

11. The **development of a new panel** – led by Professor Amanda Kirby – to advise ministers on how to get people with neurodiversity into employment to improve their career prospects and ensure a "fairer" welfare system.[40]
12. A '**Charter for Budget Responsibility'** will establish a welfare cap for the course of the Parliament and that DWP will publish an annual report on welfare spending[41]

As has been reported in recent weeks, measures which are being considered for inclusion in a Health and Disability Green Paper – and which would therefore be consulted upon – include:

- Introducing a "duty to engage" for claimants;
- For the Work Capability Assessment (WCA), used to approve incapacity benefits, to be scrapped;
- For "changes to PIP thresholds and eligibility" to be introduced;
- For UC "limited capability for work or work-related activity" (LCWRA) category to be abolished

Some short-term, tactical measures are likely also to be considered to

39. 'World leading NHS trial to boost health and support people in work', *NHS England*, 5 December 2024, [link]
40. C. Chaplain, 'Neurodivergent people on benefits to be helped into work in bid to cut welfare bill,' *The I Paper*, 31 January 2023, [link]
41. Response to Welfare Cap Breach, Statement UIN HCWS398, 29 January 2025, [link]

reorientate these benefits, including: tightening the criteria for both PIP and UC Health. This will likely revolve around changes to the PIP and UC Health gateway, especially around removing points for the 'aids and appliances' and 'prompting' descriptors in PIP (individuals qualifying through those descriptors are seen to have a lower level of need and, therefore, possibly lower extra costs.

This idea was first considered in the Budget in 2016 when the Chancellor announced that the Government would halve the points awarded for aids and appliances for Managing toilet needs or incontinence (Activity 5) and Dressing and undressing (Activity 6).[42] This plan was abandoned five days later following the resignation of the Rt Hon Sir Iain Duncan Smith MP during the height of parliamentary debate concerning Britain's withdrawal from the European Union.

The idea to once again look at aids and appliances was floated by the previous Government in April 2024. The rationale that underpins changing those criteria is that some of these aids or appliances (such as handrails, shower stools or walking sticks) are one-off costs, available for free or at low cost and could possibly be provided by local authorities or the NHS. There is a misalignment between incurring a one-off cost and receiving an ongoing benefit, and the Government will deploy that argument if that does become one of the proposed reforms. Similarly, the Government might argue that the prompting criteria need to be reevaluated because it means that someone's mental health could prevent them from washing, eating or dressing owing to a lack of motivation. One could argue that providing additional financial support for these individuals is possibly not the right type of help these individuals need.

On the WCA, the previous government looked at two separate types of reforms in the Spring and Autumn Statements of 2023. The Health and Disability White Paper was published in March 2023, proposing removing the WCA and passporting a new Universal Credit (UC) Health Element through PIP.[43] The rationale behind this approach was to remove financial disincentives and to create a more personalised approach. This line of thinking seems very much in line with the *Financial Times* recently reporting that the Government wants "to end the division" between incapacity benefits and PIP and to create "a single assessment with more graduated potentially time-limited support".[44] This approach is correct and is one of the recommendations of this report. The Government has to tackle the structural deficiencies in the benefit.

There are shorter-term descriptor changes that DWP could consult on to try and create a tighter gateway. In the Autumn of 2023, the previous government made a series of policy proposals, including removing the Mobilising activity used to assess LCWRA, reducing the points awarded for some of the 'Getting About' descriptors used to assess limited capability for work and to amend the LCWRA Substantial Risk regulations.[45] The proposals were supposed to be implemented in September 2025, and the OBR suggested that they would mean that 424,000 would now need to now prepare for work by 2028/29. This consultation was deemed

42. Personal Independence Payment and the March 2016 Budget, *House of Commons Library Briefing Paper*, 8 July 2016 [link]

43. Transforming Support: The Health and Disability White Paper, *Department for Work and Pensions* [link]

44. S. Fleming, D. Strauss & A. Gross, UK needs to tackle 'unaffordable' benefits system, says minister, *Financial Times*, 2 March 2025, [link]

45. Work Capability Assessment: activities and descriptors, *Department for Work and Pensions*, 22 November 2023 [link]

unlawful in January 2025 but the DWP have committed to reconsulting on the WCA descriptor changes alongside their wider Green Paper, and while it has been suggested that they want to focus their reforms on generosity of the benefit rather than tightening eligibility. If they focus on eligibility, it is difficult to see how radically different their reforms could be from the previous Government's proposed approach given they are trying to achieve the same savings number by the end of the Parliament. However, if they are seeking to tackle this through generosity, they could alter the amount awarded in the LCWRA to meet a savings target.[46]

It is also worth briefly noting reforms announced by the previous Government from 2022-2024 (see Table 3, below).

46. The Chancellor, the Rt Hon Rachel Reeves MP, stated: "We will deliver the savings as part of our fundamental reform to the health and disability benefits system that my right honourable friend the work and pensions secretary will bring forward." [link]

Table 3 – An Overview of Policies Announced Between 2023-2024 Aimed at Reducing Economic Inactivity

Policy	Description
DHSC	
NHS Talking Therapies	Evidence-based therapies for adults with common mental health conditions, including anxiety disorders and depression. Current policy aims to support an additional 384,000 people over the next five years by increasing the average number of therapy sessions per person.
Individual Placement and Support (IPS)	Model of supported employment, integrated within community mental health teams for people who experience severe mental health conditions or have complex mental health needs, which aims to help people gain and retain employment. Current funding will provide for an additional 100,000 people to access support.
NHS Recovery Plans	DHSC published recovery plans, aim to improve performance of core NHS services across elective recovery, emergency and urgent care and in recovering access to primary care.
DWP	
Additional Jobcentre Support in England and Scotland	Testing how intensive support can help claimants into work who remain unemployed or on low earnings after 7 weeks into their Universal Credit claim.
Extension of Restart Scheme	A work-support programme assisting claimants to get back to work through coaching, CV and interview skills. Claimant referrals being brought forward to six months from nine months.
Claimant review post-Restart	Universal Credit claimants who are still unemployed after the 12-month Restart programme will take part in a claimant review point: a new process whereby a work coach will decide what further work search conditions or employment pathways would best support a claimant into work. If a claimant refuses to accept these new conditions without good reason, their Universal Credit claim will be closed and benefits stopped.

Post-Restart pathway trials (including phased rollout of mandatory work placements)	Claimants who have not taken up suitable local job offers at the end of Restart (18 months into claim for those who start Restart at 6 months) will be required to accept time-limited work experience or another intensive activity to improve their employability prospects. This will be gradually rolled out from 2024, so the model can be tested and refined.
Targeted Case Reviews	Rooting out fraud and error using Targeted Case Reviews to review Universal Credit claims of individuals on an open-ended sanction and disengaged for over eight weeks, ensuring they receive the right entitlement.
Universal Support in England and Wales	100,000 people per year will be matched with vacancies. Participants will access up to 12 months of personalised 'place and train' support. The individual will be supported by a dedicated keyworker, with up to £4,000 of funding available to provide each participant with training, help to manage health conditions or for employers to make necessary adjustments.
Joint DWP-DHSC Programmes	
WorkWell	A new service delivered by DWP and DHSC to support 60,000 long-term sick or disabled people to start and stay in work. Integrated Care Systems across England will be encouraged to develop localised work and health strategies. Service delivered in up to 15 pilot areas.
'Fit Note' Reform	Government proposed reforms to the 'fit note'. Reforms "could lead to GPs being out of the 'fit note' system altogether".[47]

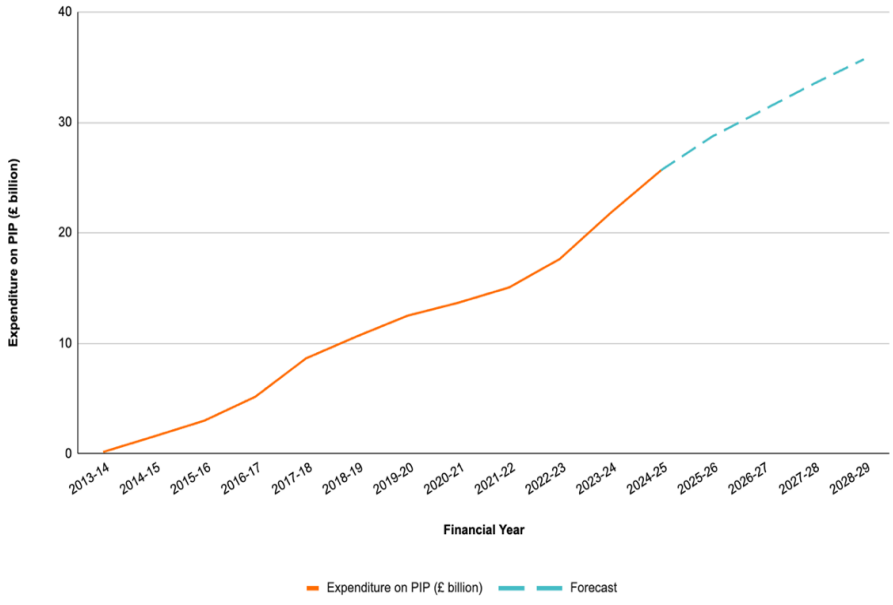
47. C. Smyth, 'Unemployed will lose free NHS prescriptions if they refuse work', *The Times*, 16 November 2023, [link]

Chapter 1 – The Development, Design and Demand for Health and Disability Benefits Today

This chapter considers how current health and disability benefits have been developed and designed overtime. It also sets out evidence, demonstrating current claimant demand. Fig. 37 (in the Appendix) provides a longer history of relevant welfare reforms to the 'Beveridge Report'.

The Personal Independence Payment (PIP)

Figure 6 – Expenditure on the Personal Independence Payment (PIP), 2013/14-2028/29



Source: 'Welfare spending: disability benefits', Office for Budget Responsibility [link]

What is it

- PIP is intended to help with the additional costs caused by a long-term health condition or disability.
- It was introduced by the Coalition Government in 2013 to replace

Disability Living Allowance (DLA).

- It is tax-free, not impacted by household income and is paid whether the claimants are in work or not.

Overview

- As of 31 October 2024, there were 3.6 million claimants entitled to PIP (caseload) in England and Wales.[48]
- PIP replaced Disabled Living Allowance and there are still people migrating to the new benefit.
- Of the individuals who currently apply for PIP, 37% are in employment in the month their PIP case is cleared. Of those awarded PIP, 23% are still in employment after 12 months.[49] Even though PIP is an extra cost benefit, there is clearly a reduction in employment figures after award of the benefit (of roughly a third).
- When people are on PIP, they largely stay on it. About two-thirds of people who start a claim are still on five years later.[50]

Eligibility

- To be eligible to apply for the first time for PIP the individual must be aged between 16 and 64, have a long-term health condition or disability and difficulties with 'daily living' or 'mobility'. There are special rules to expedite claims for people with a terminal illness.

Payment rates

- The payment rates are between £28.70 and £151.40 per week-claimants can be entitled to one or both components. The assessment focuses on how an individual is impacted by their condition, not their disability or health condition itself. (It is a functional, not a medical assessment). The rates are:

Daily Living Component	Mobility Component
Standard £72.65	Standard £28.70
Enhanced £108.55	Enhanced £75.75

Assessments

- There are ten Daily Living Activities that a claimant is judged against in order to ascertain whether they should receive the Daily Living Component. They are: Preparing food, Eating and drinking, managing your treatments, Washing and Bathing, Using the toilet

48. Personal Independence Payment statistics to October 2024, *Department for Work & Pensions*, 17 December 2024, [link]
49. Latest data based on 2021-2022 financial year (England and Wales only), see: [link]
50. Corrected oral evidence: Economic inactivity: welfare and long-term sickness, *House of Lords Economic Affairs Committee*, 29 October 2024, [link]

and managing incontinence, Dressing and Undressing, Talking, Listening and Understanding, Reading, Mixing with Other People, and Managing Money.

- There are two Mobility Activities to determine whether a claimant should receive the Mobility Component: Planning and following a journey and moving around.
- Individuals are assessed through either a face-to-face, Levels of need are determined through descriptors against each activity, which attracts a point score- the greater the help, the higher the score will be. If you get between 8 and 11 points in total, you'll get the daily living component of PIP at the standard rate. If you get at least 12 points in total, you'll get the daily living component at the enhanced rate. If you score between 8 and 11 points for your mobility needs, you get the standard rate of the mobility component. If you score 12 points or more you get the enhanced rate of mobility component.

Table 4 – Example of a Daily Living Activity: Washing and Bathing

Descriptor	Points
Can wash and bathe unaided	0
Needs to use an aid or appliance to be able to wash or bathe	2
Needs supervision or prompting to be able to wash or bathe	2
Needs assistance to be able to wash either their hair or body below the waist.	2
Needs assistance to be able to get in or out of a bath or shower.	3
Needs assistance to be able to wash their body between the shoulders and waist.	4
Cannot wash and bathe at all and needs another person to wash their entire body.	8

Table 5 – Example of a Mobility Activity- Moving Around

Descriptor	Points
Can stand and then move more than 200 metres, either aided or unaided	**0**
Can stand and then move more than 50 metres but no more than 200 metres, either aided or unaided.	**4**
Can stand and then move unaided more than 20 metres but no more than 50 metres	**8**
Can stand and then move using an aid or appliance more than 20 metres but no more than 50 metres	**10**

Can stand and then move more than 1 metre but no more than 20 metres, either aided or unaided.	**12**
cannot, either aided or unaided – (i) stand; or (ii) move more than 1 metre. 12 points	**12**

A Brief History of (and Rationale for) PIP

Two separate rationales ran through the Government's argument in support of a new disability benefit. One argument was the cost-saving argument articulated by George Osborne on June 22nd, 2010, during his Budget speech:

> *"It is right that people who are disabled are helped to lead a life of dignity. We will continue to support them, and we will not reduce the rate at which this benefit is paid. But three times as many people claim it today than when it was introduced eighteen years ago. And the costs have quadrupled in real terms to over £11 billion, making it one of the largest items of government spending. We will introduce a medical assessment for Disability Living Allowance from 2013, which will be applied to new and existing claimants. This will be a simpler process than the complex forms they have to fill out at present. That way we can continue to afford paying this important benefit to those with the greatest needs, while significantly improving incentives to work for others."*[51]

Expenditure on the Disability Living Allowance (DLA) immediately outpaced initial forecasts after its introduction in 1992 and grew by more than 200% in real terms up to 2009. DLA Benefit Gateway was not robust, based largely on claimants self-reporting combined with a lack of regular review. Only 50% of awards were corroborated by medical evidence at all and 70% of recipients have been given a lifetime award, without any regular review.[52] An ONS fraud and error review found that in 2004/2005 around £730m was overpaid on DLA (9.1% of expenditure).[53]

That cost-saving argument ran alongside the premise that Personal Independence Payment (PIP) would create a better experience for disabled people, as articulated in the December 2010 Consultation. PIP would be a "new, fairer, objective assessment, which will allow us (the Government) to identify those who face the greatest need, in a more consistent and transparent manner."[54] The Consultation stressed that the Government remained "steadfast in our support for the principles of DLA, as a non-means-tested cash benefit contributing to the extra costs incurred by disabled people" meaning that the Government's only option, in reality, was to reform the design of the benefit.

Recognising this reality, PIP was designed to be easier to alter than its predecessor, the DLA. Many essential entitlement conditions were contained in the primary legislation of DLA, while PIP used regulations. The intention was that PIP would be a more sustainable, flexible and dynamic benefit, prioritising those who needed the most support.

The design of PIP was carried out in parallel with the legislation going

51. Emergency budget: George Osborne's speech in full, published in *The Guardian*, 22 June 2010 [link]
52. Personal Independence Payment rolls out to existing claimants, 28 October 2013 [link]
53. L. Clark, 'Disability living allowance overpayment hits £730 million', *Community Care*, 14 July 2025, [link]
54. Government's response to the consultation on Disability Living Allowance reform (April 2011), Department for Work and Pensions [link]

through Parliament. PIP was legislated for (alongside Universal Credit) in the Welfare Reform Act 2012. The Bill legislated for the main structural elements of the PIP (the Mobility and Daily Living elements of the benefit). Several concessions were made to the legislation to gain passage through the House of Lords, including the obligations for independent reviews into PIP (that were carried out by Paul Grey), and there were changes to the qualifying criteria to emphasise that activities (e.g. 'preparing food' or 'taking nutrition' needed to be conducted "safely, reliably, repeatedly and in a reasonable time period". At the time, these concessions were not seen as having a significant impact on the savings forecast of the benefits but some of the changes to the wording of the legislation in the House of Lords would later lead to some of the legal challenges that have been seen with the benefit.

The design of the benefit was conducted very quickly, primarily by an Assessment Development Group, which comprised mostly of healthcare professionals and select individuals from disability organisations. This group was formulated in the summer of 2010 and the PIP program was itself established at the beginning of 2011. Resource constraints impeded the programme. It had to contend with the Spending Review settlement (resulting in a competition for resources and talent with Universal Credit and a somewhat revolving door of senior staff changes. The delivery timetable also meant that there was no real opportunity for a test-and-learn approach to the rollout of PIP, and the predominant concerns revolved around the DWP being able to deliver the new benefit rather than the assumptions underlying PIP.

The decision to 'outsource' the assessment process was realistically the only viable option for DWP. The Department did not have the capacity to deliver the PIP assessment, and there were numerous other strains on the department's resources, especially delivering Universal Credit. The Department also felt that they had experience in the commercial market, given the ESA contract and coupled with this, there was a sense that outsourcing the contract would give credence to the fact that these were independent medical assessments. PIP was rolled out in a controlled area of Bootle in April 2013.[55] There were immediate challenges with the recruitment of healthcare professionals and coupled (predominately) with some false assumptions about the time and cost of administering the assessment. These early delivery challenges led to a significant backlog, and the reassessment process was delayed in October 2013. Given the very tight timelines, the Department was unable to use the controlled start to understand whether the delivery process was functioning properly and delivering the outcomes that were expected. The Department took assumptions derived from ESA and did not allow for a learning curve to reassess the system. The department, in many respects, did not allow for the vagaries of human behaviour to impact their perceived notions of delivery.

There was an assumption that PIP would result in a 20% reduction in comparison to DLA and a 20% reduction in case volumes. This modelling

55. Personal Independence Payment: Outline evaluation proposals [link]

and forecasting were based on 900 existing DLA who volunteered to transfer onto PIP. To base a multi-year saving figure on such a small modelling sample is fraught with error, and the difference could have been foreseen given the limitations of the sample. While it appears that there were some concerns about the limitations of the methodology, they seemed to have been somewhat overlooked and only have become very clear in retrospect. Secondly, relying on a single study places a significant emphasis on it being robust.

This potted history of PIP reveals that policymakers today are grappling with the same challenges that existed two decades ago. We are entering Groundhog Day. If – as reported – the Treasury wants to generate (scorable and guaranteed) savings from PIP, they need to feel comfortable with setting boundary changes to PIP (means-testing, thresholds, eligibility). These will be crude and difficult to justify cutting across the Secretary of State's argument that her "starting point is not about how we cut individual amounts or cut the benefits bill as a whole. My objective is to get more people into work - that's my focus".[56] Fundamentally the history of PIP benefit offers a timely warning to the Government that relying on a robust saving number from disability benefit reform is a foolhardy endeavour.

Overview of Current Use

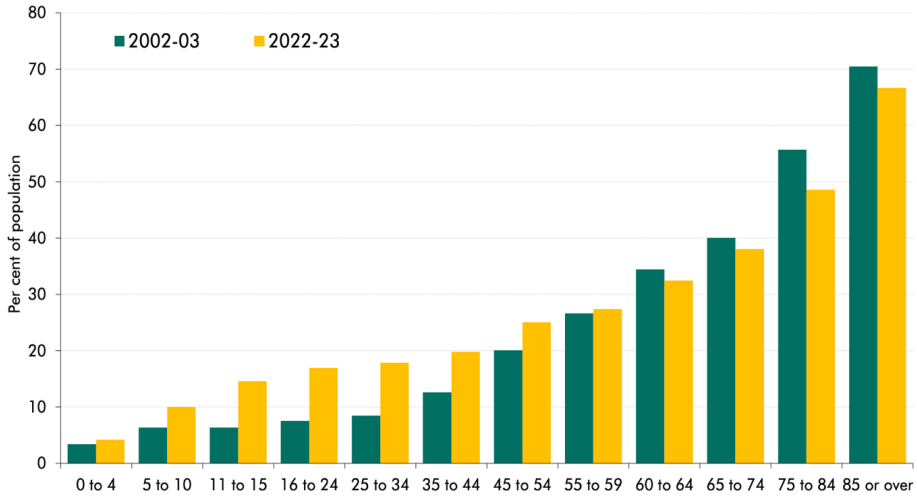
There have been significant changes to the geography and demography of welfare recipients overall in recent decades. In the mid 1990s, "a quarter of all men between fifty-five and sixty-four were receiving incapacity benefits". Claimants of incapacity benefit rose 103.4% from 1995 to 2014 (from 571,600 to 1,136,360), with the growth even steeper in recent years.[57]

Fig. 7 below shows significant changes in the self-reporting of disability over time (although the rate of growth depicted below does not necessarily correspond directly to the growth in welfare claimants). It reveals that whilst the proportion of individuals over the age of 60 reporting a disability has reduced since 2002-3, there is an inversion with a far greater proportion of the population below the age of 60 now self-reporting a disability.

