BLACKBURN AND DISTRICT TRADES UNION COUNCIL

Response to consultation on "Pathways to Work: Reforming Benefits and Support to Get Britain Working Green Paper"

Blackburn and District Trades Union Council is a local Trade Union body, registered with the Trades Union Congress, comprising delegates from Trade Unions with members working or living in the Boroughs of Blackburn with Darwen and the Ribble Valley.

Our area of responsibility overlaps, in whole or in part, the Parliamentary constituencies of Blackburn, Rossendale and Darwen, Ribble Valley, and Clitheroe and Pendle.

We want to respond to this Green Paper because we have an interest in supporting high standards in public welfare and social justice, issues that can directly affect the quality of workers' lives. We also do not subscribe to the point of view that there are workers on one side, and claimants on the other. As John Hills argued in **"Good Times, Bad Times"**, we all lead lives that can take unpredicted turns and few of us have a level of resource that makes us confident we shall never need the support of the social security system - whether out of work or not. What that support should be we measure by how we would hope to be treated ourselves under the same circumstances.

We note that some organisations have been critical of the scope of this consultation, and we agree that it is difficult to do the issues raised justice by sticking precisely to the questions posed. We therefore propose to deal with the matters raised in the round.

The Green Paper says that *"Our starting point is simple: no one should be consigned to a life on benefits just because they have a health condition or a disability"*. This is a principle with which we agree.

It is, however, not the real premise on which the Green Paper is based. That is a quite different proposition - namely, that it is somehow the "fault" of the social security system that people need to claim benefits; that the system is *"broken"* and that it *"it snares millions of people in a cycle of unemployment and inactivity"*.

There is, of course, a sort of inevitable truth in the idea that if conditions of entitlement are made more stringent, then the numbers of claimants will drop. It is hard not to believe that the Green Paper is little more than an attempt to dress up this fact, and that what it is really saying is that statistically significant numbers of people don't really "need" their benefits. It claims, nevertheless, that something a little different is possible - that change can reduce the numbers of those entitled without causing harm to anyone. Indeed - the "victims" will be better off and the state, to boot, will save money. The point of view appears to be that if initiating problems, when filtered through an individuals', beliefs, coping strategies, cultural perspectives, and social context, can be experienced as magnified, or amplified and transformed into "illness behaviour, then a withdrawal of "negative reinforcements"- such as benefit support and release from duties - will have positive outcomes.

But really? This strikes us as an implausible panacea - essentially yet another re-hash of the "biopsychosocial" model that has been ingrained in official thinking since the 1990s. Tom Clark commented in **"Prospect"** (19.03.25): *"As someone who worked in the DWP 20-odd years ago when it produced incapacity benefit reforms called Pathways to Work, things got particularly dream-like when it transpired that this was also the name of the new reform paper. Many of the buzz-phrases were the same too: about transcending a "binary divide" between those who can and can't work; about switching focus from what people can't to what they can do"*. And one of the problems we face is that this idea has already been seen to go "wrong" too many times.

Julia Modern, senior Policy and Campaigns Manager at disabled people's organisation **"Inclusion London"** was quoted in the **"Big Issue" (**17.04.25) as saying: *"We are deeply disappointed that this Labour government is repeating past mistakes, proposing exactly the kind of 'reforms' that previously caused deprivation and despair in the disabled community while failing to save the government money because of knock-on effects on health and social care budgets. Taking money away from disabled people does not mean our needs will go away".*

The “biopsychosocial model” flirts with the idea that really there are a lot of claimants essentially taking advantage, and there is a long history also of Ministers willing to try and capitalise on public concern in this respect - from Peter Lilley and George Osborne to the current incumbent. Do we believe that there are no "freeloaders"? Of course not, and of course there are. Freeloaders are an issue for every social system. The issues in respect of them, though, should be those of whether and how they can be identified and addressed as individuals. We should be resolved ***not*** to allow their existence to contaminate and undermine our social protections, which, as we say, should be modelled on how we would wish to be treated ourselves under the same circumstances - not on grounds of suspicion and denigration.

Like many bad ideas the "biopsychosocial" mode manages to convince acolytes that it is never wrong. It has just been badly implemented. We consequently face the bizarre spectacle of the Green Paper making criticisms of a "system" already built upon the "biopsychological" model - in order to present a new variation of it.

Unfortunately, the Green Paper descends to a degree of distortion and tendentiousness in doing this.

It claims that *"the system is built around a fixed “can-versus-can’t work” divide which does not reflect the variety of jobs, the reality of fluctuating health conditions, or the potential for people to expand what they can do, with the right support"*, and it says *"once judged as not able to work, most are abandoned – with no contact, no expectations, and no support to help move closer to work"*.

This is simply incorrect.

A person now claiming Universal Credit on grounds of incapacity (which covers both health and disability) does not face a "binary" outcome if they are assessed by a Work Capability Assessment (WCA).

They are given a decision afterwards that says if they:

- are fit for work (also known as ‘capable for work’),

- have limited capability for work (LCW), but need to prepare to work in the future, or
- have limited capability for work and also for any work-related activity (LCWRA).

This mirrors the long-standing ESA practice of dividing claimants between the "Work Related Activity" group and the "Support" group.