56. Comments cited here [link]

57. M. van Gerven, T. Malava, P. Saikku & M. Mesiäislehto, (2024). Towards a new era in the governance of integrated activation: A systematic review of the literature on the governance of welfare benefits and employment-related services in Europe (2010–21). Social Policy & Administration, 58(3), 329–343 [link]

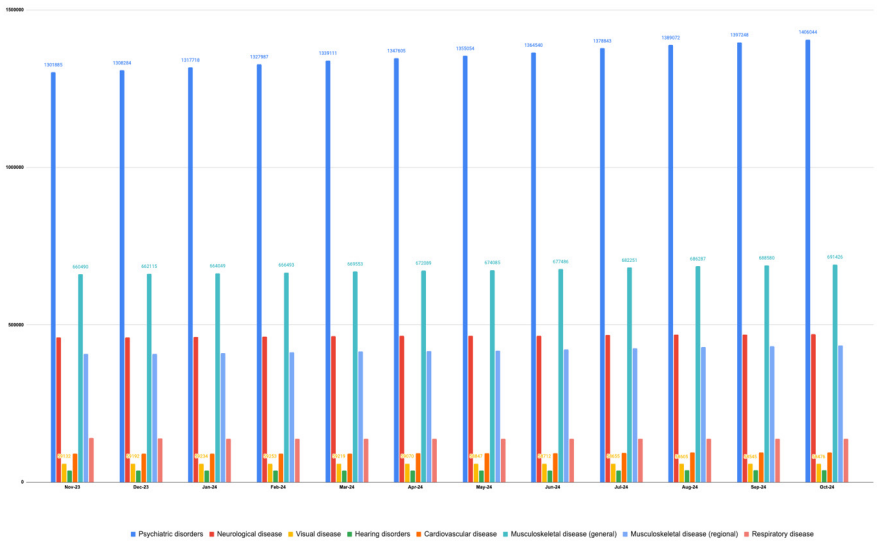
Figure 7 – Self-reported disability prevalence by age



Source: 'Fiscal risks and sustainability - September 2024', Office for Budget Responsibility [link], (p. 58)

The overall number of PIP cases with entitlement has grown considerably in recent years, driven by a growth in individuals whose primary condition is a psychiatric disorder. Psychiatric disorder(s) encompass: anxiety, panic attacks, post-traumatic stress disorder (PTSD), depression, bipolar disease, eating disorders, obsessive compulsive disorder (OCD), or addictions (including drug or alcohol misuse).[58] See Figs. 8 and 9 below.

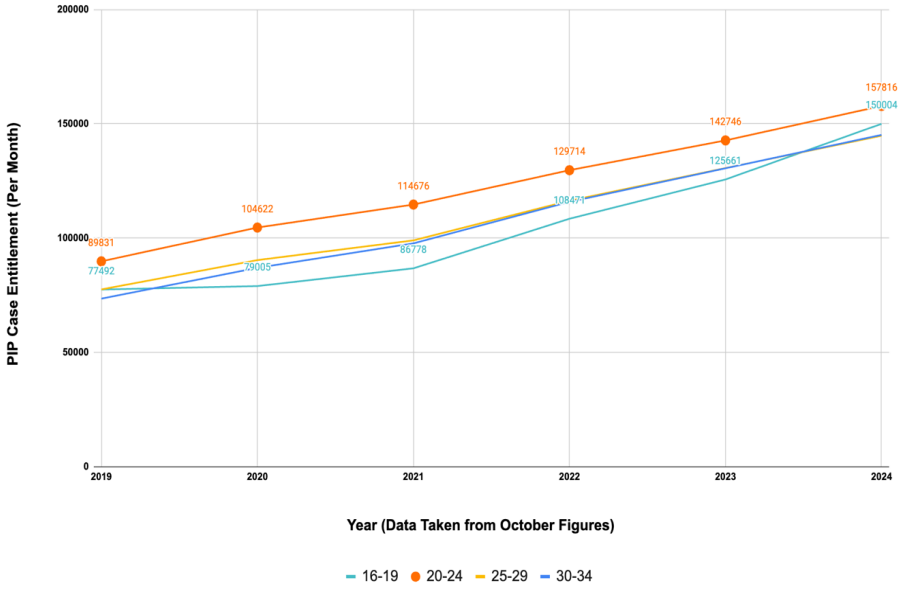
Figure 8 – Total PIP Cases with Entitlement, November 2023-October 2024



Source: Policy Exchange analysis of DWP Stat-Xplore [link]

58. K. Livesey, Personal Independence Payment (PIP): Top 5 conditions that make you eligible, *Homecare*, 10 February 2025 [link]

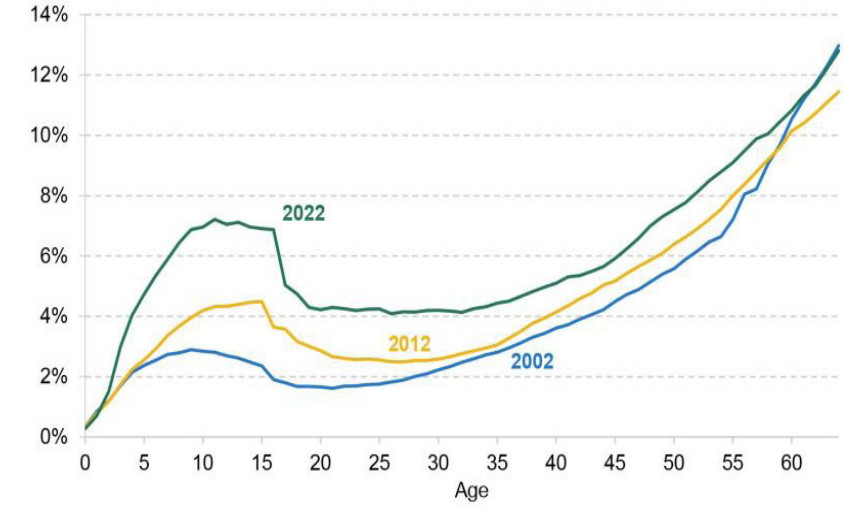
Figure 9 – PIP Case Entitlement for claimants with psychiatric disorder as primary disability (data taken from October figures in given year), 16-34 year olds



Source: Policy Exchange analysis of DWP Stat-Xplore [link]

New awards made to under-40s has grown by 150% (from 4,500 a month in 2019–20 to 11,500 in 2023–24); growth for 40- to 64-year-olds was 'only' 82% (11,000 a month to 20,000 a month).[59]

Figure 10 – Share of individuals claiming disability benefits by age (ages 0–64), Great Britain

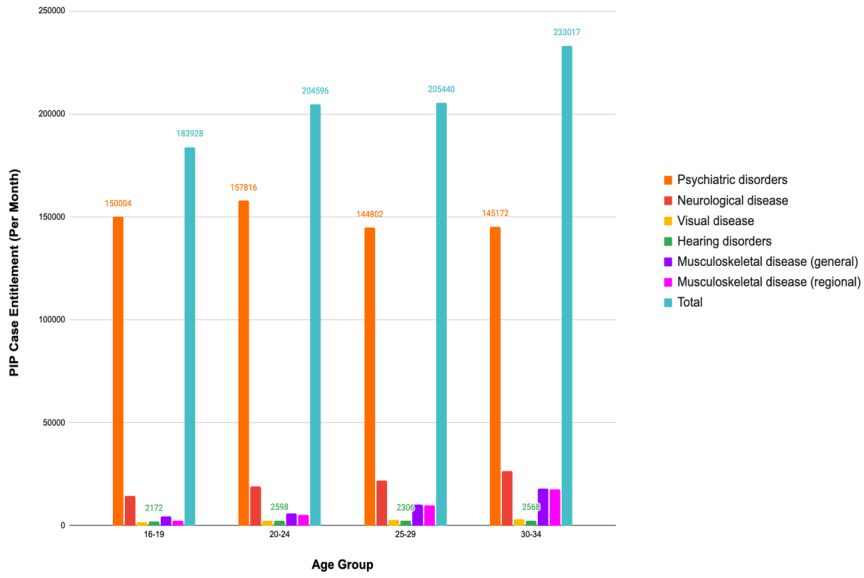


Source: A.Bancalari & B. Zaranko, 'IFS Green Budget 2024: Adult social care in England: what next?', Institute for Fiscal Studies, 10 October 2024 [link]

59. E. Latimer, F. Pflanz & T. Waters, 'Health-related benefit claims have risen substantially across every part of England and Wales – but there is little evidence of similar trends in other countries', Institute for Fiscal Studies, 19 September 2024, [link]

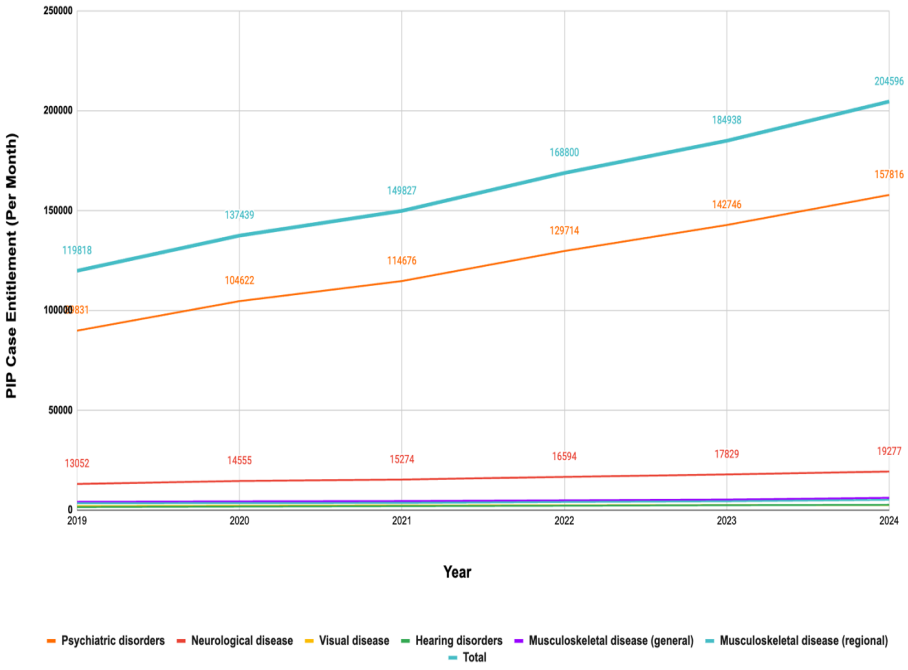
The growth in claims has been particularly notable amongst those between the ages of 16 and 35. Fig. 11 below shows PIP cases with entitlement in October 2024.

Figure 11 – PIP Cases with Entitlement, October 2024



Source: Policy Exchange analysis of DWP Stat-Xplore [link]

Figure 12 – PIP Entitlement for 20–24-year-olds cohort by primary disability (data taken from October figures in given year)



Source: Policy Exchange analysis of DWP Stat-Xplore [link]

Devolving Disability Benefit: A Brief Overview of Recent Changes in Scotland

Disability benefits were devolved to the Scottish Government in 2022–23 who replaced PIP with the Adult Disability Payment (ADP).[60]

After being piloted from March 2022, ADP was launched across the whole of Scotland from August 2022. The ADP has the same eligibility criteria (and the same rates) as PIP but has been designed to create a smoother claimant experience (i.e. easier to apply for and to renew). ADP applications can be made online or face-to-face and staff administering the benefit collect supporting information 'where necessary', rather than requiring applicants to supply medical evidence or evidence from social worker(s).

As the Institute for Fiscal Studies have shown, as of July 2024, the cumulative increase in ADP applications in Scotland – 'relative to pre-pandemic norms' – was 32%, compared with 30% in England and Wales.[61] New applications to the ADP were 41% higher in the three months to May 2023 than in the three months to May 2022.[62] There has meanwhile been a difference in approval rates for the benefit. Pre-pandemic, this stood at 43% in Scotland and 40% in England and Wales. Following the roll-out of the ADP, approval rates in Scotland rose to 58% (whilst it remained at 45% in England and Wales.[63] Part of this significant increase in the approval rate may relate to a significant cohort of claimants waiting to move onto ADP (having previously been on PIP), but it is important to enquire as to whether the design of the benefit itself and the incentives it has created also has an impact upon the success rate of claimants.

An independent review following the first year of introduction of the ADP is currently being undertaken.[64]

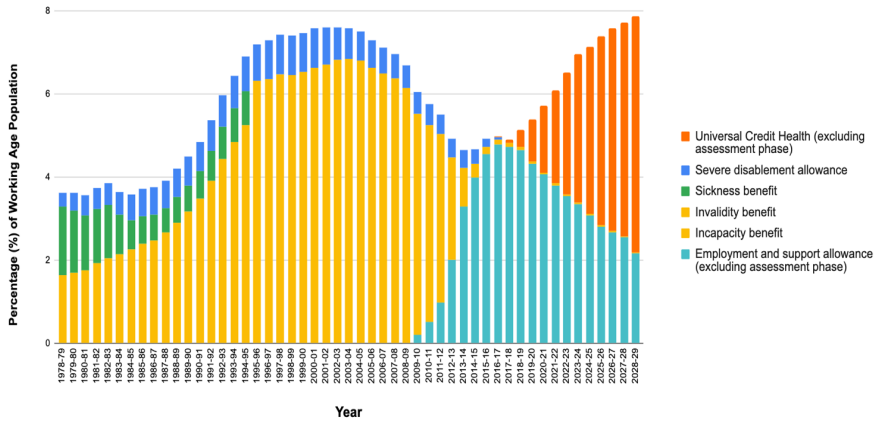
Universal Credit (UC) / Employment and Support Allowance (ESA) Employment Support Group

> *"Gone are the days when writing a sick note is writing people off for life. ESA will give more financial support to the poorest, most disabled people in society while extending the opportunity of employment to all those who can work. Today's measures are a key cultural shift in the benefit system which puts work at the heart of our support."*[65]
>
> **James Purnell MP**, former Secretary of State for Work and Pensions (March 2008)

> *"People claiming Health and Disability benefits have been classed by the system as "can't work" and shut out of jobs and have been ignored – when they've been crying out for support"*[66]
>
> **Rt Hon Liz Kendall MP**, Secretary of State for Work and Pensions (February 2025)

60. What the Adult Disability Payment is, *MyGov.Scot*, 16 October 2025, [link]
61. S. Ray-Chaudhuri & T. Waters, 'What has happened to disability benefits in Scotland? An update', *Institute for Fiscal Studies*, 8 November 2024, [link]
62. E. Latimer, F. Pflanz & T. Waters, 'Health-related benefit claims post-pandemic: UK trends and global context', *Institute for Fiscal Studies*, 19 September 2024, [link]
63. S. Ray-Chaudhuri & T. Waters, 'What has happened to disability benefits in Scotland? An update', Institute for Fiscal Studies, 8 November 2024, [link]
64. Independent Review of Adult Disability Payment (ADP): call for evidence and consultation analysis, Cabinet Secretary for Social Justice, *Scottish Government*, 29 November 2024,[link]
65. E. Parkin, 'Employment and Support Allowance: An introduction', Briefing Paper, *House of Commons*, 18 September 2015, [link]
66. New survey suggests benefits system is letting down people with mental health conditions who want to work, *Department for Work & Pensions*, 6 February 2025, [link]

Figure 13 – Caseload prevalence (%) of the working age population, incapacity benefits, 1978/9-2028/9 (forecast)



Source: 'Welfare spending: disability benefits', Office for Budget Responsibility [link]

What is it?

Universal Credit (UC) replaced six existing means-tested benefits when it was introduced in 2013. One of the benefits it replaced was the Income-related Employment and Support Allowance (IR-ESA). DWP stopped taking new applications for IR-ESA in December 2018. The rationale for IR-ESA and its UC replacement is to support disabled people and people with health conditions on low incomes who have a disability or health condition that affects how much they can work.

Eligibility:

The Work Capability Assessment (WCA) is used to decide whether or not you are fit for work for ESA and Universal Credit.

Following a Work Capacity Assessment, a claimant is placed into one of three groups:

- **Fit for Work.** The assessment does not find them eligible for disability/health specific support. They can still receive UC, but get the same money as if they had no health condition; have to look for work (and if they don't their benefit can be sanctioned); and receive a full offer of employment support.
- **Limited Capacity for Work (LCW).** This is known as the Work-Related Activity Group in ESA. Individuals in this group do not receive additional financial support (The Government made this change in April 2017). They cannot be required to look for work. But they can be required to prepare for work. In practice, they get less Jobcentre Plus (JCP) support.
- **Limited Capacity for Work and Work-Related Activity (LCWRA).** This is known as the Support Group in ESA. People

who are found to have LCWRA are awarded an extra £416.19 per month. They do not have to undertake any work-related requirements in return for receiving the benefit and there is no dedicated JCP support for them.

Assessments:

The Work Capacity Assessment is similar to a PIP assessment as it is a functional assessment, not a medical assessment. There are two categories, which the assessor will talk through with the claimant, covering 10 physical and 7 mental, cognitive and intellectual tasks. Under each category, there are a range of descriptors, which are used to assess functionality. They range in the physical category from standing and sitting to understanding communications, and in the mental, cognitive and intellectual category, from awareness of hazards to getting about. If a claimant cannot fulfil any task they can score points, depending on the extent of the limitation. If a claimant scores 15 or more points, they will not be found fit for work

The financial structure of this is flawed. It has created a significant financial cliff edge (worsened by the removal of the Limited Capacity for Work Group) – people are incentivised to show that they cannot work. And then once in the group, they are worried about taking on work, fearing they would lose the top-up and be worse off. Evidence shows that each month, between 1-2% of those deemed by DWP as being unable to carry out work or work-related activity move off ESA or UC.

Research published by DWP in the last month shows that over one-third of those that claim Health and Disability Benefits have a desire to work, either now or in the future. It reveals that 5% of claimants say they could work immediately if they were given the right support.[67] Yet, the WCA is incentivising an opposing behaviour. Labour has over recent weeks, mooted scraping the WCA (something both the Conservatives and Labour agree on) and ensuring that everyone on incapacity benefits has a 'duty to engage'. The logic behind is threefold. It drives better employment outcomes and possibly generating economic growth, it would reduce the number of assessments (reducing DEL spending) and one could construct a value for money argument around the reform.

67. Ibid.

A Brief History of (and Rationale for) the move from Incapacity Benefit to ESA

Table 6 – The main features of incapacity benefits over the past half century

Benefit	Contributory/ means-tested	Assessment regime	Assessment outcomes	Awards	Conditionality
Invalidity benefit (1971-1995)	Contributory	GP assessment (focused on the ability to carry out only "suitable work")	Two outcomes: either deemed eligible or not	Awards were higher for younger groups. Additions were paid for adult dependants and an earnings-related element was introduced from 1985. Benefit was only paid after 28 weeks, when sickness benefit/ statutory sick pay terminated	No conditionality
Incapacity benefit (1995-2008)	Contributory, but became partially means-tested over time	All work test (expanded to focus on ability to do any job), replaced by the personal capability assessment in 2000 (tighter eligibility criteria and an assessment of capabilities despite medical condition)	Two outcomes: either deemed eligible or not	Generosity decreased relative to IVB via the removal of the earnings-related element, less generous age-related additions and the introduction of lower award rates for durations below 52 weeks	No conditionality
Employment and support allowance (2008- present)	Contributory and means-tested elements	Work capability assessment (a greater focus still on capability for work rather than benefit entitlement)	Three outcomes: fit for work; plus two different groups tiered according to the severity of health conditions and their effects on ability to work (less severe incapacity: work-related activity group; more severe incapacity: support group)	Age-related and adult dependency additions were abolished. Awards based on assessment outcome, with higher payments for the more severe incapacity group, and the generosity of the less severe incapacity group reduced (to be equal to unemployment-related benefits) in 2017	Some conditionality (work-focused interviews) for the less severe incapacity group
Universal credit (2016- present)	Means-tested	Work capability assessment (as in ESA)	As in ESA (although groups go under different names; less severe incapacity: limited capability for work; more severe incapacity: limited capability for work and work-related activity)	As in ESA, although disability premiums were restructured and UC awards are typically lower for those who received the severe disability premium on ESA	As in ESA

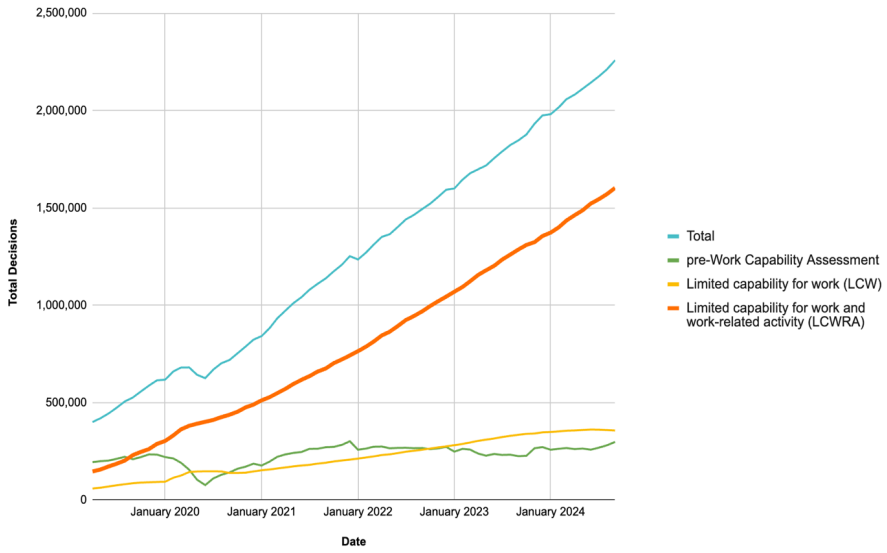
Source: 'Welfare trends report – October 2024: charts and tables', Office for Budget Responsibility [link]

Overview of Current Use

The incapacity benefits caseload grew by 35% from 2018 to 2023. (Recently-published DWP figures of adjusted caseload shows growth owing to differences between Universal Credit and the legacy system, the changing state pension age, and population aging).[68]

The approval rate for individuals to be placed into the Limited capacity for work and work-related activity (LCWRA) has grown steeply in recent years. As Fig. 14 below shows (in orange), there has been a remarkable growth in those placed into the UC Limited capacity for work and work-related activity group (LCWRA) since 2020.

Figure 14 – UC Work Capability Assessment, April 2019 to September 2024



Source: Universal Credit Work Capability Assessment statistics, April 2019 to September 2024, Gov.uk [link]

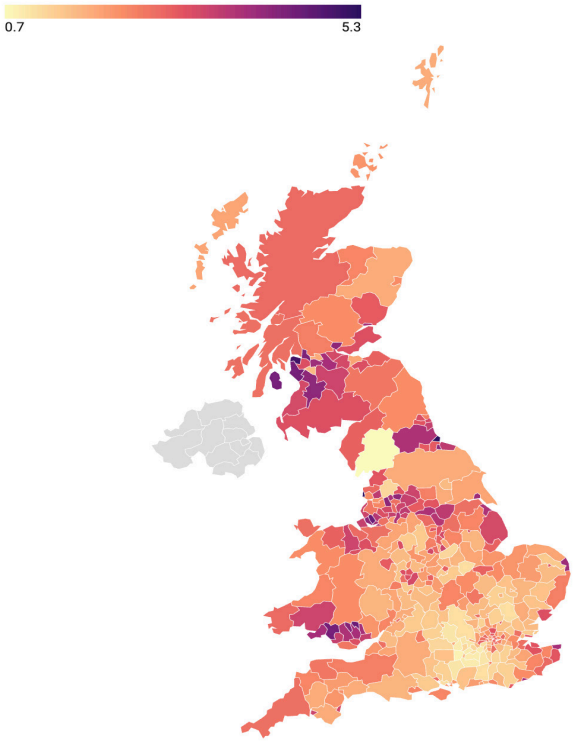
The increase in both claims (and approvals) for incapacity benefit occurred in every local authority in England and Wales (apart from the City of London) – and the official forecast is for further growth by 2028. But there are clear regional differences**:** Merthyr Tydfil and Blackpool, around 15% of 16- to 64-year-olds were in receipt of a health-related benefit before the pandemic. Now that figure is around 19%.[69]

There are notable differences in the total proportion of individuals in the LCWRA group across the country. See Fig. 15 below, a heatmap depicting the proportion of individuals within a local authority who have been placed into the UC Health group LCWRA.

68. Decomposition of growth in the number of claimants of Universal Credit with Limited Capability for Work and Work-Related Activity, or in the Employment and Support Allowance Support Group, *Department for Work & Pensions*, 29 January 2025, [link]

69. E. Latimer, F. Pflanz & T. Waters, 'Health-related benefit claims post-pandemic: UK trends and global context', *Institute for Fiscal Studies*, 19 September 2024, [link]

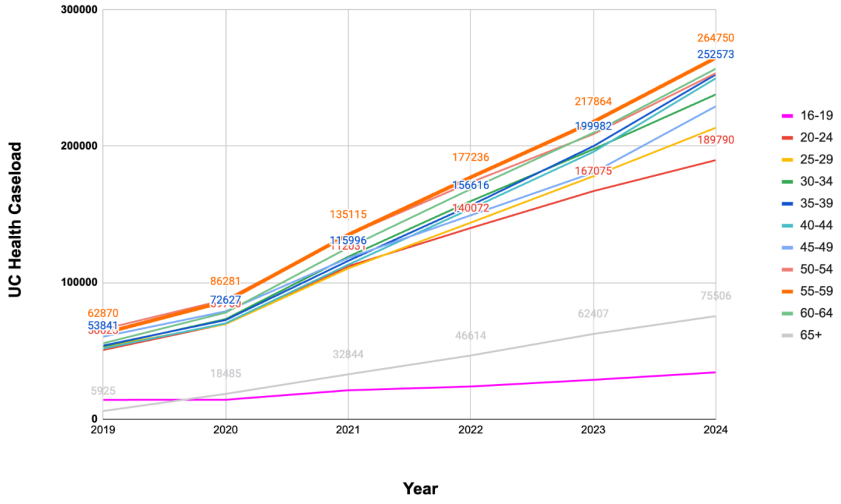
Figure 15 – % of Local Authority (Total Population) in UC LCWRA Group



Source: Policy Exchange Analysis of DWP, Stat-Xplore [link]

Since 2019, the UC Health caseload has grown for every single cohort of working age. In Fig. 16 below this growth is demonstrated with the caseload figures for 55–59-year-olds (orange), 35-29 (dark blue) and 20–24-year-olds (red) highlighted.

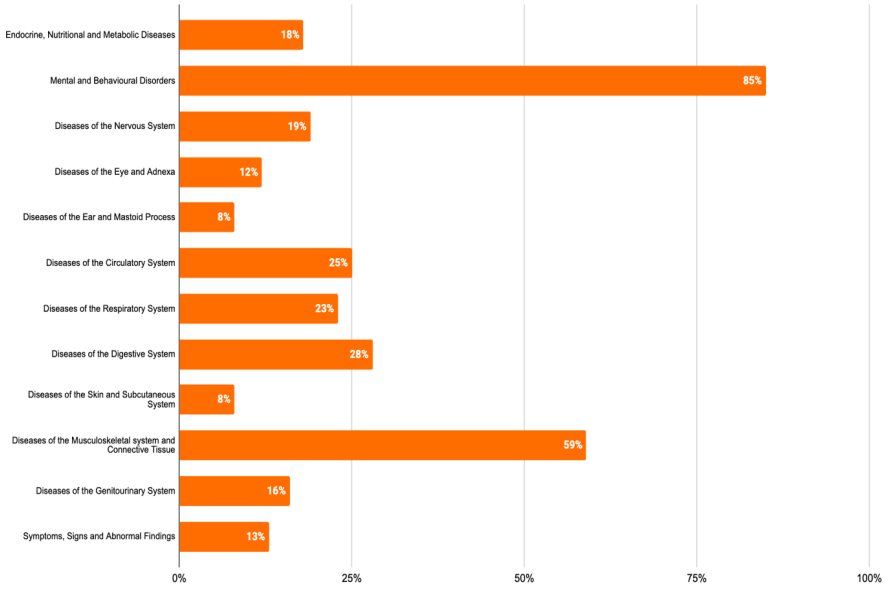
Figure 16 – UC Health Caseload, 2019-2024 (data provided September of each year), by age cohort



Source: Policy Exchange analysis of DWP Stat-Xplore [link]

Claimants are recorded as having 2.7 health conditions on average, demonstrating a growth in multiple conditions in recent years.[70] Of all the Work Capability Assessments (WCAs) conducted over the last two years, 85% of cases cite "mental and behavioural disorders" as one of the factors determining incapacity (see Fig. 17, below). Musculoskeletal conditions, such as back or joint pain was cited in 59% of claims.

Figure 17 – Proportion of Work Capability Assessments Where Condition Recorded

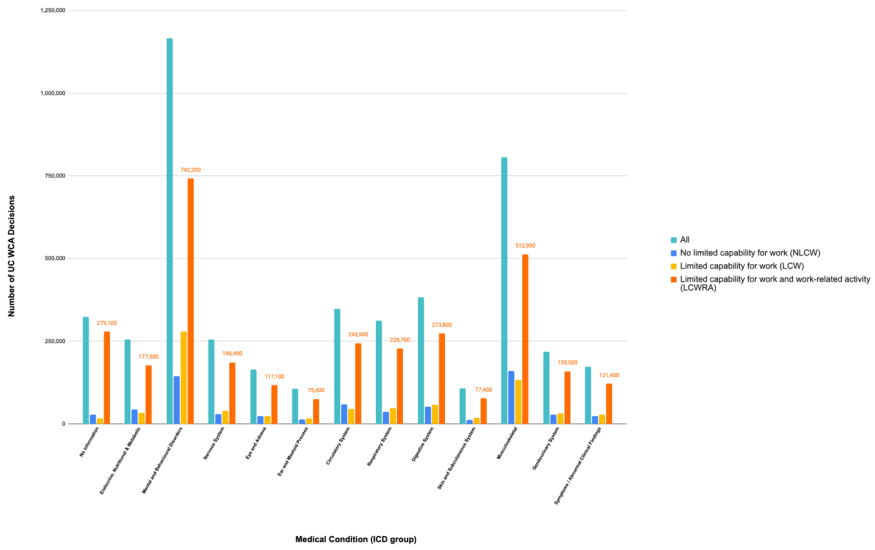


Source: Universal Credit Work Capability Assessment statistics, April 2019 to September 2024, Gov.uk [link]

70. 'Health Foundation responds to new DWP data on health conditions for Universal Credit claimants', *The Health Foundation*, 14 March 2024, [link]

Moreover, there is a substantial caseload of individuals (742,200) placed in the LCWRA group whose primary condition is a mental or behavioural disorder (see Fig. 18, below).

Figure 18 – UC Work Capability Assessment, April 2019 to September 2024, by Medical Condition (ICD Group)



Source: Universal Credit Work Capability Assessment statistics, April 2019 to September 2024, Gov.uk [link]

Access to Work (AtW)

Access to Work (AtW) is a scheme which was first introduced in 1994 to support individuals with a disability or long-term health condition to enter or remain in work. The programme offers practical and financial support, with recipients able to receive grants of up to £69,260 a year to pay for a range of support, which includes (but is not limited to) communication support for interviews, support workers or counselling. Individuals aged 16+ can apply for AtW up to six weeks before their work begins with a written job offer and they can claim online, over the phone or by post.[71]

A formal diagnosis of a condition is not required in order for an individual to apply for AtW.[72] In addition, individuals can claim AtW alongside the Employment Support Allowance (ESA) simultaneously if the individual works less than 16 hours a week. Those claiming PIP or DLA can also claim AtW.[73]

71. Access to Work: get support if you have a disability or health condition, Gov.UK, [link]
72. Paid Work includes self-employment, an apprenticeship, work trial, work experience or internships.
73. K. Ashworth & S. Salis, Feasibility of evaluating the impact of the Access to Work programme, Department for Work & Pensions, November 2018, [link]

Table 7 – Proportion of individuals who received a payment for an Access to Work element within each financial year, by employment status

Employment Status	2021/22	2022/23	2023/24
Employed	78%	78%	76%
Self-employed	9%	10%	12%
Unemployed	13%	12%	12%

Source: Access to Work Programme - Question for Department for Work and Pensions, UIN HL4833 [link]

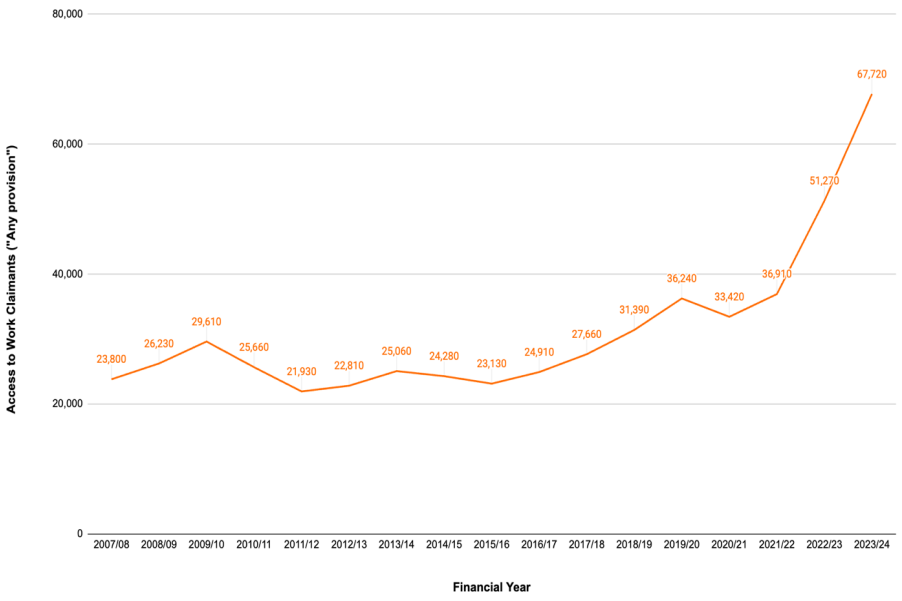
Note(s): Figures for 2024/25 are not yet available as the financial year is incomplete. Figures exclude Pre-Employment (Scotland), Engage to Change (Wales), Supported Internships (England), and Traineeships (England) and customers with missing employment status records.

AtW is often referred to by disabled people as DWP's best-kept secret. Indeed, core evaluations of the scheme have in the past identified limited knowledge of the scheme amongst individuals working in JobCentres or amongst claimants of other health and disability benefits.[74] As a recent analysis in *The Economist* has put it, "To supporters, it is world-leading and a rare example of something that is right with the benefits system". Its current workings however mean that it also "may embody everything that is wrong with it".[75]

Demand for AtW has grown considerably since 2020 – with a 72% growth in successful claimants between 2022 and 2024. (See Fig. 19, below). In October 2024, the backlog for applications stood at 55,000 – a figure higher than the entirety of those who received support in 2022/23.[76] Waiting times are currently – as the Disability Business Forum have reflected – "so long to the point of being counterproductive", with instances emerging where it becomes "'unreasonable' to keep a disabled person employed with the support for the employer to fund the adjustments that person needs".[77]

74. Ibid.
75. 'A much-praised British scheme to help disabled workers is failing them', *The Economist*, 9 January 2025, [link]
76. Ibid.
77. Written evidence from the Business Disability Forum, DYE0044, [link]

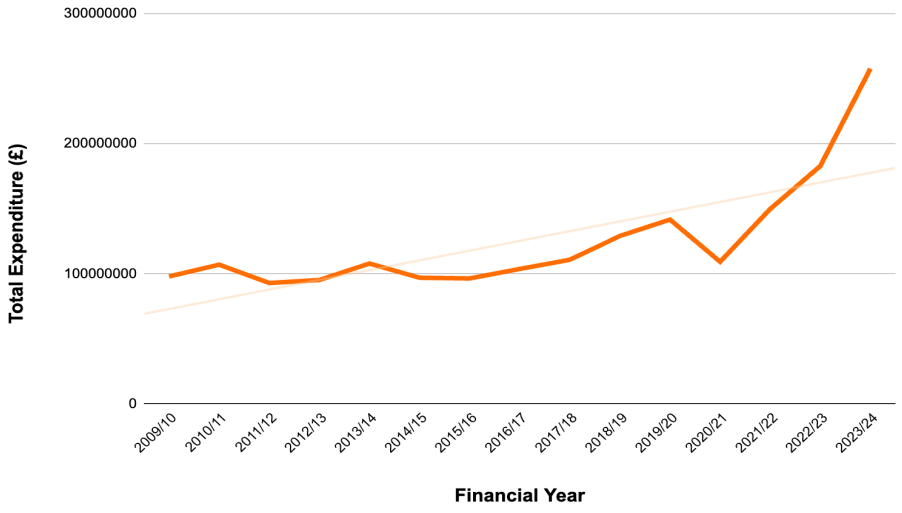
Figure 19 – The number of people who had any Access to Work provision of each type approved, 2007/8-2023/24



Source: Access to Work statistics: April 2007 to March 2024 [link]

The current overall expenditure of £258m on AtW (see Fig. 20) is a small fraction of the overall welfare budget. But there are significant issues with the trajectory and nature of current spend. Spending on AtW had not been foreseeable, with growth in real terms proven steady before 2020.

Figure 20 – Expenditure on Access to Work provision in Nominal Terms, 2009/10-2023/24



Source: Access to Work statistics: April 2007 to March 2024 [link]

But expenditure has grown considerably since with The Rt Hon Sir Stephen Timms MP, Minister of State at the DWP reflecting that the "current style of AtW is likely to be unsustainable in the long term due to high demand."[78] But this is a headache for the DWP in the near-term because the scheme is funded through Departmental Expenditure Limit (DEL) spending – a set amount of money allocated to Departments by the Treasury at the Spending Review. At the 2021 Spending Review (where DEL budgets were set three years up until 2024/2025), baseline funding for AtW was set at £140m.

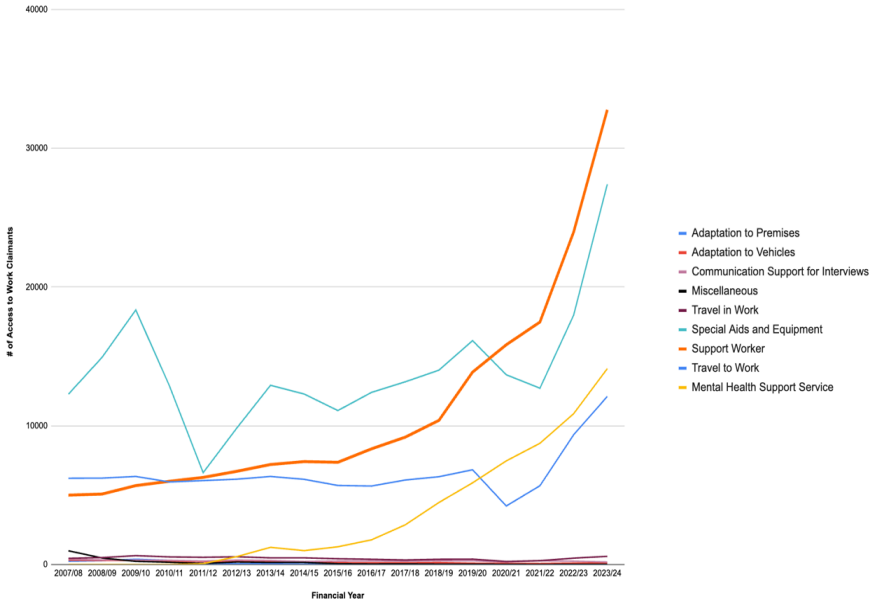
However, spend on AtW has in fact risen by 230% compared to the expected 2024/2025 allocation, with forecast expenditure on AtW grants for 2024-25 currently £290m, double the forecast expenditure and representing a shortfall of £150m.[79] This shortfall must be met by the DWP, meaning ministers and officials will be under considerable pressure to stabilise spending or to reform the program significantly. Reform to AtW would take some time, requiring a formal public consultation and because the award length is on average three years for recipients.

This significant growth is attributable to sizeable increases in expenditure on 'Support Workers' (see Fig. 21 below). There is currently a debate around whether the quality of Support Worker(s) are of a consistently high standard – and indeed whether they in fact represent value for money in every case. To counteract the direction of travel, the DWP have recently reduced the hourly costs of coaching that can be reimbursed under the scheme from £450 to £205, and restricted sessions offered to claimants.[80]

Demand for AtW has meanwhile been driven by claims from those citing their primary condition to be a mental health condition (See Fig. 23). Similarly with other health and disability benefits, there are issues with how conditions are recorded, meaning we have a more limited picture of the types of conditions which are driving demand.

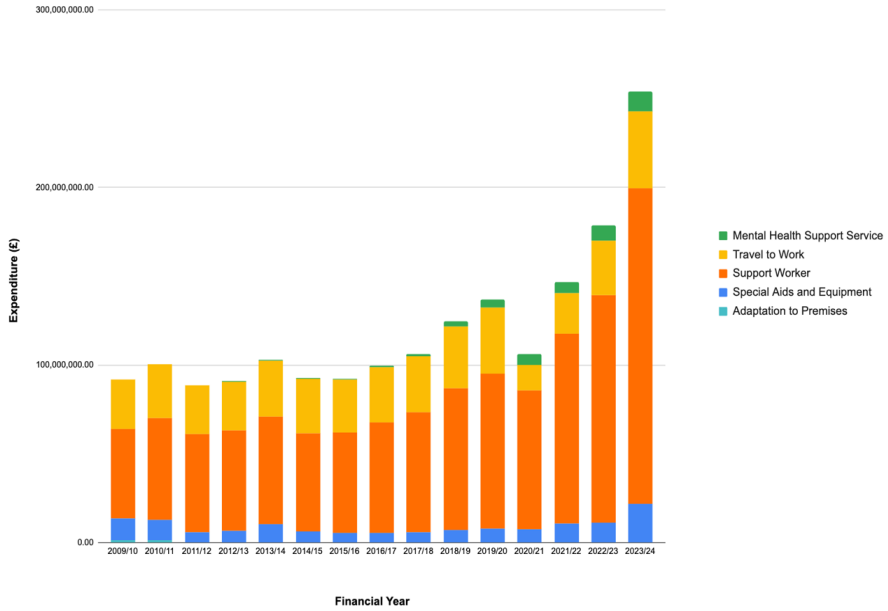
78. 'DWP admits 'Access to Work' support is failing Disabled people', *Disability Rights UK*, [link].
79. Question for Department for Work and Pensions, UIN HL4832, 7 February 2025 [link]
80. These are sign-language interpreter, lip-speaker, note-taker, palantypist, personal reader, travel-buddy, counsellor, The Mental Health Support Service, driver, job coach, carer, job aide.