Alongside this, there is nothing in the design of the system - though there may be resource constraints - to prevent people in the "Support" or "LCWRA" groups from seeking Work Coach support. We understand that all Jobcentres, for instance, are still supposed to have a Disability Employment Advisor.

The Green Paper claims that the system *"pushes people towards economic inactivity due to the stark and binary divide between benefits rates and conditionality rules for jobseekers compared to those on the health element of Universal Credit"*.

But those in the "limited capability for work" UC group already do not get the "health element", and they do face a degree of conditionality.

It is true that incapacity benefits have generally paid more than unemployment benefits - but it has been accepted that those with long-term incapacity are less likely to build up reserves at the same time as they may face additional costs (say, in respect of heating).

NIESR analysis in 2022 found that 1.5 million households were spending more on food and energy than they had in income (Bhattacharjee et al, **"Outlook for UK Households, the Devolved Nations and the English Regions,"** National Institute UK Economic Outlook, National Institute of Economic and Social Research, issue 7, pages 31-60). While this was a temporary situation for many households, as many accessed welfare support after losing a job, and therefore use accrued savings to withstand a negative budget, many – such as the long-term sick – exhausted their financial reserves within a few years of the cost-of-living crisis (Mosley, **"Box C: Household savings amid the cost-of-living crisis"**

National Institute UK Economic Outlook, National Institute of Economic and Social Research, issue 7, pages 34-36).

The Joseph Rowntree Foundation's Report **"Unlocking benefits: Tackling barriers for disabled people wanting to work"** comments: *"It is worth briefly discussing the underlying rationale for extra health-related financial support within the income-replacement benefit safety net, which disabled people in our research tapped into. That is, whereas people might be able to survive for short periods – say, a brief spell of unemployment – on very basic subsistence-level benefits, people will need a higher level of income if they are likely to be without any earnings for longer periods. The higher rate of State Pension that has developed compared to unemployment benefit has a similar rationale. Disabled people face health-related challenges that translate into a higher likelihood of needing income support above what is needed to afford basic essentials for short periods (and it should be remembered that the basic rate of UC is even currently well below this low bar)"*.

The sick and disabled have never had ***that much more***. It is a bit of a stretch to jump to the conclusion that people claiming incapacity benefits are being incentivised into idleness. The observed reality, to the contrary, is that they are more likely to be in poverty.

The UN Committee on the Rights of Persons with Disabilities March 24 **"Report on follow-up to the inquiry concerning the United Kingdom of Great Britain and Northern Ireland"**, for instance, noted: *"Several sources informed the Committee that disabled people are among the groups most severely affected by these economic challenges as they are already more likely to live in poverty, with a disposable income that is approximately 44% lower than that of other working age adults, exposing them perilously to the rising cost of essentials. A notable 41% reported they could not afford to keep their homes warm in winter 2022, and one in ten have fallen into debt due to the crisis*". It also pointed out that *"deep poverty is more common among disabled people, particularly those living alone, who cannot share costs and are twice as likely to live in deep poverty compared to single persons without disabilities. Additionally, disabled people constitute most food bank users in the UK, with recent research indicating that 69% of working-age people using food banks are disabled people, highlighting a stark contrast to the 23% prevalence in the general population*".

The House of Commons Work and Pensions Committee Report **"Benefit levels in the UK"** found (para 48): *"When considering PIP itself, we heard that many* *claimants experienced a significant shortfall between the levels of support provided and the cost of additional health and disability related costs. Scope's Disability Price Tag 2023: the extra cost of disability report found that households which included at least one disabled adult or child faced additional costs on average of £975 per month, even after accounting for PIP (or £1,122 per month when updating the figure to reflect inflation over 2022–23)102. Macmillan Cancer Support estimated that 83% of people with cancer experience a financial impact from their diagnosis, averaging an additional £891 a month. For the 39% most severely affected by cancer, they were estimated to be on average £1,038 worse off a month following their diagnosis"*. In Para 93 they commented *"the New Economics Foundation used MIS (Minimum Income Standard) as a comparable baseline to assess benefit levels in their written evidence and estimated that in 2021 PIP 'covered only 36% of the additional income a disabled person required to afford a decent standard of living'"*.

In November 2023 Daniel Jennings, Epilepsy Action's senior policy and campaigns manager, said: *"Last autumn, almost 3 in 5 people with epilepsy were worried about being able to afford their bills, including the cost of running equipment such as vital seizure alarms and monitors, and 2 in 5 were experiencing more seizures due to stress about managing rising costs"*.

The Trussell Trust reported in March this year that *"more than three quarters (77%) of people claiming Universal Credit and disability benefits have gone without essentials in the last six months"* and *"just over four in ten (43%) people claiming Universal Credit and disability benefit have skipped meals to keep up with other essential costs in the last three months*". *"A quarter (25%) of people claiming Universal Credit and disability benefits have been unable to afford pain relief or other over the counter medication in the last three months. Four in ten (37%) participants were behind on bills, with 28% behind on gas or electricity in particular".*

The Green Paper suggests that claimants seek out incapacity benefits because in that way they "escape" the harsh conditionality regime attached to unemployment benefits: *"Another possibility [for rising health-related benefits] is job search conditionality…[whereby]…if the conditionality regime becomes more demanding, that increases the incentive to apply for incapacity benefits".*

If that is the case, it is easily solved. Get rid of the current conditionality regime for unemployment benefits, which is malign and produces perverse outcomes just within its own sphere of operation. We are implacably opposed to the way that conditionality and sanctions are deployed and aghast at the implication that Ministers simply want to deploy the lash against even greater numbers of people.