Figure 21 – The number of people who had any Access to Work Elements of each type approved, 2007/8-2024/5



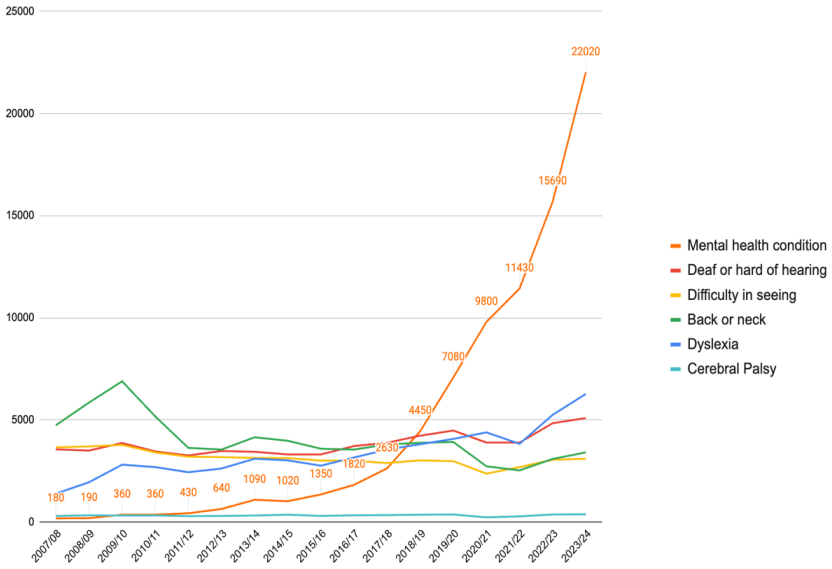
Source: Access to Work statistics: April 2007 to March 2024 [link]

Figure 22 – Expenditure on Access to Work Elements of each type in Nominal Terms, 2008/9-2023/4



Source: Access to Work statistics: April 2007 to March 2024 [link]

Figure 23 – Total Access to Work Recipients Approved by primary medical condition



Source: Access to Work statistics: April 2007 to March 2024 [link]

There are several qualitative case studies that point to the transformative impact that AtW can have on people with disabilities, but it has long been very difficult to assess – quantitively – the impact AtW has had on ensuring disabled people remain in work or obtain work.[81] The Department has been unable to robustly estimate any type of return on investment figure for AtW or make a compelling invest to save argument (The Sayce Review did estimate that for every £1 spent it returned £1.48 but that number appears to have been derived from a report carried over two decades ago in 2004 and it is unclear what methodology was used to formulate such a figure).[82] In any event, it is abundantly clear that DWP have not been able to construct a robust argument about the economic value of the scheme (notwithstanding its social benefit) over recent years.

Taken in sum, when we consider the current demand trajectory, the changing nature of need, coupled with difficulties in evaluating and justifying the overall spend, we must conclude that the scheme is unsustainable in its current form. Whilst the initial aim of AtW was to provide bespoke support for a small cohort with high needs, a rethink is needed to ensure that it delivers effective support and value for money.

There is an argument that the program should be recategorized to qualify as AME spend – a case DWP have long made given that this is a demand-led program with unstable spending that cannot be managed by the DWP because of external factors outside its control. While these arguments are logically sound, the political reality makes the prospect of a DEL-AME switch incredibly remote. The range of spending pressures that the Treasury currently must contend with makes their openness to change the assumption around the spending profile of AtW inconceivable.

81. 'Feasibility of evaluating the impact of the Access to Work programme', *Department for Work & Pensions*, 13 November 2018, [link]
82. 'Getting in, staying in and getting on; Disability employment support fit for the future', *Department for Work & Pensions*, June 2011, [link]

Chapter 2 – An Analysis of Assessments

Today, the DWP uses health assessments to inform decisions on the support it provides to those who cannot work, or who face extra costs, because of a disability or work-limiting health condition.[83] Eligibility for health and disability benefits does not depend on a formal diagnosis of a certain medical condition (although special rules apply to people diagnosed with a terminal illness).

The majority of assessments are conducted on behalf of the DWP by external Assessment Providers (APs) as part of the Health Assessment Advisory Service (HAAS) (which has been in place in its current configuration since September 2024). Currently, some 1.9 million health assessments are conducted each year.[84]

Prior to the introduction of the Work Capability Assessment (WCA) in 2008, General Practitioners (GPs) had a more prominent role in determining eligibility for benefits with medical statements recording the advice which they give to patients regarding their ability to perform their own or usual type of occupation informing whether they were eligible for Statutory Sick Pay (SSP) or a state incapacity benefit such as the then Incapacity Benefit (IB).[85]

Whilst a small number of assessments are conducted directly by the DWP today, the vast majority are undertaken by four APs, who have secured a contract from the DWP to carry out assessments in a particular geographical area, including Work Capability Assessments (WCAs) for UC and ESA, PIP and the Industrial injuries disablement benefit. Assessments for each of these benefits remains separate. In other words, there is no assessment which would determine eligibility for PIP and UC during a single assessment. The idea of assessment for PIP/ESA-UC was considered by The Rt Hon Amber Rudd, when she was Work and Pensions Secretary between 2018-2019, but was not progressed.

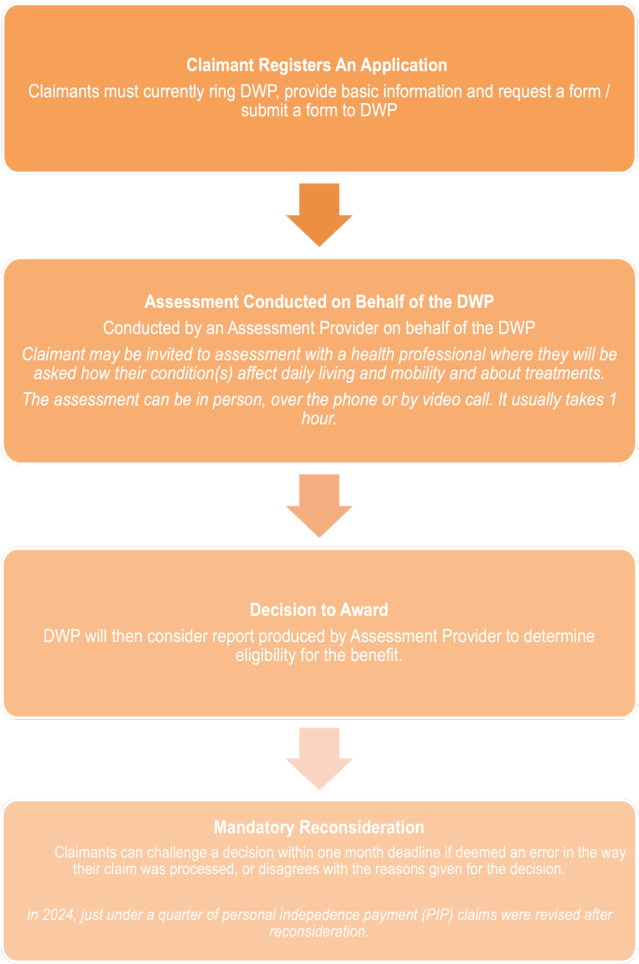
All APs offer face-to-face, video and telephone assessments. Some APs will set their assessors a target number of assessments to complete each working day, with assessments lasting around forty-five minutes to just over an hour.[86] It has been reported that some APs will use financial incentives to maximise the number of cases processed by assessors. *The Times* have reported staff at one provider are set a target of five telephone "work capability assessments" a day and receive £80 for each additional case they complete, meaning a staff member processing a further five assessments would be paid a bonus of £400.[87]

83. 'Health assessments for benefits', *House of Commons Work and Pensions Committee*, 14 April 2023, [link]
84. 'Understanding the impact of different assessment channels on participant experiences of having a health assessment for PIP, ESA or UC', Health Assessment Channels Research, *Department for Work & Pensions*, October 2024, p.16 [link]
85. J. Hiscock & J. Ritchie, The role of GPs in sickness certification , *Department for Work & Pensions*, 2001, [link]
86. 'The Role of a Functional Assessor', *Maximus*, [link]
87. T. Witherow, S. Swinford & C. Smyth, 'Sick-fluencers help followers claim benefits as 15,000 a week approved', *The Times*, 30 November 2024, [link]

These assessments are conducted by Healthcare Professionals (HPs). Eligible professionals who conduct assessments include doctors, nurses, occupational therapists, physiotherapists or pharmacists. The assessments that are conducted are *functional*, rather than *medical* assessments. In other words, "they do not focus on the diagnoses of particular conditions or disabilities, but instead look at the impact these have for a range of activities".[88]

Following an assessment, the HP will compile a report which is then shared with the decision-maker within DWP who will decide whether the claimant is eligible for the benefit – and at what level.

Figure 24 – Flow Diagram, Possible PIP Claimant Journey



For instance, everyone applying for PIP will have an initial fifteen-minute phone call to register their personal details (which can also be done via a form sent in the post). Some people who register an application are never assessed because they do not fill in subsequent forms or attend the assessment. In 2019–20, 72% of those who registered an application reached assessment; this had risen to 86% in 2023–24, accounting for around 10% of the overall increase in inflows.[89] A recent trial has enabled claimants to register online ('Apply for PIP Digital Self-Serve').[90] The trial

88. 'Health assessments for benefits', *House of Commons Work & Pensions Committee*, 14 April 2023, p.13 [link]
89. T. Calver, 'Have people stopped working because benefits are too generous?', *The Times*, 17 November 2024, [link]
90. 'Apply for PIP Digital Self-Serve: Evaluation Summary, Key findings from evaluating the GOV.UK PIP application service', *Department for Work & Pensions*, December 2024, [link]

showed applications for PIP increasing by 22% relative to control areas. Analysis of the figures of the trial published by the DWP by Eduin Latimer at the IFS, found individuals awarded PIP increased by 7%.[91]

Challenges with Current Assessments

For many years there has been a lively debate about the most effective approach to take to determining both fitness for work and eligibility for benefits.

Some of those who object to the current approach object to the *content* of the assessment, reflecting that assessments are "subjective" and "don't create an openness to discussion".

One recently-published article suggests they "are overly medicalised, focused on physical disability, and do not capture claimants' experiences of mental ill-health".[92]

Others focus on the *culture* of assessments. In 2018, the Work and Pensions Committee concluded there were significant challenges, finding that "trust in the system is low, and this will not improve without better transparency."[93] There is a significant literature which highlights poor claimant experience. One academic article suggests PIP assessments are "severely re-traumatising, with a prolonged adverse effect on mental health".[94]

During an evidence session conducted by the Work and Pensions Committee in 2021, the then Minister for Disabled People, Health and Work, Justin Tomlinson MP, told members that the WCA "creates perverse incentives within the system for people to then feel that they cannot seek to engage for employment opportunities for fear of potentially losing additional financial support".[95]

This has led – for instance – for the Cystic Fibrosis Trust to call for an end to repeat assessments for those whose health which is unlikely to improve and for claim and review forms and processes to become more 'claimant-friendly' so that they are clear on what sort of evidence they can provide.[96]

There are, however, a range of issues with the current assessment process which are widely recognised and worthy of summary here:

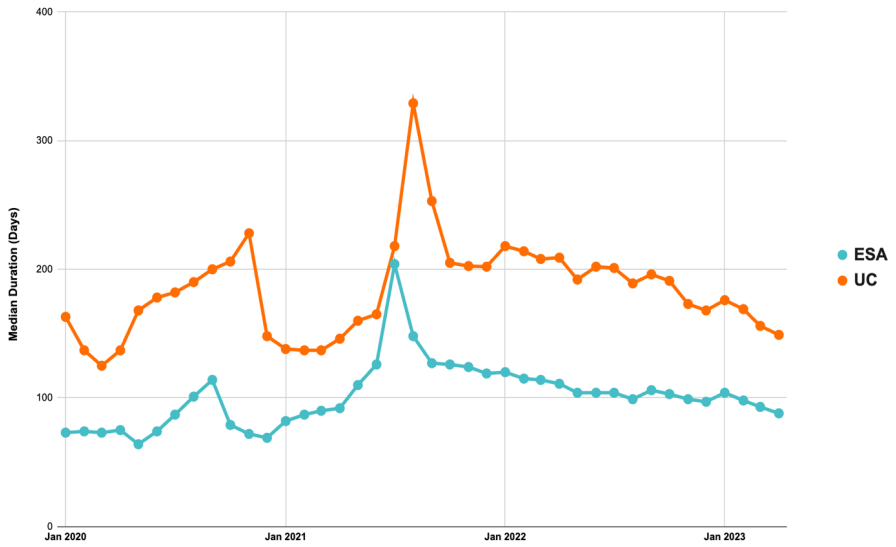
1. There remain long waits for assessment and a substantial backlog of claims.

For instance, PIP has a backlog of over 300,000 new claims waiting to be processed (as well as 450,000 cases awaiting a review decision). The median PIP clearance time is 15 weeks from registration to decision**,** and 22 per cent of new pension-credit claimants wait more than 10 weeks for a decision.[97] Whilst there is a temptation, therefore to improve the speed at which claims are processed, the Government's policy overall has been to ensure "focus…on making the right decision and not the speed of clearance".[98]

Fig. 25 below shows the reduction in process times for incapacity benefit, since a peak in the wake of the pandemic in the Summer of 2021.

91. Eduin Latimer, *X*, 18 December 2024, [link]
92. Pybus, K. et al. (2021) 'Functional assessments in the UK social security system: the experiences of claimants with mental health conditions', Journal of Social Policy, 50(2), pp. 305–320, [link]
93. 'Health assessments for benefits', *House of Commons Work & Pensions Committee*, 14 April 2023, p.7, [link]
94. H. Roberts et al. (2024) '"It's Like the Sword of Damocles" – A Trauma-Informed Framework Analysis of Individuals' Experiences of Assessment for the Personal Independence Payment Benefit in the UK', *Journal of Social Policy*, 53(4), pp. 997–1015, [link]
95. 'Health assessments for benefits', *House of Commons Work & Pensions Committee*, 14 April 2023, p.26, [link]
96. Written evidence submitted by Cystic Fibrosis Trust, *UK Parliament*, June 2023, [link]
97. See 'clearance times' [link]
98. A. Toth, 'DWP benefit claimants forced to wait more than three months for reviews as backlog bites', *The Independent*, 13 January 2025, [link]

Figure 25 – Median duration of assessment process for an initial claim, incapacity benefit (ESA / UC)



Source: Source: 'Welfare trends report – October 2024: charts and tables', Office for Budget Responsibility [link]

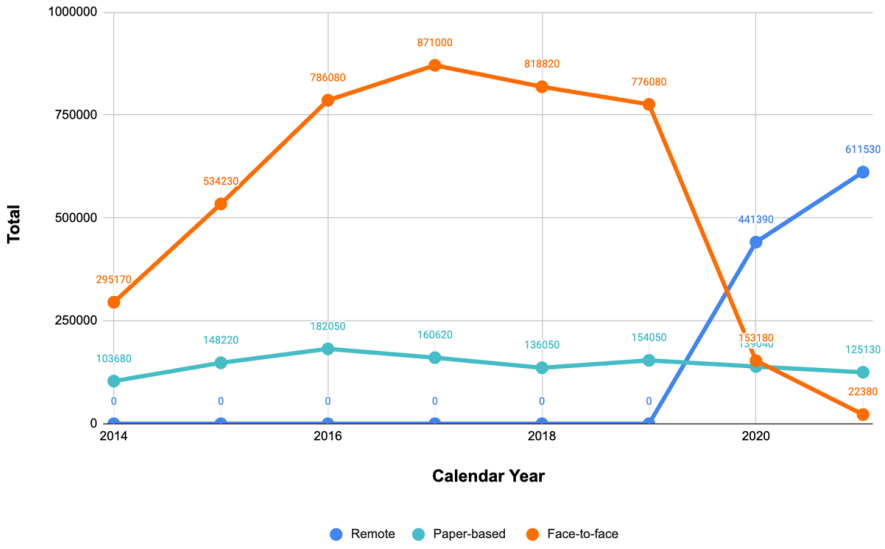
2. The majority of assessments are now conducted remotely (e.g. either over the telephone or via video), improving claimant experience, but changing the nature of assessments and leading to a shift in behaviours.

Before the COVID-19 pandemic, 80% of assessments were conducted face-to-face and 20% were based on a review of application forms and supporting evidence. During the COVID-19 pandemic face-to-face assessments were halted and remote health assessments by telephone and video were introduced.[99] As it stands today, the DWP has developed a multi-channel approach with contracts between the DWP and its assessment suppliers' stating – according to the Government's response to a recent written question – that 80% of assessments should be carried out remotely (via telephone or video) and 20% carried out face-to-face, including home visits.[100] There has, in other words, been a complete inversion in the assessment modality over the past five years, the impacts of which are not yet fully understood. Fig. 26 below which sets out the proportion of successful claims by assessment modality suggests that – besides paper-based assessments – suggests modality has only a limited impact upon outcomes. Based on last year's figures, the proportion of face-to-face claimants likely to be successful is the lowest of all channels. This is a matter which the DWP ought to scrutinise and keep under close review over the coming months.

99. 'Understanding the impact of different assessment channels on participant experiences of having a health assessment for PIP, ESA or UC', Health Assessment Channels Research, Department for Work & Pensions, October 2024, [link]

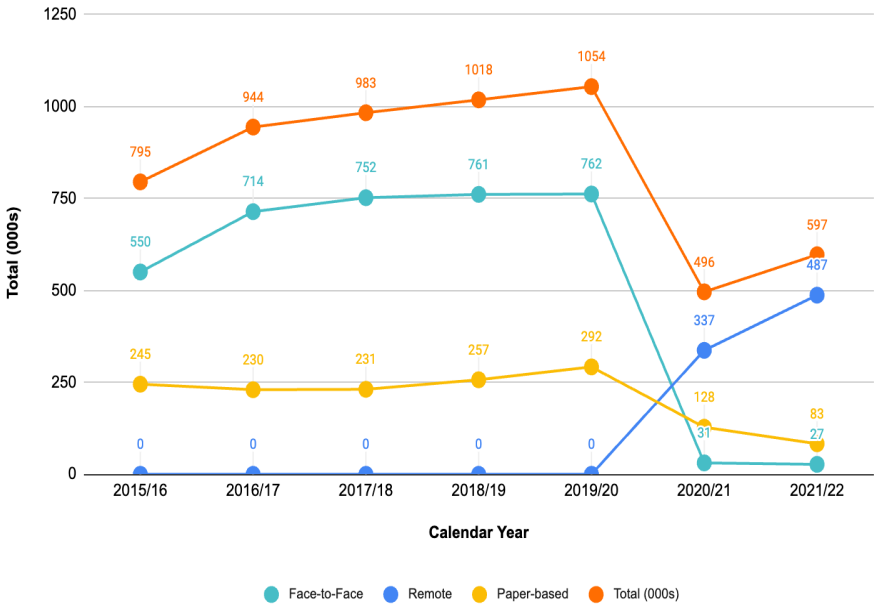
100. Question for Department for Work and Pensions, UIN HL4885, 10 February 2025 [link]

Figure 26 – PIP assessment modality (combined provider stats), 2013–22



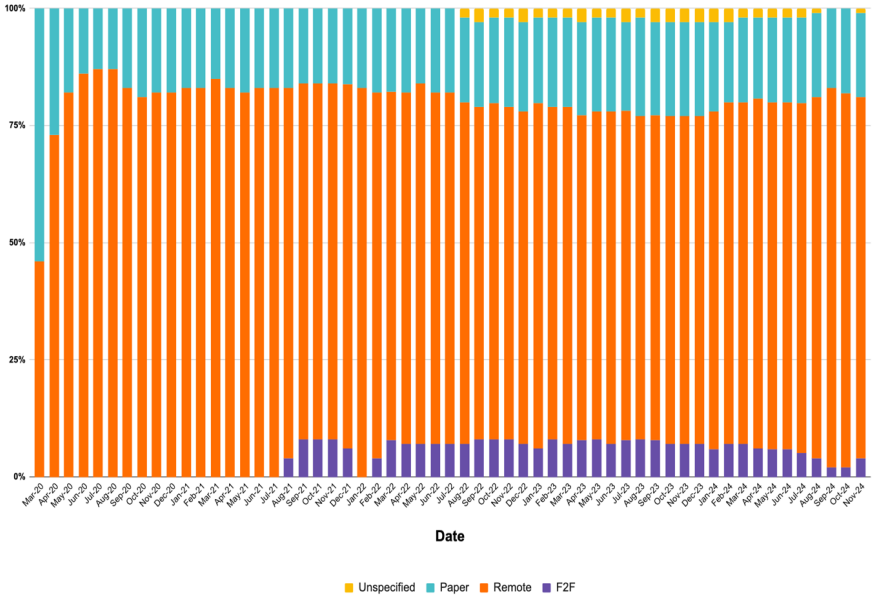
Source: Health assessments for benefits, Fifth Report of Session 2022–23, Work and Pensions Committee [link], p. 30

Figure 27 – WCAs (conducted by Maximus) by contract year since 2015 (000s)



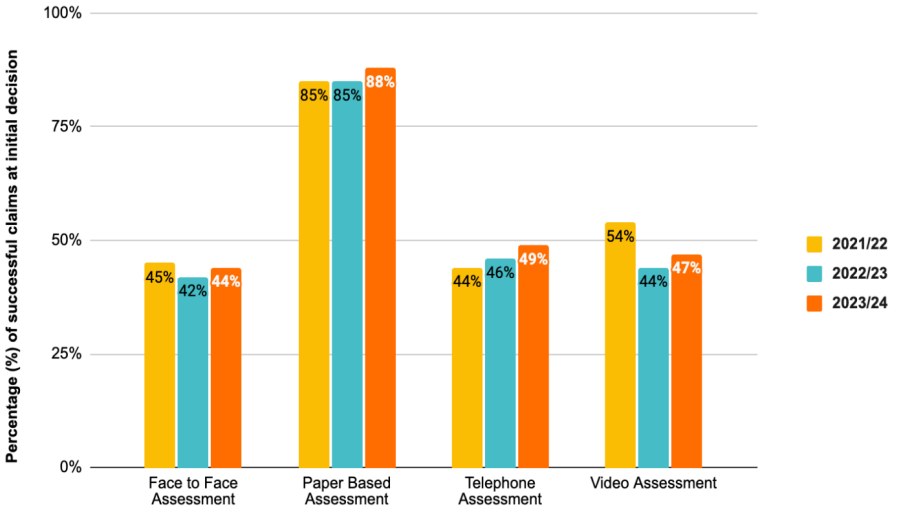
Source: Health assessments for benefits, Fifth Report of Session 2022–23, Work and Pensions Committee [link], p. 29

Figure 28 – Proportion (% of total) of Personal Independence Payment (PIP) assessments carried out by modality



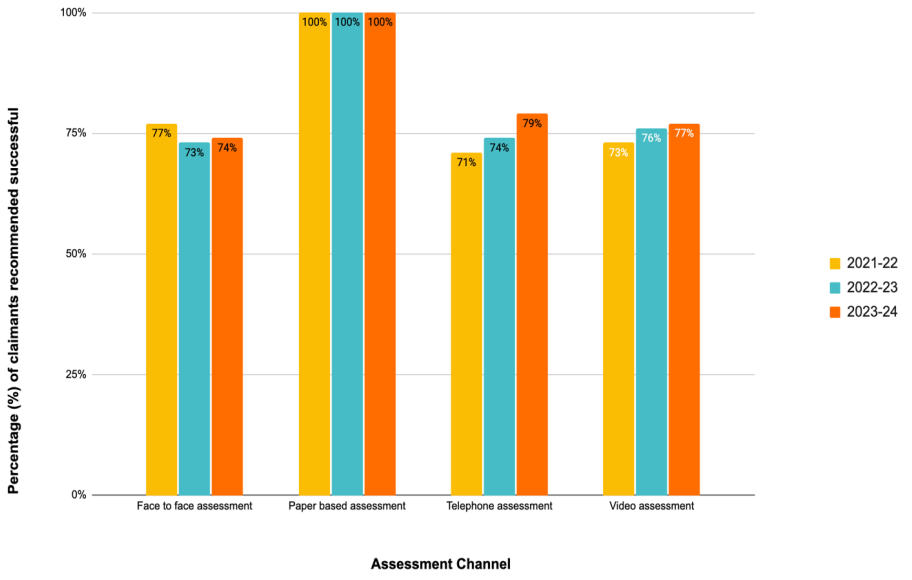
Source: Personal Independence Payment: Medical Examinations: Question for Department for Work and Pensions, UIN HL3669 [link]
Note: Remote assessments include telephone and video assessments. "All the above data is derived from contractual management information produced by the assessment suppliers."

Figure 29 – The percentage of successful claims for Personal Independence Payment (PIP) at initial decision by financial year and assessment channel



Source: Social Security Benefits: Disability - Question for Department for Work and Pensions, UIN HL4835 [link]

Figure 30 – The percentage of claimants recommended to be successful during their Work Capability Assessment for Employment and Support Allowance and Universal Credit by financial year and assessment channel



Source: Social Security Benefits: Disability - Question for Department for Work and Pensions, UIN HL4835 [link]

Note: Percentages provided above are based on recommendations made by assessment providers for claimants undergoing ESA or Universal Credit work capability assessments.

Claimants currently have the option of requesting to amend the channel through which their claim is assessed: the two most common reasons why participants had an assessment using a different channel than originally offered were: a) the channel was changed by the Assessment Provider (23%); b) the participant did not feel able to attend using the original channel because of their health condition (22%). Other reasons included being anxious about completing the assessment in that way (15%), technical issues (14%) or being unable to travel to the assessment centre (11%).[101]

This is a noteworthy development, because recently-published research conducted on behalf of the DWP has shown that younger participants were most likely to say that having a face-to-face assessment would make them less likely to apply. About three in ten (31%) of those aged 18-24 and 25% of those in the 25-34 age group said that a face-to-face assessment would mean they were less likely to apply, compared to 4% of participants aged 65 or more. Similarly, people with psychiatric disorders (26%), anxiety and/or depression (21%) or any sensory disability or health condition (also 20%) were less likely to apply if this required attending an in-person

101. Understanding the impact of different assessment channels on participant experiences of having a health assessment for PIP, ESA or UC', Health Assessment Channels Research, *Department for Work & Pensions*, October 2024, [link]

assessment. In the qualitative research, these groups were more likely to find an in-person assessment difficult to attend. A greater proportion of people claiming PIP (17%) said that the assessment being conducted in-person made them less likely to apply than those claiming ESA (10%) or UC (14%).[102]

Telephone assessments are regarded by claimants as the most accessible channel. Nearly three in ten (29%) said this made them more likely to apply for the benefit (60% no difference, 8% less likely). This was particularly the case for the groups who with psychiatric disorders (35%), anxiety/depression (32%), and younger participants (37% of 18-24s and 35% of 25-34s).[103] Familiarity with the process of claiming also has some bearing on outcomes. Those who were confident that they would receive a benefit award were more likely to know someone else who was claiming PIP, ESA or in the UC LCW or LCWRA conditionality group.[104]

In addition – although it is difficult to quantify the overall influence and effect of their influence on claimant behaviour – the prevalence of "sickfluencers" on social media (e.g. on Reddit or TikTok) who provide information or advocate approaches to maximise claims may also have an influence on boosting familiarity and an ability to achieve successful claims.[105]

3. Increasing challenge – both to initial decisions on claims and to prospective reforms.

In recent years, reforms proposed by the DWP to amend assessment criteria or to alter the structure of benefits have been subject to increasing challenge.

Since the introduction of PIP, a series of legal challenges to individual decisions have expanded the scope of eligibility for a PIP award. Many cases have centred around the interpretation of the qualifying criteria, introduced in 2013, that the activities under assessment need to be conducted "safely, to an acceptable standard, repeatedly and in a reasonable time period" by the claimant if they are to be deemed ineligible.[106] The definition of safety was addressed in *RJ, GMcL and CS v Secretary of State for Work and Pensions v RJ (PIP): [2017] UKUT 105 (AAC)*.[107] The court lowered the threshold of what was unsafe by ruling that it did not require an occurrence of harm to be "more likely than not", rather that there must be a "real possibility of harm occurring," which is to be balanced against the severity of harm.[108] One of the particular examples the court considered in this case was the likelihood of a fire occurring when the claimant was in the bath, which it deemed to meet the threshold of an activity carried out unsafely.[109]

TR v Secretary of State for Work and Pensions (PIP) [2015] UKUT 626 (AAC)) concerned the definition of "repeatedly."[110] The court overturned the tribunal's decision "that the descriptors were not met simply because there was only a difficulty for part of the day" ruling that "it was sufficient that the claimant was unable to perform the relevant task at some point in a day."[111] The court also addressed the Government's advice in the PIP assessment guide that a claimant can be still considered to conduct an

102. Ibid.
103. Ibid.
104. Ibid.
105. T. Witherow, S. Swinford & C. Smyth, 'Sick-fluencers help followers claim benefits as 15,000 a week approved', *The Times*, 30 November 2024, [link]
106. The Social Security (Personal Independence Payment) Regulations 2013, Section 4,[link]
107. [2017] AACR 32, *RJ, GMcL and CS v Secretary of State for Work and Pensions* (PIP), [2017] UKUT 105 (AAC), [link]
108. Ibid.
109. Ibid.
110. [2016] AACR 23, *TR v Secretary of State for Work and Pensions* (PIP), [2015] UKUT 626 (AAC), [link]
111. PIP Assessment Guide Part Two - The Assessment Criteria, *Department for Work & Pensions*, [link]

activity repeatedly, even if they cannot do so without painkillers. Here the judge decided that the activities cannot be carried out to a reasonable standard "if he or she is obliged to wait for a disruptive period of time until the painkillers take effect."[112]

The meaning of "to an acceptable standard" has also been addressed by the courts, notably in *PS v Secretary of State for Work and Pensions (PIP): [2016] UKUT 326 (AAC)* in which the effects of pain were considered.[113] It was ruled that any applicant may not be able to complete an activity 'to an acceptable standard' if they do so with difficulties such as pain or breathlessness. This was applied in *PA v Secretary of State for Work and Pensions (PIP) [2019] UKUT 270 (AAC)*, which concerned a claimant, whose throat ulcers made swallowing "very uncomfortable" which led to her consuming more of her food in liquid form and to a loss of appetite.[114] The court found that the tribunal, which initially had rejected the claim on the grounds that the claimant "could improve the problem by adapting the food she eats to those foods which are easier to swallow," had not properly applied regulation 4 and subsequently allowed the claimant's appeal.

Two other challenges have proven to be of significant consequence in recent years. The first of these, *[2018] AACR 12 (MH v Secretary of State for Work and Pensions) [2016] UKUT 0531 (AAC))* entailed a panel looking at three separate cases, all of which concerned the impact of mental health and psychological distress upon an applicant's mobility.[115] In one of the cases the tribunal did not think that descriptor 1(d) for the mobility element, "cannot follow the route of an unfamiliar journey without another person, assistance dog or orientation aid", pertained to someone who was in need due to anxiety. The court overruled the tribunal, to which the then government subsequently responded with a change to exclude those experiencing psychological distress from the PIP mobility component. This attempt, however, was struck down by the courts on the grounds that it was "blatantly discriminatory," in breach of Article 14 of the ECHR and therefore unlawful.[116] In January 2018, the government decided not to appeal this decision and announced a review of 1.6m PIP claims, dating from the initial decision.[117]

Secretary of State for Work and Pensions (Appellant) v MM (Respondent) (Scotland) redefined how the government should understand the meaning of "social support" in the PIP assessment.[118] The case involved a claimant who applied for PIP partially on the grounds that he needed social support engaging with others due to the mental health reasons. The Supreme Court found that a "narrow and technical" approach to social support was unwarranted and that it could include just "prompting". The Court also ruled that such social support would not need to be offered concurrently to the engagement, in this case "engaging with other people face to face." By 31 August 2023, DWP had reviewed around 79,000 cases against the MM judgment, and made 14,000 payments totaling 74 million as a result.[119]

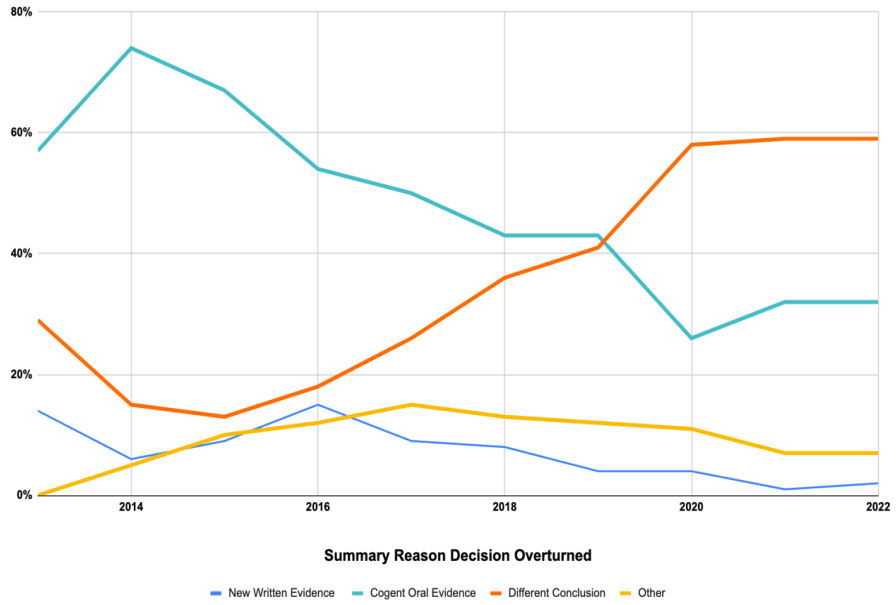
Finally, on 16 January 2025, the High Court ruled in *R (on the application of Ellen Clifford) and The Secretary of State for Work and Pensions* that a consultation run by the DWP from 5 September 2023 to 30 October 2023, on proposals

112. [2016] AACR 23, TR v Secretary of State for Work and Pensions (PIP), [2015] UKUT 626 (AAC), [link]
113. [2016] *PS v SSWP* UKUT 0326 (AAC), Appeal No. CPIP/665, 11 July 2016, [link]
114. [2019] *PA v Secretary of State for Work and Pensions (PIP)* UKUT 270 (AAC), 2 September 2019, [link]
115. [2018] AACR 12, *MH v Secretary of State for Work and Pensions* [2016] UKUT 0531 (AAC) [link]
116. [2017] *RF v Secretary of State for Work and Pensions* EWHC 3375 (Admin), 21 December 2017, [link]
117. 'Personal Independence payments: All 1.6 million claims to be reviewed', *BBC News*, 30 January 2018, [link].
118. [2019] UKSC 34, *Secretary of State for Work and Pensions (Appellant) v MM (Respondent)* (Scotland),18 July 2019, [link]
119. PIP administrative exercise for MM: progress report to 31 August 2023, Gov.uk, 26 October 2023 [link]

to make legislative amendments to the Work Capability Assessment, was unlawful.[120] The court's rationale was that the DWP had failed to "explain adequately the proposals themselves", failed to explain that the central motivation for the consultation was to cut costs, rather than, as was claimed by the DWP, move recipients back into work, and failed to provide sufficient time for consultees to respond given the consultation took eight weeks.[121]

In addition to this, currently, more than half the decisions to refuse an application for PIP that are appealed end up being overturned by a tribunal panel who draw a different conclusion from "substantially similar" evidence. (The success rate of these appeals has gone up significantly from c. 10% to over 60% in recent years).[122] See Fig. 31 below.

Figure 31 – Summary reason DWP decision overturned at Tribunal hearing



Source: Personal Independence Payment: Tribunals - Question for Department for Work and Pensions, UIN 42121 [link]

4. There is too little 'ongoing assessment' and/or reassessment for a cohort of claimants who may be fit for work.

Clearly there are claimants of health and disability benefits where their condition(s) mean that frequent reassessment is neither proportionate nor appropriate. Reassessment moreover is regarded by many claimants as a pejorative process – something which is fraud-seeking, rather than condition-supporting. A number of the health professionals we spoke to for this research spoke about the importance of reassessment – and more effective ongoing management of conditions than is currently commonplace. A refreshed cohort-driven approach which identifies those

120. Clifford v SSWP Judgment 16 January 2025 [link]
121. Ibid.
122. Question for Department for Work and Pensions, UIN 42121, 21 July 2022, [link]

individuals who would benefit from more routine reassessment – and more proactive support would be valuable.

Reassessment for UC health is currently undertaken under following conditions:

- When a claimant themselves report a change of circumstances in their health condition;
- If a claimant has been awarded LCWRA for pregnancy risk, or cancer treatment where the prognosis for recovery is expected to be short-term;
- Review period set between 6 and 36 months
- If a claimant has been declared as having LCWRA under the new risk provisions;
- In cases of suspected fraud.

5. There are too many instances where further medical evidence is not provided to support a claim.

UC Work Capability Assessments (provided in their current form since July 2023) provide statistics that cover the number of people on Universal Credit with a health condition or disability restricting their ability to work.[123] Claimants often have complex health issues and can therefore be recorded with multiple conditions according to the International Classification of Disease (ICD10) Codes. Unlike Employment and Support Allowance (ESA) medical statistics, a primary medical condition is not recorded. As such, UC WCA medical conditions convey all recorded medical conditions, but do not necessarily relate to a primary medical condition. By DWP's own assessment, "coverage is not complete for data on medical conditions for UC WCA". Of all WCA decisions in the period January 2022 to February 2024 (1.6 million), 81% have a medical condition recorded on the Medical Services Referral System (MSRS).[124]

Information, is not however readily available on the extent to which medical evidence is provided to support claims. In response to a written question, the DWP has recently stated that it "does not hold data centrally on whether a health care professional had supplied any medical evidence prior to a claimant's assessment".[125]

There is also an argument – as a number of interviewees put it to us – where current descriptors used for both the PIP assessment and the WCA can "push assessors into a corner" given their subjectivity and flexible interpretation.

NHS GPs are under no obligation to provide reports, letters of support, to offer an opinion for benefit claims direct to patients or anyone else, or to provide it free of charge. This includes the Citizens Advice Bureau or Tribunal Service. Under the present GP contract they are however obliged to provide information relating to patients on whom a certificate is being considered. Fees for the delivery of this work are £33.50 at the time of writing. Some reports, such as the ESA113, are included in the NHS GP contract and do not attract an additional fee.[126]

123. Universal Credit Work Capability Assessment statistics, *Department for Work & Pensions*, Updated 12 December 2024, [link]
124. Universal Credit Work Capability Assessment statistics: methodology, *Department for Work & Pensions*, 13 June 2024, [link]
125. Question for Department for Work and Pensions, House of Lords, UIN HL4836, 7 February 2025 [link]
126. DWP forms for healthcare professionals, *Department for Work & Pensions*, Updated 23 December 2024, [link]

6. Do we have the right approach to assess and monitor individuals with fluctuating, severe and degenerative conditions?

One challenge associated with assessments is how to accurately assess fluctuating conditions.

A recent research report, commissioned by the DWP into *The Impact of Fluctuating Health Conditions on Assessment* suggests that questions could be aligned to a five-part framework to better understand the individual's: underlying condition/s; triggers; ability to prevent or manage flare ups; outcomes in terms of physical, cognitive, and emotional capability, and; impacts on everyday activities and compromises or implications of activities.[127]

More than half a million people in the UK are living with Crohn's disease or colitis, but fewer than 3% are in receipt of PIP. These are conditions which can have a debilitating effect and can drive absences from work (for example). Parliamentarians have also drawn attention to individuals with brain injury. In recent years, the Government sought to refine its approach, consulting on changes which could create a new category within PIP for those with severe, degenerative or terminal conditions, but this has yet to be implemented.

Despite these concerns and for the faults of the current assessment process, there is recognition that –one interviewee put it to us, "won't be a world where there isn't something to check." There will ultimately have to be a gateway to support from the state meaning we must iterate the assessment process to ensure it is as objective and robust as possible.