The Green Paper does not advance any actual evidence to substantiate the premise on which it is built, arbitrarily dismissing the plausible alternatives - that people are out of work on grounds of ill-health mainly because of their capacity and partly also because of the demands being made on workers by contemporary employment practices in Britain.

Kayleigh Garthwaite, whose research, published under the title **"Fear of the Brown Envelope"**, involved in-depth interviews with 25 long-term sickness benefit recipients, noted in it that *"evidence from the DWP (2011a) suggests that fraud levels are, in fact, very low. The latest available figures from the DWP state that the fraud rate for sickness benefits is just 0.5 per cent, meaning that 99.5 per cent of claimants are not fraudulent, with figures for official error actually higher than the level of fraud at 1.7 per cent. By focusing on this issue as if it were one of the most important features of the system is completely unbalanced and thus manufactures an entirely flawed impression of sick and disabled people receiving benefits". She subsequently commented in an LSE Blog, "What does it mean for sickness benefit claimants to live in a climate of suspicion?" that: "for the people I spoke to, I must wholeheartedly disagree that people are not genuinely sick or disabled. The people I spoke to had multiple health problems that they negotiated every single day"*.

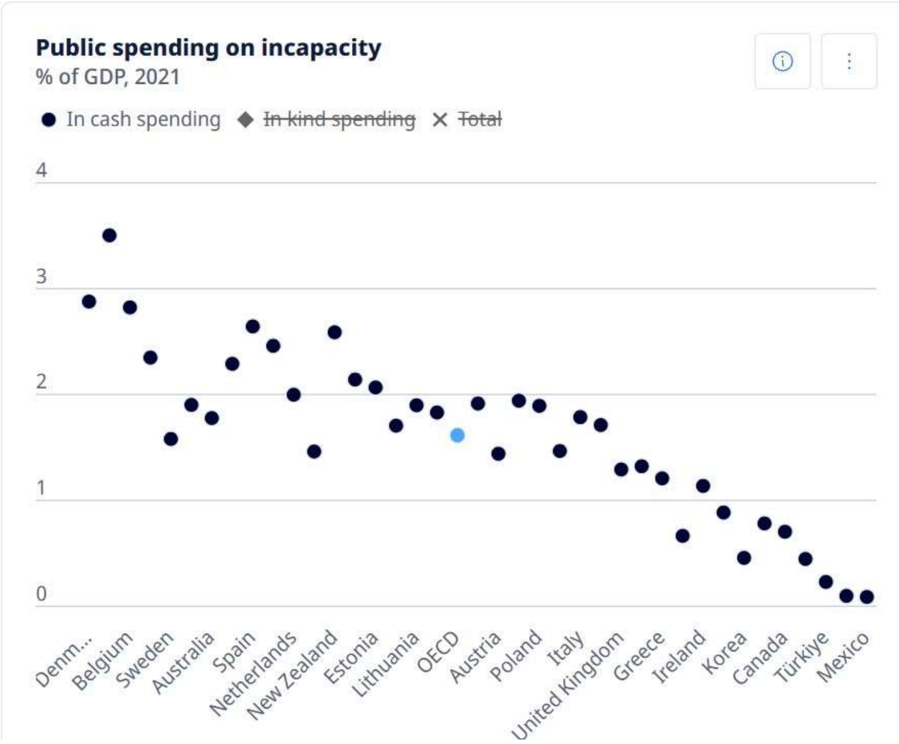
The DWP Study on **"Experiences of PIP applicants who received zero points at assessment**", published in October 2024, accepted that the participants they interviewed applied for PIP did so *"because they had a health condition or disability that impacted their daily life, and they needed extra money to support themselves"*. They also found that *"learning about PIP typically came through others"* - whether that be friends, clinicians, Citizen’s Advice or Jobcentre Plus. They reported both being encouraged to apply and being told *"how difficult PIP would be to qualify for"* - hardly symptoms of a system behaving in the way the Green Paper describes. There was also a suggestion that the complexity of the application form was a deterrent, rather than an incentive: *"The size of the form* *and the number of questions to be completed were reported as being daunting for some of the participants. For some, this could lead to putting the form to one side and not starting to complete it until they received a prompt from DWP"*.

The credibility of the Green Paper's central argument is further undermined by the introduction of "affordability" into the equation. - *"We simply can't justify spending this much"* and *"the share of GDP spent on disability and incapacity benefits has risen from 1.1% in 2007/2008 to 1.8% in 2024/2025".*

So, it ***is*** just all about the money, is it?

Certainly, if one is not convinced by the proposition that the benefits system is somehow to blame for the number of claimants then the introduction of a cost consideration makes that approach seem little more than a pretext or attempt to justify spending cuts.

We accept that there are difficulties in comparing welfare spending between countries, but the OECD figures for public spending on incapacity in cash as a % of GDP (2021) show that it was less in the UK than in many other countries:



In July 2023, the OBR Reported (“**International comparisons of health-related welfare spending and generosity”**) that: *"the UK’s spending on incapacity-related benefits (1.3 percent of GDP) was slightly below the OECD average (1.6 per cent of GDP), by a margin that has remained broadly consistent since 2010 (when these figures were 1.5 and 1.7 per cent of GDP, respectively)"*.