127. The Impact of Fluctuating Health Conditions on Assessment: Improving the understanding of fluctuating health conditions and their impacts on the disability community and on the assessment process, *Department for Work & Pensions and Government Social Research*, October 2024, p.15 [link]

Chapter 3 – The Value of Good Work: The Importance of Addressing the Disability Employment Gap

> *"A good job doesn't just pay the bills. It's about new skills, meeting new people and getting on…But right now, the system is failing people. There is so much wasted potential – not just for people, but for the country as well."*
>
> Rt Hon Sir Keir Starmer KC MP[128]

There is an important fiscal and moral imperative in enabling more individuals with a disability into employment. The number of disabled people who are in employment has been increasing since 2013, but dedicated schemes to improve employment rates and to reduce the 'disability employment gap' have had mixed success. The current economic inactivity rate for disabled people is 42.6%, compared with a rate of 14.9% for those who were not disabled.[129]

Our understanding however of the drivers behind this employment gap overall however, "remains limited".[130]

There remain notable differences in employment rates by disability. For instance, the employment rate for individuals with autism for instance stands at 31 per cent, compared with 54.7 per cent for all disabled people. There's also plenty of evidence that poor health is co-incident with many other factors that negatively influence labour market outcomes, including lower levels of education and lower income and wealth.[131] People with disabilities with multiple health conditions have a lower employment rate than those with a single health condition. (People with a single health condition have an employment rate of 65%, but this falls to 29% for people with five or more health conditions.)[132]

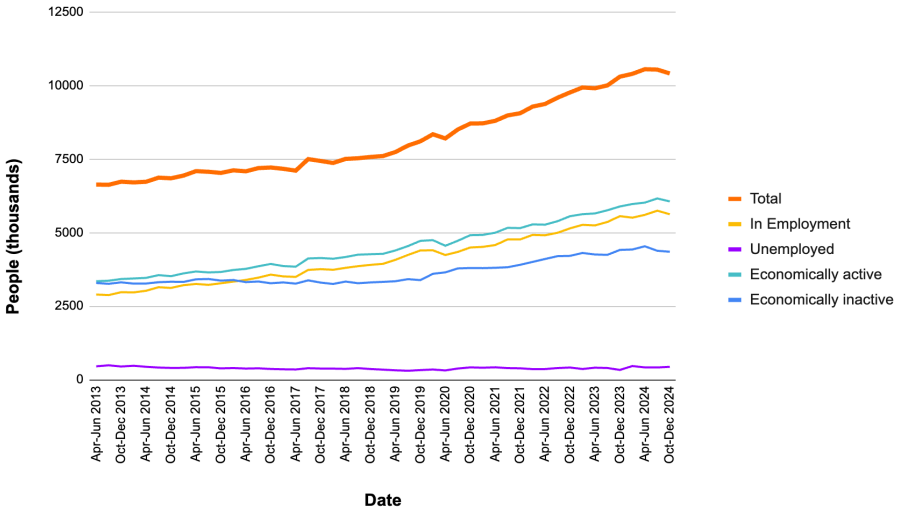
Disabled people are less likely to work remotely than the wider population. As working habits and patterns have adapted, significant opportunities have emerged, enabling us to reconsider how best to support employment for those with disability and long-term health conditions. Increased flexible and remote working options clearly present opportunities.

But whilst working from home might increase disabled people's control over their working environment and to assist a staged return-to-work, organisations in which working from home is more commonplace do

128. Sir Keir Starmer, 'Jobs are about dignity and pride... not just paying the bills', *Daily Mail*, 23 November 2024, [link]
129. A. Powell, 'Disabled people in employment', Research Briefing, *House of Commons*, 18 March 2024, [link]
130. Written evidence from Dr Armenak Antinyan, Professor Ian Burn & Professor Melanie Jones, DYE0024, [link]
131. C. Baker & L. Gardiner, 'How health status affects labour market participation', *Office for Budget Responsibility*,12 December 2024, [link]
132. Statistics on 'The employment of disabled people,' *Department for Work and Pensions*, updated 5 November 2024, [link]

not currently employ a higher proportion of disabled people.[133] Indeed, 12.8 per cent of disabled people stated that in the last 12 months they had either worked from home or that the option to work from home was available to them, compared with 19.3 per cent of non-disabled people.[134]

Figure 32 – Economic activity of people, United Kingdom (thousands) with disabilities aged 16-59 (using the Harmonised Standard Definition of 'Disabled')



Source: Labour market status of disabled people, Office for National Statistics, 18 February 2025 [link]

The Perspective of Claimants

Individuals who are on incapacity benefits currently receive little support to find work. The Learning & Work Institute have suggested that just "one in ten out of-work disabled people get help to find work each year, and only 1% of people economically inactive due to long-term sickness are in work six months later, compared to 33% of unemployed people".[135] So what are the reasons for this, according to current recipients of benefits themselves?

Research recently published by the DWP – the 'Work Aspirations of Health and Disability Claimants', see Table 8, below, is instructive in revealing some of the key challenges associated with the search for work.

133. K. Hoque & N. Bacon, 'Does working from home benefit disabled people', *Disability at Work*, November 2021, [link]
134. Ibid.
135. S. Evans, 'The benefit trap: Better support for disabled people and people with long-term health conditions', *Learning and Work Institute*, February 2025, [link]

Table 8 – What barriers impact customers' ability to find work now or in the future?

Type of Barrier	Proportion (%) who Agreed / Strongly Agreed
Health-related barriers	
I am worried that working could make my health condition worse	76%
I may find it difficult to travel to work with my health condition	76%
My health condition/disability fluctuates too much for me to work	70%
Managing my health condition/disability means I don't have time to work	55%
My ability to work is dependent on receiving health treatment	50%
Having a job would be beneficial for my health	20%
Confidence, skills and knowledge-related barriers	
I know how to present myself and my health condition or disability in my CV or at interviews	29%
I have the right skills or experience to be successful in applying for jobs	27%
I know what suitable jobs are available	20%
I feel confident about applying for jobs	16%
Employer and workplace related barriers	
I am worried people won't employ me because of my health condition	69%
I am worried people won't employ me because of my age	41%
The adaptations I would need to be able to work are too expensive to be an option	26%

DWP and benefits-related barriers	
I am worried DWP will make me look for work that I'm not suitable for if I ask for help	60%
I am worried that I wouldn't get my benefits back if I try paid employment and then it doesn't work out	50%
Barriers related to personal circumstances	
I have other personal or family issues that need to be sorted out before I can consider working, e.g. debt or housing issues, childcare and caring responsibilities	38%
I have family or caring responsibilities that make working difficult	28%

Source: Work aspirations and support needs of health and disability customers: Interim findings report (February 2025), Department for Work and Pensions [link]

This research reveals**:**

1. That most claimants regard their health or disability as being the most significant factor which impedes them from working;
2. The majority of respondents do not feel that work would be beneficial to their health – or that it would in fact make their condition(s) worse;
3. That a majority of claimants do not feel confident that employers will support their return to or entry into the workplace;
4. That half of claimants are concerned that seeking and trying out new employment options could result in an inability to (re)claim benefits;
5. That further advice and support is needed for claimants to be able to clarify their circumstances when seeking and applying for work;
6. It clearly demonstrates – as the Government have rightly identified and seek to tackle through reforms set out in their recent White Paper – that there is ineffective join up between Jobcentre Plus, NHS services and DWP-administered services. We have employment services which are infrequently used, with just one in five jobseekers utilising them.[136]

What Works? Lessons from Recent History

Various policy initiatives have been developed by Labour, Coalition and Conservative Governments in recent years which have aimed to support disabled people into (and to remain in) work (in addition to the Access to Work scheme) or which have targeted engagement and paths to employment for those on incapacity benefit.[137]

136. 'Working for the Future', *The Commission on the Future of Employment Support*, [link]

137. These are helpfully summarised in the following [link]

An analysis of schemes (since 1997) is set out below which will be instructive in important to understand some of the current barriers to current claimants' ability to find work today which will be essential to the effective delivery of 'The Pathways to Work' programme, which will seek to ensure greater support, obligations and incentives for claimants of incapacity benefits with the goal of encouraging employment.[138]

1997-2010

Welfare reforms introduced under Labour Governments between 1997-2005 were underpinned by a number of key programmes, including the New Deals (from 1998), the Welfare to Work Programme (2001), the creation of Jobcentre Plus (2002) and Pathways to Work (from 2002).[139]

Initiative	Description	Findings
The New Deal for Young People (NDYP) **1998**	Launched in April 1998 – less than 12 months after Labour had entered Government in 1997 –an extensive programme of assistance for young people who were unemployed for six months or more By the end of January 2002, 753,600 individuals had taken part (or were taking part) in the NDYP.[140] Scheme based on intensive support to secure employment over a four-month period, with individuals on the scheme who remained in the programme beyond this period offered one of four options: 1) Employment Option, offering subsidised employment; 2) Full-time Education and Training; 3) Voluntary Sector Option or 4) 'Environment Task Force'.	An evaluation published by The National Institute of Economic and Social Research estimated that over the first two years of the programme (1998-2000), 60,000 more young people moved into jobs than would have been the case without the scheme, with more than half moved into unsubsidised jobs.[141]
New Deal for Disabled People (NDDP) (from 1998)	Voluntary programme designed to help people with disabilities and health conditions move from incapacity benefits into sustainable employment.[142]	From July 2001 and June 2004, nearly 100,000 people registered with NDDP. The overall rate of take-up of NDDP was

138. S. Adam, A. Bozio & C. Emmerson, 'Can we estimate the impact of the Choices package in Pathways to Work?', *Department for Work and Pensions*, 2009, via The National Archives, [link]
139. 'The challenges facing DWP in the future: Deliberative research with the public', *Department for Work and Pensions*, December 2007, via The National Archives, [link]
140. M. White & R. Riley, 'Findings from the Macro evaluation of the New Deal for Young People', *Department* for *Work and Pensions*, 2002, [link]
141. Ibid.
142. L. Orr, S. Bell & K. Lam, Long-term impacts of the New Deal for Disabled People, *Department for Work and Pensions*, 2007, [link]

	Introduced by the then Department for Education and Employment and Department of Social Security In 2001, programme extended nationally for three years, and in July 2003 it was announced that it would be further extended for two years to March 2006. Programme delivered locally by Job Brokers – a mixture of voluntary, public and private sector organisations. Job Brokers varied in size and in they operated, but most worked to assist clients with job searches, to engage in job development, and attempt to increase clients' confidence in their ability to work.[143] A Personal Adviser Service' Pilot was also tested in six areas. It was extended to six other areas in the April 1999 and delivered by partnerships that include private and voluntary sector organisations.[144] Forty-seven per cent of participants had been receiving a qualifying benefit for at least three years compared with 60 per cent of non-participants. Participants were more likely ever to have worked and more were actively seeking work. Ninety-six per cent had worked at some time although half had not done so for at least three years.	around two per cent of the eligible population Of those registering between July 2001 and April 2004, 35 per cent are known to have moved into work. Of those who had entered work, almost one-third (32 per cent) had done so within one month of registration, over half (55 per cent) had started work within three months, and three-quarters (76 per cent) had started within six months. The total cost of operating NDDP is £700 to £1,100 for each registrant.[145] Including both costs incurred by Job Brokers and the central administrative costs incurred by Jobcentre Plus, the cost per placement under the NDDP programme was £2,000 to £3,000 and the cost per sustainment is £4,000 to £5,000 (where a 'sustainment' is defined as retaining a job for at least six months). An analysis undertaken indicated the NDDP reduced the Government's budgetary requirements by over £2,500 for a typical continuing claimant who registered and by over £750 for an

143. D. Greenberg & A. Davis, 'Evaluation of the New Deal for Disabled People: The cost and cost-benefit analyses', *Department for Work and Pensions*, 2007, [link]

144. S. Arthur et al. 'New Deal for Disabled People: Early Implementation', *Department of Social Security*, [link]

145. D. Greenberg & A. Davis, 'Evaluation of the New Deal for Disabled People: The cost and cost-benefit analyses', *Department for Work and Pensions*, 2007, p. 2, [link]

		average new claimant who registered. For each pound spent on NDDP, the Government saved between £3.41 and £4.50 for An analysis undertaken indicated the NDDP reduced the Government's budgetary requirements by over £2,500 for a typical continuing claimant who registered and by over £750 for an average new claimant who registered. For each pound spent on NDDP, the Government saved between £3.41 and £4.50 for.
Work Trial **1999-2000**	Launched in April 1999 and piloted for one year allowing claimants to try employment by filling a job vacancy for up to 15 working days, during which time they are not paid but continue to receive benefit).[146]	Work Trial, Jobfinder's Grant and Jobmatch were Employment Service programmes, but staff in the Benefits Agency and the New Deal for Disabled People Personal Adviser Service were also involved in advising and enabling access. The four measures were piloted in 15 areas of Great Britain, 12 of which had a Personal Adviser Service pilot project.
Jobfinder's Grant **(1999-200)**	Launched in April 1999 and piloted for one year allowing claimants a lump sum paid to people entering employment and coming off benefit	Launched in April 1999 and piloted for one year allowing claimants a lump sum paid to Disability Employment Advisers and Personal Advisers had varied experience of advising clients about Jobfinder's Grant. Some felt that the grant did provide an incentive in

146.A. Corden & R. Sainsbury, 'Incapacity Benefits & Work Incentives', Department for Work and Pensions, 2001, p.6, [link]

		reducing financial insecurities, but time limits were tight. Some lost confidence in promoting the measure after clients had to wait several weeks to receive grants or applications they had advised had failed. [147]
Jobmatch Payment **(1999-2000)**	Launched in April 1999 and piloted for one year, this was an earnings supplement for people entering employment) which provided an extra weekly allowance of £50 for people moving off incapacity benefits into a job of fewer than 30 hours per week, and was paid for up to 26 weeks.)	There was limited understanding and experience of Jobmatch among staff. Personal Advisers expressed some unease about the form of discretion required and the responsibility for providing full information, six months in advance, about options for clients at the end of the payment period. The support element offered as part of Jobmatch was deemed attractive and proved effective in helping people stay in work.[148]
The ONE service (from 1999)	A joint initiative between the Department for Education and Employment, Department of Social Security, Employment Service and Benefits Agency. ONE created a single point of entry to the benefits system (and put facilitating a return to the labour market at the centre of the claim making process). Aim of ONE to increase economic activity, encourage people (back) into work where possible and to provide claimants with a more integrated service.	ONE introduced between June and November 1999 in 12 pilot areas. Three different service models are being trialled: a basic model, a call centre model and a private/voluntary sector model.[149]

147. Ibid.

148. Ibid

149. K. Blunt, J. Shury, D. Vivian & F. Allard, 'Recruiting benefit claimants: A survey of employers in ONE pilot areas', *Department of Social Security*, 2001, [link]

Employment Zones (EZs) (2000)	Introduced in April 2000 in fifteen areas of the UK experiencing high concentrations of long-term unemployment. EZs targeted unemployed people aged 25 and over who had been claiming Jobseeker's Allowance (JSA) for at least 12 months. Participation was mandatory for this client group.	EZs work for a group of long-term unemployed people for whom mainstream Jobcentre Plus services have been unsuccessful in the past. EZ participants were found to achieve a higher rate of job outcomes than would otherwise have occurred if they had participated in 'New Deal 25 Plus'.[150]
Pathways to Work (from 2003)	Pilot begins October 2003, aiming to assist incapacity benefits claimants into, and towards, paid work. Programme focused on those making a new or repeat claim for incapacity benefits and introduced mandatory Work Focused Interviews (WFI) with specialist Incapacity Benefit Personal Advisors (IBPA) and offered a range of services focusing on work and health, including the innovative Condition Management Programme (CMP).[151]	A third of new and repeat customers (34 per cent) were in paid work two years after their start on Pathways to Work. A further 17 per cent were actively seeking work but half of all customers (49 per cent) were not looking for work.[152]

150. R. Griffiths & G. Jones, 'Evaluation of Single Provider Employment Zone Extensions to Young People, Lone Parents and Early Entrants', Interim Report, *Department for Work & Pensions*, 2005, [link]

151. E. Becker, O. Hayllar & M. Wood, 'Pathways to Work: programme engagement and work patterns Findings from follow-up surveys of new and repeat and existing incapacity benefits customers in the Jobcentre Plus pilot and expansion areas', *Department for Work & Pensions*, 2010, p.7, accessed via The National Archives, [link]

152. Ibid

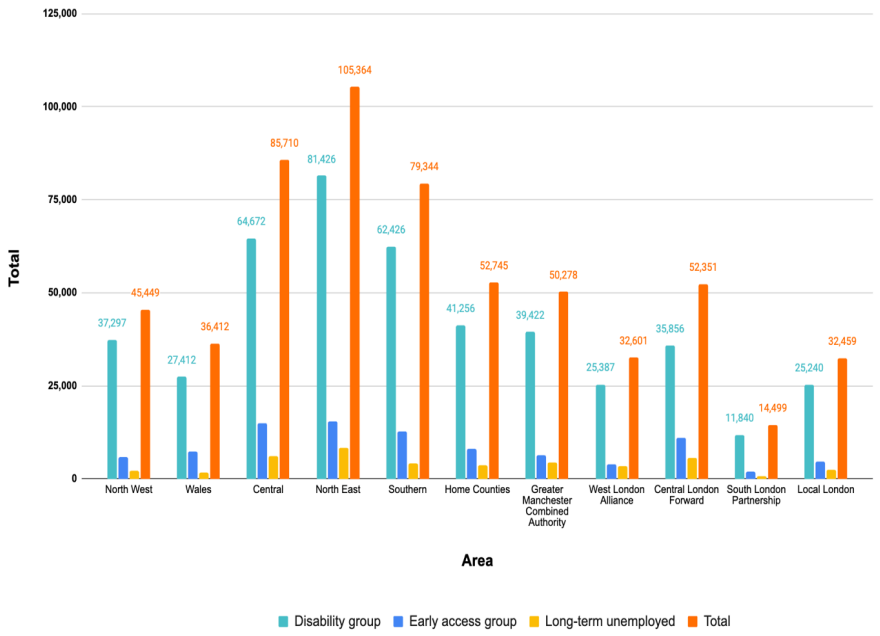
2010-Present

Initiative	Description	Findings
The Work Programme **2011-2017**	Offered support to individuals out of work who had been claiming Jobseeker's Allowance or Universal Credit for 12 months and required to search for work.[153]	Those who took part in the Work Programme had 46 additional days in employment where they didn't receive benefits over the two years. They also received out of work benefits for 70 fewer days than those not on the programme. Considering this, the Cost Benefit Analysis found a return of £3.21 for each £1 spent on the Work Programme.[154]
Health-led Employment Trials (HLTs) **2015**	Delivered by Work and Health Unit (WHU) – a joint unit between DHSC and DWP) working with NHS England. Tested (e.g.) provision of Individual Placement and Support (IPS) for people living with severe and enduring mental illness in secondary care – with a group experiencing mild/moderate mental and/or physical health conditions in primary and community care settings.[155]	Health outcomes produced stronger return to society and Exchequer than employment outcomes. Led to a return-on-investment for every £1 invested in the IPS services of £0.01 in WMCA, and in SCR, of £2.02 (SCR OOW) and £2.32 (SCR IW) and £1.22 for the pooled out of work group.[156]
The Work and Health Programme (WHP) **2017-2024**	Employment support programme to assist the disabled, long-term unemployed, and early access groups to enter and stay in work.	Support will continue until July 2026 for all those who had already been referred to the programme, but the scheme is now closed to new referrals

153. 'The Work Programme: A quantitative impact assessment', *Department for Work & Pensions*, November 2020, [link]
154. The Work Programme Evaluation 2020 [link]
155. Health-led Employment Trials Evaluation 12-month outcomes evidence synthesis, *Department for Work & Pensions and Department of Health & Social Care*, August 2022, [link]
156. Ibid.

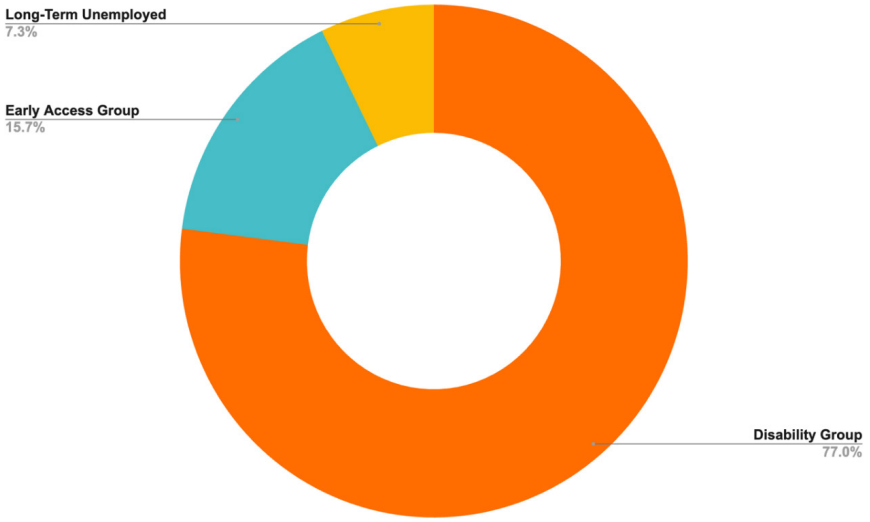
	Providers paid a service delivery fee as well as outcome related payments when a participant reaches a specified level of earnings in employment, or records 6 months of self-employment. Providers support participants for a maximum total of 21 months on the Programme. In September 2023, the WHP was expanded to include WHP Pioneer, targeted at economically inactive individuals with a disability through a 'place and train' model.	(as of August 2024).

Figure 33 – Work and Health Programme Referrals (by Area), 2017-2024



Source: DWP Stat-Xplore

Figure 34 – Work and Health Programme Referrals (Total), 2017-2024



Source: DWP Stat-Xplore

The Personal Support Package (PSP) **2017-2021**	Aimed at new claimants in Employment and Support Allowance (ESA) work-related activity group (WRAG) and equivalents in UC LCW. (Eligibility was later widened to all ESA and UC Health Journey claimants.) Packages included: 1) New Initiatives Small Employer Offer (SEO): work with small employers to match people to jobs (via Jobcentre Plus); 2) Journey to Employment (J2E) Disabled Peoples' User Led Organisations and local Voluntary Sector; 3) Community Partner (CP) specialist role employed by Jobcentre Plus for their expertise and local knowledge of disability issues. The role ceased on 31st March 2019.[157]	46% of claimants said that the support and advice received had increased their motivation to find work. Nearly half (44%) of respondents who had taken up support reported participating in work-related activities as a result of the support received, this included 13% who had found some form of work.[158]

157. Evaluation of the Personal Support Package, *Department for Work & Pensions and Government Social Research, July* 2021, [link]

158. Evaluation of the Personal Support Package [link]

Intensive Personalised Employment Support (IPES) Programme **2019-present**	Launched to provide personalised support to disabled claimants who are likely to have complex support needs and barriers to work (and where other support such as Work and Health programme are not suitable). Open to all those who want to work, it brings employment specialists into clinical teams. Provides time unlimited, individualised support for the individual (and their employer). Access to specialist benefits counselling is included (IPS Employment Centre, undated).	Considered to save "£20,000 per person over five years" through reduced public spending on health and welfare.[159] The Office for Budget Responsibility (OBR) has concluded the scheme more than pays for itself, with a £200m expansion announced by the previous government expected to boost employment by around 10,000 and reduce welfare spending by a further £200m.[160]
Work Choice **2010-2019**	A voluntary employment programme for people with disability barriers to employment, and people at risk of losing their job as a result of their disability, for whom other DWP provision was not suitable. DWP contracted external providers to deliver Work Choice. Providers offered both work entry support to help participants find and obtain employment, and in-work support to help participants progress and develop in work. Work Choice was introduced across	Work Choice reduced the likelihood of individuals being neither in payrolled employment nor receiving looking for work/low-income benefits. Eight years after referral to Work Choice early cohort participants were 2.6 pp less likely to be neither in employment nor receiving looking for work/low-income benefits than the comparison group, and had spent, on average, 101 fewer

159.S. Ping Chan, 'Labour to lean on NHS to solve Britain's worklessness crisis', *The Telegraph*, 23 November 2024, [link]

160.Ibid.

	England, Scotland, and Wales in October 2010. The final referrals to Work Choice occurred in February 2018 and Work Choice support ended in March 2019	days in this state (-3.5pp) over that time. Four years after referral to Work Choice, later cohort participants were 2.3 pp less likely to be neither in employment nor receiving looking for work/low income benefits than the comparison group, and had spent, on average, 45 fewer days in this state (-3.1pp) over that time[161]

Conclusions

1. **There are a range of measures which make a material difference to improving employment rates for those with disabilities, including: the use of specialist advisors, ensuring effective employer engagement and creating integrated support.[162]**
2. **There have been a myriad of initiatives launched in recent years, targeting the young, the disabled, individuals with ill-health (or a combination of all three), but too many initiatives have proven short-term in nature.**
3. **Moreover, the continuation of a largely pilot-based approach has meant there have been ongoing difficulties in securing OBR and/or Treasury backing to support a larger-scale and longer-term intervention.**
4. **The DWP would be advised to back a select number of schemes over the long-term from those already in operation, e.g. Intensive Personalised Support (IPS).**
5. **There is a real need to ensure that robust, ongoing evaluation, linking Government pilots with ongoing academic research into the links between work and health overall become commonplace. This is essential to enable an improvement to the evidence-base which can underpin future policymaking in this space.**

162. Written evidence from Learning and Work Institute, DYE0017, [link]

161. Work Choice Impact Evaluation: A voluntary employment programme for people with disability barriers to employment, February 2025 [link]

Chapter 4 – Proposals for Reform

This chapter sets out our policy recommendations – and a package of reforms – which seek to address the issues identified in the previous chapters and to deliver a new social contract.

1. The Personal Independence Payment (PIP) should become a conditional benefit for those aged 16-30, creating an age-defined approach and to improve engagement.

It has long been recognised that disabled people continue to face barriers to long-term employment which – as a recent House of Lords Public Services Committee report concludes –can be traced from "early years, primary and secondary school, and through to how they are prepared for work and supported during their transition from education to employment both within and outside the education system". Given there is a recognition that a focus on early support and intervention is needed, this cohort is deserving of particular focus and attention from policymakers.[163]

The Government has suggested that it may develop a 'duty to engage' as part of a package of reforms to the health element of UC. We propose to go a step further and suggest that for those who are 16-30 there should be an obligation for recipients of PIP to volunteer, partake in further education, training or to enter formal employment. We recognise that for a small cohort of people none of these options will not be possible, so the decision-maker in the DWP has the discretion to not enforce this provision in what should be exceptional circumstances.

While recognising this benefit is intended to cover the additional cost of disability, the growing demand for this benefit – particularly amongst those under 35 for mental ill-health means we need to reconsider what types of support are most appropriate and to encourage greater behavioural change.

Such an approach would have international precedence and does – to some extent – emulate reforms introduced, for instance, in the Netherlands who have in place the 'Wajong' benefit. A case study of its implementation is detailed below.

We too have been here before. As we explored in previous chapters, in 1998, the New Deal for Young People created fixed, but escalating sanctions for participants who failed to attend regular interviews or to take part in mandatory programmes, but also provided immediate support to enter employment or to volunteer. The 2015 Summer Budget meanwhile

163. 'Think Work First: The transition from education to work for young disabled people', *House of Lords Public Services Committee*, 15 October 2024, [link]

provided the outline of a 'Youth Obligation', a new way of supporting 18–21-year-olds Universal Credit recipients into work, where young people would receive intensive support on day one of their claim.[164] Policy Exchange has also long advocated for a more targeted approach toward young people. *Welfare, Work and Young People* proposed trialling Youth Employment Centres which would operate separately from the rest of the Jobcentre to provide specialist, targeted advice to individuals under the age of 25.[165]

The Government should proceed with reform for individuals aged 18-21, so there is a clear link to ongoing reforms and the introduction of the 'Youth Guarantee', but this should be swiftly expanded. The Government should then raise the age at which PIP can be claimed, rising from 16 to 25 over the course of the Parliament. This would better align PIP with other support to help young disabled people. The DWP should be able to opt individuals out of conditionality based on severity of condition, on instances where individuals have a terminal condition for example. Given the DWP's desire to improve the digital offering to service users, utilising an improved online portal to engage these claimants, to signpost support and opportunities should be regarded as a priority.[166]

Whilst any modelling the fiscal impacts of changes to health and disability benefits has become very challenging, owing to the significance of behavioural change with accompany reforms, we nonetheless thought it beneficial to give an indicative sense of the type of savings (and economic benefit) that may be achieved through reform.

The Government estimate that having one extra disabled person in full-time work, rather than being out of work and fully reliant on benefits, would mean the Government could save an estimated £18,000 a year. It could provide societal savings of £28,000 a year when considering increases in output, reductions in healthcare costs and increased travel, with societal savings increasing to £34,000 a year if including Quality Adjusted Life Year (QALY) impacts, or £36,000 a year if including subjective wellbeing impacts. [167] For a disabled person working part-time, the equivalent figures could be a saving to the Government of £8,000 a year, a societal saving of £15,000 a year, rising to £19,000 a year if including QALY impacts, or £20,000 a year if including subjective wellbeing impacts.[168]

The number of young people (aged 16 to 34) who are economically inactive due to long-term sickness and have a mental condition stands at currently 270,000. Moving all of these claimants off health and/or disability benefits would save DWP £4.86bn each year based on the current caseload, with societal savings of £7.56bn each year. The upper limit, when a QALY is added to societal savings would be £9.18bn.

A recent survey from the DWP finds that 44% of customers whose main health condition was a mental health condition felt they might be able to work again 'if their health improved'. That equals 118,800 individuals between the ages of 16-34. We think – based on these assumptions– that it is plausible the DWP could achieve annual savings of £2.14bn (and

164. Summer Budget 2015, *HM Treasury*, 8 July 2015, [link]
165. S. Hughes, 'Welfare, Work and Young People: How to improve prospects for 16-24 year olds', *Policy Exchange*, 18 August 2016, [link]
166. 'Digital Skills, Channel Preferences and Access Needs', *Department for Work & Pensions and Government Social Research*, March 2024, p.63, [link]
167. 'Occupational Health: Working Better', *Department for Work & Pensions*, July 2023, [link]
168. Question HL3665, *House of Lords*, 19 December 2024, [link]

societal savings of £3.30bn) through targeting interventions to support this cohort.

Learning from The Netherlands: 'Wajong' – An Age-Defined, 'Youth' Benefit

- In 1990, the Netherlands spent 4.7 percent of its GDP on disability insurance – which was 2.2 percentage points higher than Norway, the second highest representing significant levels of spending which were dubbed the 'Dutch disease'.[169]
- Reforms mean that employers now pay for sickness leave for up to two years of an employee's absence (via reforms introduced in 1996) [170] 'Invalidity benefit' is only granted if the recipient unable to work after 2 years or can only earn 65% or less of their previous income
- A distinctive feature of the Dutch system is the Wajong benefit (Disablement Assistance Act for Handicapped Young Persons, Wet arbeidsongeschiktheidsvoorziening jonggehandicapten), a programme provided exclusively for 18–30-year-olds. Whilst first introduced in 1976, it was in the 2010s when the most salient and efficacious reforms were carried out.
- The 2010, it comprised of a benefit programme, ensuring those deemed unfit for work (not able to earn more than 35% of the statutory minimum wage) are granted an income, and an employment programme, which provides a participation plan to help the recipient find work.[171] If work is not found, the Dutch Employee Insurance Agency will offer the claimant a job if it is suitable.
- The claimant has an obligation to accept this offer otherwise their benefits could be withdrawn.
- In 2015, Wajong was reformed again through a tightening of the eligibility criteria. Only those unable to work at all are eligible for the full benefit. Those with any capacity to work are not eligible to received Wajong, but instead are covered by the participation plan, where they are mandated to search for a job.
- As Fig. 35 below shows, the 2015 reforms reduced the number of young people on the Wajong benefit.[172]

169. Ibid.

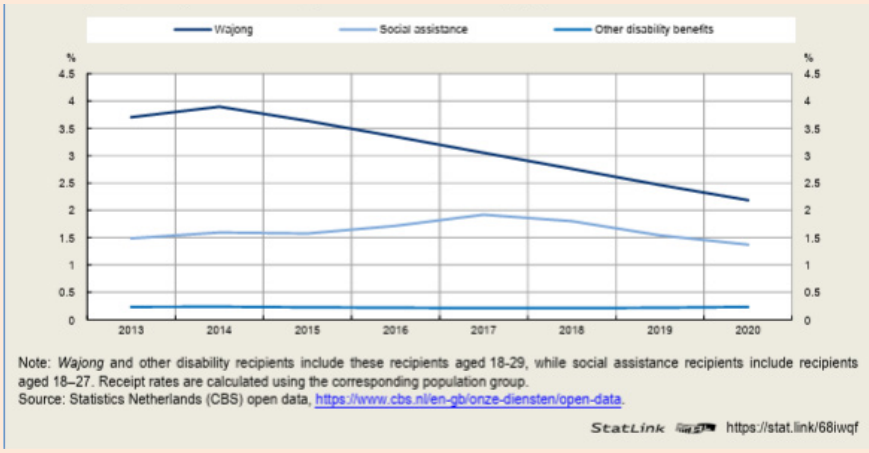
170. P. Koning & M. Lindeboom (2015) "The Rise and Fall of Disability Insurance Enrollment in the Netherlands." Journal of Economic Perspectives 29 (2): p.158, [link]

171. E. De Vos, 'Measures on prevention of disability benefit dependency and activation of young persons

Netherlands: Young persons with Health Problems and Employment', October 2016, [link]

172. Disability, Work and Inclusion: Mainstreaming in all policies and practices , *OECD*, 2022, [link]

Figure 35 – Share of Dutch youth in receipt of social assistance and Wajong benefits



Source: Disability, Work and Inclusion, OECD [link], p. 76

Recommendation(s)

For those aged 16 to 30, The Personal Independence Payment (PIP) should become a conditional benefit, creating an age-defined approach.

a. The Government should proceed to begin initially introduce reforms to the benefit for individuals aged 18-21, linked to wider proposals for a 'Youth Guarantee', but should expand the programme over the coming months.
b. The Government should seek to improve the alignment of PIP claims with Education, Health and Care Plans, starting by changing the age you can first claim to 18 – and prospectively raising this to 25 over time.
c. In exceptional circumstances, the DWP should be able to opt individuals out of this proposed conditionality based on severity of condition, or where individuals have a terminal condition.

2. Parliament should play a greater role and have a greater say in scrutinising the eligibility criteria for health and disability benefits – and wider welfare reforms.

Reforming the health and disability benefits system over the past two decades has been fraught with difficulty. Any debate about benefit entitlement has become existential, which has sadly meant that reasoned debate about eligibility criteria has been hard to come by. We want to

make the debate about eligibility less fraught and more adaptable to the changing circumstances of society. We therefore believe that the eligibility criteria should be reviewed in a more dynamic fashion – and more routinely (e.g. every two years).

Currently, given much of the criteria for PIP and WCA is in regulations (secondary legislation) it has been increasingly subject to widening scope and challenge. To democratise the debate on reform – and to restore a sense of power to Parliamentarians and their electorate over the system. Akin to a Budget debate, Parliament should have the ability to vote on reforms.

Primary legislation should be used as the means of achieving this.

To ensure expert input in changes to qualifying criteria, Ministers should appoint and give direction to a small panel of experts with representation from expert functional assessors and disability medicine (a 'Health Panel') which would be akin to the Joint Committee on Vaccination and Immunisation (JCVI) who would be requested by Ministers to review and to propose amendments to qualifying criteria for health and disability benefits on a regular basis. Ministers would then be able to put these suggestions to Parliament.

Recommendation

The Government should evaluate the criteria and descriptors for health and disability benefits regularly and Parliament should play a more active role in scrutinising and voting upon changes.

a. Primary legislation should be introduced for future reform(s) as a means of returning greater (and more routine) Parliamentary scrutiny and oversight.
b. To ensure expert input in changes to qualifying criteria, Ministers should appoint a 'Health Panel', akin to the Joint Committee on Vaccination and Immunisation (JCVI), who would receive Ministerial instruction(s) to propose changes to qualifying criteria on a regular basis. Based on an advisory opinion from the Panel, Ministers these suggestions should be put to Parliament for a vote.

3. Significant reforms should be introduced to Access to Work (AtW)

During our interviews for this report, we heard – anecdotally – that around two thirds of those in receipt of AtW were employed by a large organisation (those who have 250 employees or more), at either private sector or public sector employers. We also understand that over 90% of claimants to AtW are already in a job when they claim, rather than seeking

a new job or being self-employed.

This is not to suggest that people already in a job are not in need of support, but it does beg the question as to whether AtW is being used to offer disabled people more job opportunities or is being used by employers to offset costs. Civil Servants are not eligible for AtW and one could expand this to the wider public sector. Currently, it appears as if we are 'robbing Peter to pay Paul' where such a significant proportion of the total spend of AtW is being made in the public sector. One also needs to consider whether the complexity of the scheme is making the scheme inaccessible to SMEs. We should refocus the programme to ensure smaller organisations and those truly in most need of support are indeed the target of support.

There are a series of pragmatic measures which should be introduced which can ensure improved affordability of AtW. We are of the view that the DWP should expand cost-sharing agreements with employers by creating a standard rate contribution for all the eligible elements/packages of support. This should be introduced for the 'Support Worker' category as a priority given the current trajectory of spending. The DWP should also create an approved supplier list to ensure more consistent quality for Support Worker(s).

Greater use of medical evidence should also be introduced to determine eligibility for 'Support Worker(s)'. In addition, the DWP should ensure that individuals with 'short-term' conditions (e.g. fractures) are ineligible for this benefit.

AtW currently gives the impression of delivering a specialised service, but it isn't in reality. The scheme ultimately needs to become more specialised, but less individualised. We propose the development of an online 'marketplace of support'. The process would begin with DWP compiling data to understand the types of conditions who claim AtW so there is far greater consistency in the what is reported so we can build a better picture of the types of individuals claiming AtW and the types of support they ultimately receive.

Once a clearer – more forensic – picture is generated of the types of support provided, one would be able to deliver long-term, structural reform.

We propose the creation of a tiered system and digital marketplace where a basic level of support is provided, in line with what the DWP perceives the need of the individual to be. These support packages should be consistently reviewed to make sure they provide the most up-to-date solutions, tailored to people's support needs and to deliver value for money for the taxpayer. If a claimant believes that they need additional support, then they should provide supporting medical evidence – ideally via occupational health – to be eligible to receive additional support.

Given the increasingly long waiting and clearance times for AtW, this reform – whilst seemingly less personalised – could deliver significantly better results for disabled people and refocuses AtW on being an innovative scheme rather than an administrative headache.

Recommendation(s)

Significant reforms should be introduced to Access to Work (AtW) to ensure swifter access to support and to ensure greater financial sustainability.

a. An online 'marketplace of support' should be created by the DWP with the aim of developing 'packages' of tools, specialist aids and equipment, based upon the requirements of existing AtW claimant cohorts. The purpose is to improve overall levels of support and to maximise the advantages of 'bulk buying' target items.
b. The DWP should expand the use of cost sharing agreements (with employers) through an expansion of a standard rate contribution. This should be introduced for the 'Support Worker' category as a priority.
c. Reforms should be introduced to ensure that 'short-term' conditions (e.g. fractures) are ineligible for the benefit.
d. Greater use of medical evidence should be introduced to determine eligibility for the 'Support Worker' category.
e. An approved supplier list should be introduced to ensure improved quality for Support Worker(s)
f. Improved capture and coding of individual and groupings of health conditions should be required – and this should be aligned to the coding of conditions for other health and disability benefits to ensure greater consistency and comparison of demand for support by medical condition.

4. Health Assessors for PIP and the Work Capability Assessment (WCA) should have the ability to signpost and to refer a claimant to other DWP support as part of/during the assessment process (e.g. to Access to Work)

In previous chapters we have discussed the inherent challenge with the binary nature of the current health and disability system – and particularly our current approach to assessments for benefit eligibility. It drives the wrong incentives for claimants, assessors and the state. It is also creates an adversarial nature to the benefit system where one either successfully receives a financial transfer – or is unsuccessful.

We propose that as part of the assessment process in the future, functional assessors – given they are all healthcare professionals – should be given the opportunity and encouraged to signpost claimants to other avenues of suitable support. This is most obviously achieved in the first instance by signposting claimants to other DWP programmes (e.g. Access to Work). However, in the future, a truly holistic assessment system – barring fiscal constraints – would create an ability to signpost and refer

individuals to relevant NHS services, e.g. musculoskeletal hubs, delivered in community settings, or services provided by local authorities or the VCSE sector.

Recommendation(s)

Health Assessors for PIP and the Work Capability Assessment (WCA) should have the ability to signpost and to refer a claimant to other DWP support as part of/during the assessment process (e.g. to Access to Work).

DWP should begin with their own programmes (e.g. Connect to Work, Access to Work), but over time this could be expanded to clinical services, social prescribing programmes etc.

5. Reforms should be made to the assessment process to create a more dynamic approach that fully reflects the changing nature of ill-health & disability.

Given that the criteria for the WCA was designed almost two decades ago and PIP was introduced over a decade ago, our understanding of disability has evolved considerably – as have the reasons for claims. Legal challenges have also meant that the activities and descriptors have morphed over the same time period to no longer resemble their original intention. Politicians meanwhile have suggested that the criteria does not fulfil the original intention of the benefit, so action has been taken to re-define the assessment process.

We believe a number of criteria need to be looked at again, namely 'activity 11' which concerns 'planning a journey'. We also believe that there may be duplication in activities and how they correlate to functional capability. However, we are not health or medical professionals, so are not well-placed to make sweeping assertions about what the 'right' criteria should be. Instead, we have formulated two distinct approaches that one could take:

As part of our work, we considered whether there may have been utility in emulating elements of the role performed by the Joint Committee on Vaccination and Immunisation (JCVI). This would entail the development of an expert panel that the Secretary of State could direct every two years to undertake a review of the assessment criteria to determine whether it remained appropriate – and so they can make recommendations to update them.

There are some benefits we foresee to this approach: namely ensuring expert input into changes. However, we ultimately determined – given the nature and trajectory of spend – that Parliamentary scrutiny of changes should be paramount. Therefore, one should put any changes into primary

legislation so that Parliament can decide what changes ultimately ought to be made.

We are supportive of previous discussion around reforms to the WCA and believe it should be phased out. Moreover, for a small cohort of claimants, measures should be introduced so they never have to undergo assessment and the transition from the Disability Living Allowance (DLA) to PIP should be simplified for those with the most severe conditions. We also think that for those with life-long conditions, the assessment process should be streamlined.

Recommendation(s)

The assessment process, determining eligibility for benefits, should be simplified through the creation of a Single Assessment.

a. As has been suggested by both the Labour Government and the Conservatives (when they were in Government). The Work Capability Assessment should be phased out. In its place, a Single Assessment should be introduced for claimants for all health and disability benefits – ultimately, to reduce waiting times and to embed the joined-up approach advocated in our recommendations above.
b. Through this reform, the DWP should embed an expectation of more regular reassessment for claimants.
c. Transition from the Disability Living Allowance (DLA) to PIP should be simplified for those with the most severe conditions through the provision of evidence provided by a healthcare professional which proves (or suggests) their condition will not change. We also think that for a small group of individuals with severe, or terminal conditions, we should streamline the assessment process and reduce the requirement for further assessments.