More immediately, there has been something specific happening in the UK, in that it has shown a post-pandemic spurt in incapacity claims that appears to be unlike most other places. But the context would suggest that this cannot be put down to our sickness benefit system being unusually generous and, as Latimer et al say in their IFS Paper **"Health-related benefit claims post-pandemic: UK trends and global context"**: *"Even if health-related benefits grow as fast as official forecasts suggest, the UK’s 2028 health-related benefit spending would still be similar to the 2019 levels for comparable countries such as the Netherlands or New Zealand"*.

We are, moreover, not going to accept that a country with the 11th highest ratio of dollar millionaires per capita, where an estimated 2.1 million households reported owning at least one second property in 2021-22, and where it was estimated in 2024 that the luxury goods market was worth £81bn a year ("Walpole" Report: **"Luxury in the Making")** can no longer afford to care for its sick and disabled.

As we note above, there have undoubtedly been recent changes that are a legitimate cause for concern, especially as they seem to be very much indicative of the "health", in its broadest terms, of British society.

Where there have been such changes, however, it seems counter-intuitive to identify as the cause an element - the benefit system - which has ***not significantly changed***, in respect of allowance of incapacity benefits, rather than to seek to Identify potential influences which show more obvious signs of potential agency.

The Chair of the House of Lords Economic Affairs Committee has said *that "Given we received no convincing evidence that the main driver of the rise in these benefits is deteriorating health or high NHS waiting lists, the Government should* *instead focus on the benefit system itself..."*. But this amounts to ignoring a symptom because it does not fit the preferred diagnosis.

The Resolution Foundation Briefing **"Under strain |Investigating trends in working-age disability and incapacity benefits"** noted that (p18) *"..if the receipt rate (i.e. the likelihood that anyone receives a working age disability benefit) had remained unchanged since 2013, then population change plus the rising incidence of self-reported disability alone would have pushed up the caseload by an additional 933,000, more than four-fifths (87 per cent) of the actual increase of 1.07 million"*.

The" New Economics Foundation", **"What's behind the rise in disability benefit claims?"** (06.05.25) make the plausible suggestion that some of the increase can be accounted for by the impact of worsening overall hardship, and that people who have lived with an ailment without making any claim have now done so in the face of intensified cost of living pressures. Just as we know is the case with other benefits, like Pension Credit, there can be a gap between the numbers eligible and those who actually claim: *"not all disabled people who may be eligible for PIP are claiming, which in turn suggests that other factors are mediating whether people apply beyond just the severity and impact of their disabilities"*. One of our delegates gave an example of this from personal experience: *"Someone I know well (a factory worker) has been significantly disabled by a medical condition for around 16 years, but claimed nothing, until they eventually applied for PIP about 2 years ago".*

But the "New Economics Foundation" also acknowledges *"rising rates of disability"* and this is widely reflected in other work.

Britain sets off with a disadvantage insofar as there appears to be a correlation between the levels of inequality in an industrial society and its overall wellbeing. – and we are a comparatively unequal country. According to the **Inequality.org website**, *"high levels of inequality, the epidemiological research shows, negatively affect the health of even the affluent, mainly because, researchers contend, inequality reduces social cohesion, a dynamic that leads to more stress, fear, and insecurity for everyone"*. *"Extreme inequality appears to affect how people perceive their well-being. In nations where the top 1 percent hold a greater share of national income, people tend to have a lower sense of personal well-being, according to University of Oxford Saïd Business School research. Researchers are also finding links between inequality and mental health. Countries with larger rich-poor gaps have a higher risk of schizophrenia* *incidences. In general, a 0.2 point increase in a country's Gini coefficient results in eight additional incidences of schizophrenia per 100,000 people. Researchers believe that higher inequality undercuts social cohesion and capital and increases chronic stress"*.

Several recent studies have tried to pin-point, in addition to this, the specific combination of circumstances now affecting the health of the British workforce. What is least suspicious as a cause is what the Green Paper grasps at.

In his 2022 piece for the **"Financial Times", "Chronic illness makes UK workforce the sickest in developed world"**, John Burn-Murdoch argued that the main reason why the British workforce did not "bounce back" after COVID actually was the overall state of our health, and our health services: *"With direct impacts of Covid ruled out, the most plausible remaining explanation is grim: we may be witnessing the collapse of the NHS, as hundreds of thousands of patients, unable to access timely care, see their condition worsen to the point of being unable to work. The 332,000 people who have been waiting more than a year for hospital treatment in Britain is a close numerical match for the 309,000 now missing from the labour force due to long-term sickness"*.

Thomas et al) **"Healthy people, prosperous lives: The first interim report of the IPPR Commission on Health and Prosperity"**, IPPR (2023) said that *"While it might be tempting to think that Covid-19 must be behind the UK's current population health challenges, a wider view of the evidence suggests that the UK was on a trajectory towards becoming a sicker nation a long time before Covid-19 emerged"*. They identified a turning point around 2011 in respect of deaths from all causes and disability-adjusted years of life lost to disease.