6. Medical evidence should be used to support all claims for health and disability benefits – which must be underpinned by more effective information sharing between the DWP, employment support services and NHS organisations.

As the previous Prime Minister, the Rt Rishi Sunak MP indicated, there is a legitimate debate to be had over the subjectivity of assessments at present. We think they should be more closely linked to one's health condition(s). We believe no claim for health and disability benefits should be decided without the provision of suitable medical evidence. However, obtaining medical evidence is not always straight-forward.

As part of a wider packages of reforms in work and health, there is a

need for employment or 'occupational' information to be more routinely and effectively linked with patient health records**.**

DWP should work with the NHS to make better use of medical records and we propose the development of a 'Health Impact Record' which should become mandatory for every claimant of a health-related benefit. .[173]

Developments in France may provide a helpful comparison given they have a measure which bears some resemblance to PIP in the form of its 'PCH' benefit. Unlike the UK however, this benefit is both income-linked and requires a medical certificate as part of the application process. The below case study sets out their approach.

Expanding the use of medical evidence: France - PCH (ePrestation de compensation du handicap)

- PCH is the most equivalent to PIP in that it provides assistance to those whose autonomy is hindered by disability and is not related to work capacity, although like Access to Work the benefit often comes in the form of financed support.
- PCH includes 6 forms of aid, the amount of which is determined according to calculation rules specific to each of them. These forms are: human help, technical assistance, assistance with housing development, transport assistance, specific or exceptional aid, Animal aid. As an example, transport assistance is used to finance the fitting out of a vehicle and the additional costs associated with travelling.[174]
- Whilst PCH is not related to work capability or conditional upon financial means, income does determine the extent of the benefit. it gives access to 100% support to people whose resources are less than or equal to a threshold of €30,398.54, 80% if they are higher than this amount.[175]
- Notably, receipt of PCH requires the claimant to file a medical certificate as part of their application.[176]

173. Economies for Healthier Lives, *Liverpool City Region Combined Authority* [link]
174. Qu'est-ce que la prestation de compensation du handicap (PCH)? [link]
175. Prestation de compensation du handicap (PCH), *Service-Publique.fr* [link]
176. Ibid.

Recommendation(s)

Every claim for health and disability benefits should be backed by medical evidence to support claims. A 'Health Impact Record' should be introduced and should be mandatory for every claimant.

a. Every claimant of a health-related benefit should provide medical evidence to support eligibility of their claim;
b. Improved information sharing between NHS organisations (particularly general practice) and the DWP will be required to achieve this objective.

7. Enhancing the Role and Professional Status of Functional Assessors

Today, there remains a significant challenge in retaining professionals who act as functional assessors. Part of that challenge relates to the challenge of making tough decisions on the level of support people require – which may rub against the caring, therapeutic instinct and training these professionals have had. When the NHS increases pay – via the Agenda for Change pay-banding scheme – this can also disincentive these professionals from working at an assessment provider – or increases the case for their departure.

We need to think differently about how to effectively retain these professionals. Part of the approach should be – as we suggest above – in making the assessment a consultation and enabling professionals to refer or to guide claimants to other forms of support.

There is also something important to be said for raising the prestige and professional status of those undertaking the role also. We suggest that a diploma in functional assessment should be developed by organisations including (but not limited to) the Society of Occupational Medicine – with greater ability for professionals to specialise and to transfer skills to other 'occupational' specialisms such as vocational rehabilitation or disability medicine.

Recommendation

Improving career pathway and qualification for Functional Assessors – to improve recruitment and retention

a. Health benefit reform should be regarded as an opportunity to enhance career progression and professional autonomy for the healthcare professionals who conduct medical and/or functional assessments for Assessment Providers or for the DWP itself.
b. Creation of dedicated diploma and or certification for individuals who meet standard.

8. There is a need for the DWP and Assessment Providers (APs) to boost transparency over the KPIs and outcomes from assessments

The contract(s) that DWP makes with Assessment Providers (APs) are commercially sensitive, and therefore there is limited public awareness or understanding of the underlying key performance indicators or incentives upon which they are based.

For instance, we have heard – anecdotally – that upper limits have been agreed with APs on the number of face-to-face appointments that they must provide, meaning that the vast majority will be delivered remotely. Given our view is that this shift in assessment modality has changed claimant behaviour (due to the nature of the assessment and how it impacts an ability to test criteria), this ought to be subject to far greater scrutiny and to open, public debate.

Recommendation(s)

The DWP should boost transparency over the Key Performance Indicators (KPIs) and outcomes upon which their contracts with Assessment Providers (for benefit assessments) are based.

a. This is to improve public understanding of the requirements upon Assessment Providers – and to reduce incentives in the system which may act against the policy objectives of the benefit.
b. There should – for instance – be quarterly publication by the DWP of outcomes of assessments by modality (e.g. paper-based, face-to-face, video or telephone).

9. More effective, targeted support is required for individuals who have recently fallen out of work due to health conditions or disability where absence is likely to be more than a month – to improve return-to-work rates

The evidence suggests that early intervention is critical to increasing the likelihood of a return to work. Nick Pahl of the Society of Occupational Medicine has reflected that "one third of people are signed off work for four weeks or longer, by which time 20 per cent will never return to work". "Once signed off work for six months, 80 per cent will never return to work."[177] As Policy Exchange has previously found the current use of the fit note in primary care – and ineffective communication and cooperation between employment services, the DWP assessment process and formal healthcare provision impedes this approach.

Mental and behavioural disorders are cited as the reason for a fit note being issued in 37% of cases (where a diagnosis is provided). Of these instances, 41% are 'signed-off' for between one and three months. In 75% of cases, individuals are signed from two weeks to three months with just 15% from between one and fourteen days.[178] Fig. 36 below demonstrates this, based on an analysis of the use of fit notes between 2021-2023.

As we have argued, the 'fit note' in its current form remains uniform and analogue, but needs to become a more dynamic, digital tool to capture a complex range of needs: those with multiple or long-term conditions that will need recurrent support with periods in and out of full-time work; the young who are at risk of falling out of employment and education but where more proactive intervention is needed.

We are of the view that a 'Rapid Response Model' should be developed across NHS GP services – as part of a new core 'neighbourhood health' offer, which would be set out in further detail in the 10 Year Health Plan.

The Rapid Response Model should be developed, and predicated on evaluations and learnings from recent research into primary care services which have trialled linking healthcare and vocational support. The work of Dr Shriti Pattani and colleagues and the findings of the Work and Vocational advice (WAVE) project would be instructive.[179]

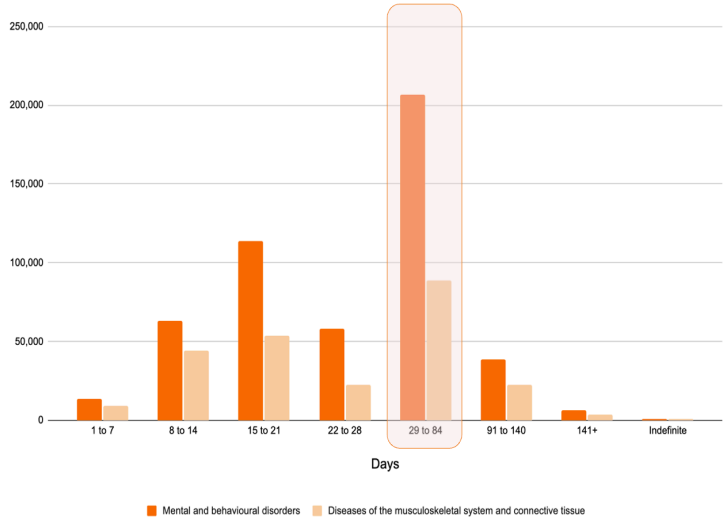
The model should identify and target individuals of working-age who have recently fallen ill and/or dropped out of employment (when they have been absent for more than 28 days, are in receipt of a fit note which is longer than 14 days in length or when an individual first make contact with DWP to begin a claim) individuals should be 'flagged' for 'further assessment' and offered wrap-around support.

177. Y. Cholteeva, 'Doctors may be told to sign fewer people off work – what would that mean for HR?', *People Management*, 16 February 2023, [link]

178. S. Phillips & S. Carroll, Not Fit for Purpose: An Appraisal of the 'Fit Note' and Assessments of Fitness for Work, *Policy Exchange*, 13 April 2024, [link]

179. S. Pattani, M. Line El Asmar et al., 'Embedding work coaches in GP practices: Findings from an interview-based study in the UK', *Public Health in Practice*, Vol. 8 (December 2024) [link]; S. Pattani, K. Varghese, L. Shemtob, A. El-Osta, 'Back-to-work initiatives in primary care: lessons for the future of work and health', *British Journal of Healthcare Management*, Vol. 30, No. 12 [link]; 'Work And Vocational advicE (WAVE) in primary care: a randomised controlled trial [link]

Figure 36 – Duration of fit notes for diagnoses of mental and behavioural disorders and diseases of the musculoskeletal system, England, April 2021 to September 2023



Source: Fit Notes Issued by GP Practices, England, September 2023, NHS Digital [link]

Reforms to the 'fit note' that Policy Exchange has recently proposed, include adding options for healthcare professionals to refer individuals for 'further' and 'ongoing' assessment:

Move to a 'cohort-based' approach. Healthcare professionals should be able to encourage incentivise onward referral for more detailed assessment – particularly from occupational health professionals, but also those able to offer vocational support .

FURTHER ASSESSMENT	ONGOING ASSESSMENT
Options should be added to the current 'fit note' to enable healthcare professionals to "Recommend further assessment from an occupational health professional"	Should be introduced for those with long-term or chronic conditions where more routine appraisal of fitness to work would be required.

Recommendation(s)

A Rapid Response Model should be developed which is targeted at individuals of working-age who have recently fallen ill and dropped out of employment, or have been absent for more than 28 days.

- Every individual who is 'in work' and issued with a 'fit note' or who is likely to be absent for longer than 28 days, for reasons other than short-term illness, fractures or terminal conditions, should be 'flagged' for further assessment and offered wrap-around support.

10. Improvements should be made to the official recording and publication of data relating to unemployment owing to ill-health or due to a health condition

There is a need to improve the quality and granularity of information with which to inform the public policy debate on the link between health, disability and employment. There would be advantages to the DWP creating a data collection method in which the *reasons* and circumstances for moving in or out of employment are understood.

Moreover, there remains a need to ensure that data collected by the DWP provides greater precision relating to the burden of ill-health amongst those in receipt of disability and incapacity benefits. Currently it is of limited use to quantify the proportion of benefit claimants with objective evidence of clinically significant disease.

Recommendation

Individuals who are unemployed owing to ill-health or due to a health condition should be counted in official unemployment figures produced by the Office for National Statistics.

Conclusion

> *"We need to find ways of making the welfare state fit for the 21st century. It needs to be made more relevant, more flexible, more transparent, and more cost effective. Only after this is achieved will public trust be restored in the way benefits are managed and paid."*[180]

This was the case made by Policy Exchange over a decade ago. But the case to address these fundamental issues are more pressing today than ever before.

The projected expenditure on health and disability benefits over the coming decade is significant – and unsustainable. Both the number of individuals claiming, the grounds upon which claims are made, and overall size of the bill runs the risk of further eroding the public's trust in the welfare system. That trust needs to be restored as a matter of urgency by the Government.

This report has set out a series of radical, evolutionary reforms to our health and disability benefits system. Rather than a focus upon reforms which base their success on the amount trimmed from our demand-led health and disability benefit spending, we have instead made the case that the Government – and society at large – must take the opportunity to change how we view ill-health and disability from what an individual can't do to what they can.

We have sought to encourage greater engagement amongst those under 30 through reforms to PIP, whilst also seeking to improve the objectivity of assessments by ensuring that medical evidence is used to support all claims. To ensure discussion on benefit reform remains an ongoing conversation amongst politicians and the public, we envisage Parliament playing a greater role in scrutinising and voting upon welfare reforms in the years to come.

Ultimately, we require a new social contract which sets out to incentivise and enable people with health conditions and disabilities so that they can pursue their individual aspirations and contribute to the wealth of the nation – safe in the knowledge that they will be protected by a safety net made constant and dependable by its affordability.

180.S. Hughes, 'It is time for more radical ideas to make welfare fit for purpose', *Policy Exchange*, 17 October 2014 [link]

Appendix

Figure 37 – A History of Welfare Reforms relating to Health and Disability Benefits since the publication of the 'Beveridge Report'

Year	Policy Development
1942	**'Social Insurance and Allied Services', or Beveridge Report** sets out proposals for a comprehensive programme of social reform "from the cradle to the grave". Calls for a universal flat-rate, low value benefit payable to all, on the basis of fixed national insurance contributions
1948	**The National Insurance medical certificate, or 'sick note' introduced**
1971	**Introduction of Invalidity Benefit** and reform to benefit rate structure[181]
1992	**Disability Living Allowance (DLA)** introduced
1994	**Access to Work** launched Providing financial support for the extra costs of being in work which go beyond "reasonable adjustments" in law.
1995	**Incapacity Benefit (IB)** introduced, replacing Invalidity Benefit and Sickness Benefit as the main income-replacement benefit for ill or disabled people. It is a contributory benefit, that is, you have to have made sufficient National Insurance (NI) contributions to receive it. Those who are ill or disabled but with insufficient NI contributions for IB can claim Income Support with a disability premium.[182] **Disability Discrimination Act (DDA) passed**. Provisions in the Act give protection for disabled people in employment, education and in access to goods, facilities and services. This means employers cannot discriminate against employees or potential employees on grounds of disability and are required to make reasonable adjustments to the workplace.[183]
1996	**Jobseeker's Allowance** Unemployed people required to actively seek work, sign a jobseeker's agreement, and attend fortnightly interviews. New power to sanction claimants for 2 weeks and subsequently 4 weeks for any further offences.

181. J. Banks, R. Blundell & C. Emmerson, 'Disability benefit receipt and reform: reconciling trends in the United Kingdom', *Institute for Fiscal Studies*, March 2015, p.2, [link]
182. Work and Pensions - Third Report, *Work & Pensions Committee*, 26 April 2006, [link]
183. Ibid.

1998	**'New Deals' Launched, including the New Deal for Young People** Introduces fixed, but escalating, sanctions for participants who fail to attend regular interviews or take part in one of four mandatory programmes. **The New Deal for Disabled People Personal Adviser Service pilot also** launched to run for two years. Personal Adviser Service aims both to assist disabled people and those with a longstanding illness who want to work to do so, and to help those who are already in work to retain their employment. It also seeks to promote the abilities of disabled people and to extend the range of services available to them.
1999	**The Disability Rights Commission (DRC) established**
2000	**The All-Work Test replaced by the Personal Capability Assessment** assesses a person's ability to do any work, and is applied after 28 weeks of incapacity, for purposes of deciding entitlement to incapacity benefits. The test looks at ability to carry out a range of activities such as walking, standing and sitting, and includes an assessment of mental health where appropriate.[184]
2001	**New Deal for 25 Plus** (formerly New Deal for the Long-term Unemployed) strengthened: participants up to the age of 49 must start a more intensive regime of help and support 22 months into a claim.
2003	**Pathways to Work introduced** In pilot areas, all those making claims for incapacity benefit obliged to attend a work-focused interview (WFI), with a further five mandatory interviews at roughly monthly intervals. WFIs can be deferred or waived by a personal adviser, otherwise a benefit sanction may be imposed for a failure to attend. Other measures in pilots include: early support from personal advisers; a package of interventions offering access to specialist programmes; the 'Return to Work credit', worth £40 per week for up to 52 weeks; and in-work support.
2005	**DWP Five Year Strategy** Announces "long-term aspiration of moving towards an employment rate equivalent to 80% of the working-age population". Also aims to reduce the number of people claiming incapacity benefits by one million.

184.A. Corden & R. Sainsbury, 'Incapacity Benefits and Work Incentives, *Department for Work & Pensions*, 2001, [link]

2007	**David Freud publishes *Reducing dependency, increasing opportunity: options for the future of welfare to work*** Calls for the greater use of private sector companies who would be paid by results, for substantial resources to be made available to help lone parents and people on Incapacity Benefit back into work, and for a single working-age benefit payment to replace Housing Benefit, Jobseekers Allowance, etc
2008	**Employment Support Allowance (ESA)** introduced, replacing Incapacity Benefit
2009	**Welfare Reform Act** passed[185]
2010	**The Equality Act** introduced, prohibiting both direct and indirect disability discrimination in employment and recruitment. Also states employers must make reasonable adjustments to support disabled job applicants and employees. **The Statement of Fitness for Work (or 'Fit Note', Med3 form) introduced** across England, Wales and Scotland replacing the previous medical statement which had been largely unchanged for forty years. ***Universal Credit: Welfare That Works* published**. Brings jobseeker's allowance, child tax credit, income support, employment and support allowance, and housing benefit all under one umbrella of 'Universal Credit'
2012	**Welfare Reform Act** legislates for the introduction of Universal Credit and the Personal Independence Payment
2013	**Personal Independence Payment (PIP)** replaces the Disability Living Allowance (DLA) for people of working age. Like the DLA, PIP is non-means-tested and is intended to help with the extra costs arising from ill health or disability. It has two components: a 'mobility' component, based on an individual's ability to get around; and a 'daily living' component, based on ability to carry out various day to day activities. **Disability Confident Campaign** launched by the Prime Minister, aiming to encourage employers to become more confident in employing disabled people, by removing barriers and increase understanding.
2014	**Dr Paul Litchfield publishes An Independent Review of the Work Capability Assessment – year five**[186]
2016	**Welfare Reform and Work Act**

185. Welfare Reform Act 2009, [link]

186. P. Litchfield, 'An Independent Review of the Work Capability Assessment – year five', *Department for Work & Pensions*, November 2014, [link]

2017	***Improving lives: the future of work, health and disability* white paper published** **Personal Support Package** launches offering tailored employment support for people with disabilities and health conditions, delivered through Jobcentre Plus. Includes Disability Employment Advisers **Work and Health Programme** launched: an employment support programme which was launched in North West England and Wales in November 2017. The programme rolled out across the rest of England during early 2018 **DWP introduces regulations to reverse the effect of two Upper Tribunal judgments relating to the PIP eligibility criteria** – The most significant change made by the regulations was to tighten the rules on access to the mobility component for people unable to undertake journeys due to "overwhelming psychological distress." This would potentially affect people with a wide range of conditions including learning disability.[187] **Intensive Personalised Employment Support Programme Introduced** – intended to provide "highly personalised packages" of employment support for disabled people who are at least a year away from moving into work. The Government has reported that this will roll out by the end of 2019. 39 The Department for Work and Pensions worked with nine local authorities on a Proof of Concept for a Local Supported Employment scheme. This will support people with a learning difficulty or autism. The Proof of Concept ran until May 2019, and it is not yet apparent whether there will be a full trial of this scheme
2019	**Health Transformation Programme (HTP) launched**. Integrates services that deliver Personal Independence Payment (PIP) and Work Capability Assessments (WCA) "to make the assessment process simpler, more user-friendly, easier to navigate and more joined-up for claimants, whilst delivering better value for money for taxpayers".

187.S. Kennedy, Changes to the Personal Independence Payment eligibility criteria, Research Briefing, *House of Commons*, 17 April 2018, [link]

2023	***Transforming Support*: The Health and Disability White Paper published.**[188] Includes updates on improvements to accessibility and efficiency, and a more radical proposal to scrap the Work Capability Assessment (WCA) and introduce a new health component to UC linked to receipt of PIP. **At Autumn Statement, reforms to three Work Capability Assessment (WCA) descriptors announced**: • Removal of the Mobilising activity used to assess limited capability for work and work-related activity (LCWRA). • Realignment of LCWRA Substantial Risk rules with the original policy intent of only applying in exceptional circumstances. • Reduction in points for some of the descriptors under the Getting About activity used to assess limited capability for work (LCW).
2024	**April** – DWP publishes open consultation on proposed changes to various aspects of The Personal Independence Payment Scheme (PIP). ***June – Modernising Support for Independent Living Green Paper published***[189] **September - Health Assessment Advisory Service established**[190]: • Integrates services that deliver Personal Independence Payment (PIP) and Work Capability Assessments (WCA) **November – *Get Britain Working* White Paper published.**[191]
2025	**Spring**- anticipated publication of a green paper on health and disability benefits. **A 'Charter for Budget Responsibility'** proposed to establish a welfare cap for the course of the Parliament. **DWP to publish an annual report on welfare spending.**[192]

188. 'Transforming Support: The Health and Disability White Paper', *Department for Work & Pensions*, Updated 16 March 2023, [link]
189. 'Modernising support for independent living: the health and disability green paper', *Department for Work & Pensions*, Updated 13 June 2024, [link]
190. 'Health assessments for benefits', *House of Commons Work and Pensions Committee*, 14 April 2023, [link]
191. 'Get Britain Working', *HM Government*, November 2024, [link]
192. Response to Welfare Cap Breach, Statement UIN HCWS398, 29 January 2025, [link]

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