Lucinda Hiam and Michael Marmot, **"Is Britain sicker than a decade ago?"** ("Prospect" 17/01/24) argue that life expectancy and infant mortality rates point to an ailing population: *"Britain is objectively sicker than it was a decade ago: people are dying earlier than had been anticipated, as previous rates of improvement have not continued, and more babies are dying in their first year of life than three years ago. The deterioration in these measures cannot be consistent with implications of patients malingering or doctors signing too many sick notes. These figures are appalling, but perhaps not unexpected in a country where nine million adults (17 per cent of households) are experiencing food insecurity, and the number of children of living in destitution has more than doubled since 2017. It is therefore unsurprising that 75 per cent of adults think the UK is in a worse state in 2024 than it was in 2010"*. *"More people are being* *signed off sick because today's Britain is a sick society. It is sick due to consistent, relentless underfunding—not only of the NHS itself, but to social care, public health, and other areas of society that can support people to be healthy.."*.

The **Government Actuary's Department** has reported that: *"According to the most recent data from the ONS male healthy life expectancy (HLE) at birth in England for the period 2021 to 2023 is estimated to be 61.5 years. Similar to trends in life expectancy, HLE is higher for females at 61.9 years in England for the same period. HLE in England remained relatively stable between the 2011 to 2013 data, and the 2017 to 2019 data. Since this pre-coronavirus pandemic period, HLE at birth has fallen in England by 1.7 years for males and 1.9 years for females"*. This is a further sign of worsening population health. It also means there is a widening gap between HLE and the state retirement age. The "Pathways to Work" interim evidence base says that of the increased caseload on the higher rates of UC health and ESA between May 2018 and May 2024, almost 10% was because of changes to state pension age (96,000 out of 1m).

Latimer et al, **"The role of changing health in rising health-related benefit claims**" (2025) are less certain about the population background, but still notice that *"The Labour Force Survey (LFS) and Family Resources Survey (FRS) – both of which capture the rise in health-related benefit claims –show significant growth in the number of people reporting long-term health conditions since 2019 – from 28% to 32% in the FRS and from 31% to 36% in the LFS"*.

In another IFS Report, **"Health-related benefit claims post-pandemic: UK trends and global context",** it is pointed out that: *"The shift towards mental health conditions mirrors the wider shift in population health. Of people with disabilities, 38% reported a mental health problem (including learning disabilities) in 2014, 45% in 2019 and 52% in 2023.12 In Autumn 2022, 16% of adults had moderate to severe depressive symptoms up from 10% in 2019–20 (Office for National Statistics, 2022). We should interpret these figures with some caution as it is difficult to isolate changes in mental health from changes in norms about reporting mental health problems, but they do indicate worsening mental health across the population"*.

Dr Lade Smith CBE, President of the Royal College of Psychiatrists, said in a public statement on 17th March 2025 that: *"The significant rise in the number of people being diagnosed with a mental illness in recent years has been driven by real issues that affect us all, such as increases in poverty, housing and food insecurity,* *as well as loneliness and isolation. This crisis is having a substantial impact on people's lives, the health service and the economy*".

it is probably worth asking if there are knock-on effects specifically from the condition of community mental health services. The Care Quality Commission has reported that *"people's experiences of NHS mental health services provided in the community are poor"*: "**Community mental health survey 2023"**.

The Royal College of Emergency Medicine's **"Best Practice Guideline – Frequent Attendance in the Emergency Department"** has noted how unmet mental health need washes up on the shore of A&E Departments: *"The number of patients frequently attending EDs as a result of unmet health and care needs, or with underlying vulnerabilities is rising*".

Last year's Report for the Commission for Healthier Working Lives, **"Exploring the interactions between job quality, industries and health"**, found that British workplaces rank among the worst in Europe for workplace demands, control at work and job strain. Three fifths of the workforce report having to work to tight deadlines and two fifths at high speed, both of which are among the highest rates in Europe. Just one third of workers say they have control over how they work – the lowest rate in Europe. The Report points out that *"In 2022/23, 1.7 million workers in Great Britain reported work-related ill health, underlining the need to address job quality issues that affect health" and "there is clear evidence that work intensity and job strain have increased significantly over the last 25 years, to a point where around half of the UK workforce report being regularly exhausted from work*".

A particular correlation was identified between precarity and poor mental health; *"....there are a number of country-level studies that do suggest significant and direct links between job insecurity and ill-health, with research from the UK and Denmark standing out. In the UK, findings from the Whitehall II study, which was a long-term, longitudinal study following British civil servants from the mid-1980s onwards, found that workers who were exposed to chronic job insecurity had the highest self-reported morbidity. Furthermore, these effects were long-standing, continuing to some extent even after job security had been given. 16 Meanwhile a largescale, longitudinal study of Danish employees similarly found that perceived job insecurity, including perceived threats of internal job mobility, was associated with poorer wellbeing and mental health*".

Annie Irvine, in **"Mental health in context: The role of precarious and insecure work"**, makes the point that it is not always just the strain of precarious work that can tip the balance. By its very nature, people in precarious work can lose it when they are at a vulnerable point, with knock-on consequences: *"When we look in close, contextualised detail at the circumstances and specifics of people's work transitions, we see that at times of mental distress, it may well be unrelated factors that cause people to leave work. This is most apparent in the case of precarious or insecure employment. People may be struggling on in work, in spite of high levels of anxiety, depression or even psychosis. But their job ends due to redundancy, the end of a temporary contract, failing a probationary period, an employer closing down or being unable to offer work hours that are compatible with parenthood. Circumstances outside the workplace also affect both mental health and work capacity in tandem, for example caring for an ill or disabled family member, becoming homeless or escaping domestic violence"*.

The "Work Foundation" report **"UK Insecure Work Index 2024"** pointed out that the end of the pandemic was accompanied by a fresh surge in precarious work. *"In 2023, an estimated 6.8 million people (21.4%) were in severely insecure work. Since we last reported on this data in the UK Insecure Work Index 2022, this has risen by 600,000 people. The increase predominantly happened between Spring 2022 and Spring 2023 when it rose by 500,000 people"*.

Another "Work Foundation" report, **"Stemming the tide: Healthier jobs to tackle economic inactivity"** (December 2024), explored why British workers quit their jobs following a decline in their health. It surveyed 1,117 business leaders, reviewed occupational health approaches and studied the employment journeys of 9,169 workers aged 16-60 over a four-year period. According to researchers Alice Martin and Stavroula Leka, the study: *"found that nearly one in ten employees (9%) who experienced a decline in their health left their job within four years. Critically, nearly half of these exits were in the first 12 months, suggesting that once sick pay entitlements run out, people who have not recovered may face little choice but to quit and enter the welfare system. Workers grappling with multiple health challenges face even greater risks. Those with three or more conditions are 5.6 times more likely to quit work than their healthier peers. And those with poor mental health are almost twice as likely to leave"*.

They say that *"poor work quality is one of the things that is harming health in many ways. Long hours, shift work and work-related stress all take their toll"*, *and "In 2023-24, half of all UK work-related ill health was due to stress, anxiety or depression"*.

We are, then, overall, sick and disabled because we are sick and disabled. Social security has nothing to do with this. But bad work and crumbling health and social care services do. Thomas et al) **"Healthy people, prosperous lives: The first interim report of the IPPR Commission on Health and Prosperity"**, IPPR (2023) were particularly firm on the notion that the government will not be able to generate prosperity unless it tackles the issue of health - *"the UK stands at an important crossroads. If population health continues to get worse, it could lead to a vicious cycle between health and prosperity: where weak health undermines our economy, and a weak economy supresses health in turn"*.

As the Green Paper moves onto specific proposals it becomes clear that **the most significant outcome will be simply a reduction in the income of people who, as we have argued above, already feature as being more likley to already be poor.**

The New Economics Foundation **"The true scale and impact of benefit cuts for ill and disabled people"** says: *"The Department for Work and Pensions' (DWP) impact assessment suggests that the changes to the PIP assessment will push 300,000 people into poverty, while the cuts to the UC health top-up will have this effect on 50,000 people. However, these figures are (unhelpfully) rounded to the nearest 50,000, meaning the actual impact of each of these changes could be 25,000 either side".*

The introduction of changes to PIP assessment, to introduce a requirement for people to score at least 4 points in one daily living activity to be eligible for the daily living part, is explained bluntly as being *"to control the rising increase in spend"* - and it is hard to see any other justification for it.

The best estimates are that it will radically reduce the numbers of those eligible.

Data released by the DWP in response to a Freedom of Information request from disability rights campaigner Martin Bonner, revealed that 87% of the 1,283,000 working age people currently receiving the standard daily living PIP payment scored less than four points in each of the ten "daily living" categories in the PIP assessment – meaning that they would no longer qualify for the daily living PIP benefit under the proposed new rules. Someone who needs to use an aid or appliance to be able to either prepare or cook a simple meal, needs to use an aid or appliance to be able to wash or bathe, needs to use an aid or appliance to be able to manage toilet needs or incontinence, and needs to use an aid or appliance to be able to speak or hear will be excluded.

The idea that the "Health Element" of Universal Credit should in future be determined not by a Work Capability Assessment, but by a PIP Assessment also seems designed, fundamentally, to reduce the numbers eligible.

This is made the case, in fact, insofar as it is already well understood that not everyone who is too sick to work will qualify for PIP - a benefit not designed to identify whether or not an individual is able to work, but whether or not they have certain characteristics in limited and specific areas that are likley to add to their living costs, whether they are in work or not.

This whole idea is riddled with flaws.

The Green Paper is unclear as to which PIP assessment it has in mind. It refers, in Para 111, to the *"current PIP assessment"* - which we can only take to mean the PIP assessment as it is now, and not as it is proposed to be. Do the Government really intend to apply to the Health Element of UC an assessment they no longer intend to apply to PIP itself?

Few people will not be glad to see the back of the WCA. But the reason for its unpopularity has been its lack of sensitivity to real situations, and the extent to which it has ***underestimated*** incapacity. It is very much lack of confidence in both WCA and PIP assessments which lies at the root of why the Green Paper (para 6) has to acknowledge that the system *"generates poor experiences and low trust among many people who use it"*. It is as simple as Ed Kiely puts it in his review of John Pring's **"The Department"** in the "London Review of Books" (17/04/25): *"Carre, Whiting and Graham had all been found capable of work and their benefits had been stopped shortly before their deaths"*. When we organised a local screening of the Ken Loach film **"I am Daniel Blake"** in 2017 several people said that the film powerfully reflected their own experience. As one woman tearfully put it, *"I am Daniel Blake".*

The DWP Research Report on **"Experiences of PIP applicants who received zero points at assessment"** reports the PIP application experience of "John". *"It took him 3 months to complete the PIP application as he had to use voice dictation and could only manage about 5-minutes of this per day. He was not able to review his responses, as this was too laborious for him. In his application, he included a letter of diagnosis, a letter from his occupational therapist, and a 7-day diary he wrote by hand. He struggled with answering some questions, for example, he reported a question being posed on how far he can walk in a day, in metres. He can walk only about 100 steps per day, so he had to try to figure out what that is in metres*". The Study then notes, somewhat laconically, *"At the time of interview John was going through the appeals process".*

The DWP Research Report on **"The Impact of Fluctuating Health Conditions on Assessment"**, published in 2024, noted that: *"The current DWP disability application and assessment processes do not make it easy for people with fluctuating conditions to describe changing levels of disablement that they experience. This has caused differing degrees of difficulty, frustration, fear, and a sense of inequality for applicants with such conditions"*. *"Application questions give little opportunity to provide information on changes in conditions and the context of these changes. This includes describing triggers, predictability, and manageability of fluctuations, and the impact on capability and everyday activities"*.

Either way - it is clear - as the Green Paper itself says, that there are, and will be, people who are too ill to work and who would justify a "health element" payment but for whom a PIP assessment will be irrelevant. There are 1.1m people on the health element of UC or claiming Employment and Support Allowance (ESA) who either do not qualify for, or who have never claimed, PIP (para 110) - precisely because there is only overlap between the two benefits in some circumstances. Not all of these will be in the Support or LCWRA groups – but some could be.

There are two things significant here, however.

One is that some people who do not qualify for PIP should qualify for the support of the "health element" and the Support Group or LCWRA conditions.

The other is what happens to how those people are to be treated who, under current arrangements, would be simply in the Work Related Activity or LCW Groups.

Those assessed as having a ‘limited capability for work’ (rather than limited capability for work and also for any work-related activity) – indicating a less severe incapacity – do not receive additional support but are currently exempted from some job-search requirements. Para.236 of the Green Paper says: *"For disabled people and people with health conditions there will be no WCA in the reformed system and we therefore need a different approach to determining appropriate conditionality requirements"*, leaving this crucial process unacceptably vague.

Who decides who fits into this category if there is no WCA? The Work Coach? The Green Paper says that *"it will be important in the reformed system for all disabled people and people with health conditions to have conditionality expectations tailored to their needs and capabilities*", but leaving the Work Coaches to decide what is "tailored" or not is a recipe for disaster and endless wrangling. If this is going to be the approach there must at least be also a significant overhaul of the procedures around disputed claimant committments, where the citizen is currently presented with what is very much like an agreement reached with a highwayman. You have a very limited "cooling off" period in which to register agreement, and if you don't agree your claim fails. Section 15(3) of the regulations does allow for an extension of the "cooling off" period where:

"the person requests that the Secretary of State review—

(a)any action proposed as a work search requirement or a work availability requirement; or

(b)whether any limitation should apply to those requirements"

But that only applies if *"the Secretary of State considers that the request is reasonable"*.

There is inevitably and imbalance of power between the state and the new claimant and it is disingenuous to present the claimant committment as if it were some mutually agreed compact between equal parties. Making make individual work coaches solely responsible for deciding what conditions are attached to social security claims without any safeguards is a road map to for unfairness, and it is also likely to make the issue of broader distrust in work coaches even worse - increasing another key barrier to engagement with employment support.

We have no complaint about the proposition that the system could make it easier for people to "try" work, or to remove any fear there may be that taking a job and then not sticking with it, for whatever reason, might lead to a period without any income at all. Research by the Joseph Rowntree Foundation has shown that fear of having to reclaim if a job does not work out is a major reason for people worrying about trying a new job.

It seems to us, however, that the simplest way to address this issue would be to remove the high-level sanction that applies if someone leaves a job *"without a good reason"* before claiming. According to the International Labour Organisation Convention on "forced labour" *"the term forced or compulsory labour shall mean all work or service which is exacted from any person under the menace of any penalty"*, and so it is reasonable to expect that all workers should have the right to enter into and leave employment voluntarily and freely, without the threat of a detriment. Abolishing the Universal Credit "sanction" that penalises anyone held to have left employment voluntarily, without good reason, would both comply with this and make the idea of "trial periods" largely irrelevant (except where the idea could speed up reassessment).

We call upon the Government to **abandon all measures and legislation that will reduce the incomes of people with incapacities and to maintain the LCW group, or something equivalent to it** - essentially, an entitlement to social security based on capacity.

Policy must focus on improving population health and healthcare, concentrate on positive measures to promote the practical support individuals receive, improve the relationship between claimants and Jobcentre Plus, and look at how we can improve the way people are treated whilst they are still in work.

In respect of the WCA we should be discussing with the NHS the possibility of returning to a position where there is greater input from medical practitioners familiar with a person's circumstances. We appreciate that there is concern in the NHS about this, but it would have the benefit of ensuring that people off work were in constant contact with medical advice regarding their situation.

We would advocate a review of how easy it is now for employers to dismiss people on grounds of ill health - and suggest that the DWP could lead the way here by not being so quick on the trigger itself in this regard.

The Centre for Better Aging Report, **"Why the over 50s are key to solving the health and work dilemma"**, notes that: *"Evidence ..... shows that workers in their fifties and sixties who acquire new health conditions face challenges in securing and managing adjustments to the type and intensity of work, alongside an assumed age-related deterioration in their capacity to work. Tackling health-related economic inactivity among people aged 50 and over means tackling both the practical barriers faced by people with health conditions in the workplace and the ageist assumptions implying that it is not worth helping people in their fifties and sixties to stay in or return to the labour market"*. Thomas et al) **"Healthy people, prosperous lives: The first interim report of the IPPR Commission on Health and Prosperity"**, IPPR (2023) found that *"As people get older, the impact of the onset of a health condition increases the likelihood of exiting employment"*.

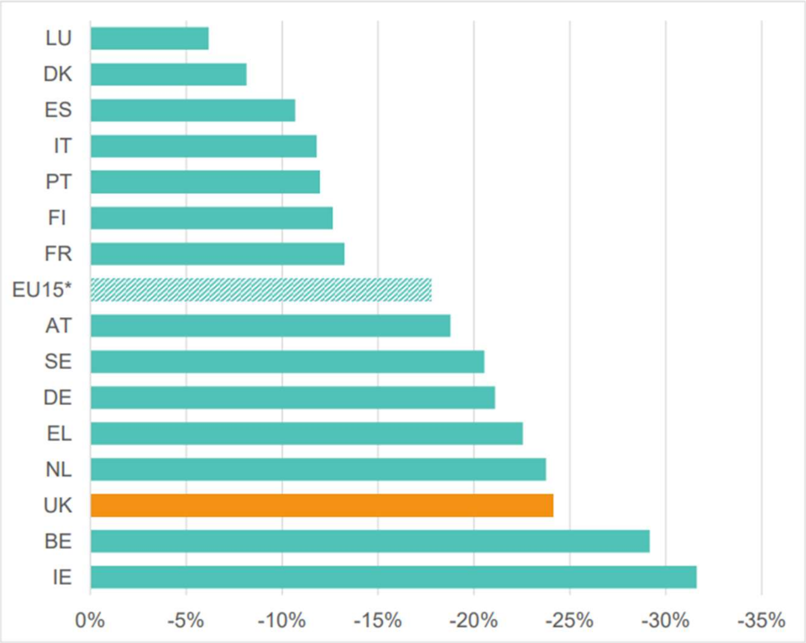
The Joseph Rowntree Foundation's Report **"Unlocking benefits: Tackling barriers for disabled people wanting to work"** comments: *"In addition to ill health, the most significant barriers holding disabled people back from work include inaccessible jobs that lack in health-related adaptations or support; inflexible or negative employer attitudes; and a lack of support for health conditions or related care needs. Many of these barriers are the same factors driving people out of work in the first place if they get ill"*.

New Health Foundation analysis for the Commission for Healthier Working Lives, has shown that around 300,000 people a year move from employment to being out of the workforce with work-limiting health conditions. Once out of the workforce, they are almost three times less likely to return to work than those without health conditions.

The Institute for Employment Studies Report **"Work and health: international comparisons with the UK"** suggests that other comparable countries manage better than the UK when it comes to enabling people to keep on working when they have health limitations:

Figure 5: The UK's ill health 'employment gap' is one of the widest among the EU15* countries

Percentage point gaps in employment rates between people with and without health limitations in EU15 countries, aged 16-64, 2022



Source: Institute for Employment Studies analysis of EU-SILC and Understanding Society.
Note: Employment rate gaps are calculated relative to those without limitations.

It argues that some of this difference may be explained by differences in ways of working, such as:

- Tighter regulation of excessive working hours,
- Stronger employee representation over working conditions,
- government funding for workplace health interventions, and
- Occupational Health Services.

Perhaps most importantly, the Report says that there is scope for improvement in the expectation the UK places on employers, and the support it gives them, when it comes to making adjustments to enable people to carry on working or return to work from sickness absence: (p.27) *"more comprehensive provisions are evident in some other countries". "This requires a considered and holistic approach to workplace adjustments. Research shows that levels of support for return-to-work initiatives vary greatly between countries, suggesting that government policies and incentives have a significant impact on this area.66*

Those approaches that actively engage with employers, employees and health practitioners are more successful than others and the UK may wish to further understand such approaches".

The Health Foundation Interim report of the Commission for Healthier Working Lives, **"Towards a healthier workforce"**, was not greatly complimentary about how well Access to Work and Disability Confident were working, whilst acknowledging that Access to Work could deliver good outcomes where people pushed through the complicated application process and back-log:

"Awareness of schemes like Access to Work and Disability Confident – designed to help recruit and retain employees with health challenges – remains low. A 2022 survey found that only 26% of organisations were aware of the Access to Work scheme, and just 14% knew about Disability Confident.

“This low awareness, coupled with other challenges, undermines the effectiveness of both programmes. Access to Work, which has been in place since 1994, has been shown to help individuals and employers by providing necessary adjustments that enable people to stay in work.

“In recent years, however, the scheme has been criticised for its complicated application processes, delays in processing claims and inadequate funding. Disability Confident lacks clear accountability or external evaluation mechanisms, and there are serious doubts about its ability to deliver meaningful outcomes".

Maybe, rather than a grand review of these, we need first to get them working as well as intended?

Ian Gallagher
Secretary
Blackburn and District Trades Union Council

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