Moving between sickness and work

Alan Hedges and Wendy Sykes

A report of research carried out by Alan Hedges in association with Wendy Sykes on behalf of the Department for Work and Pensions
8 Possible ways forward 163
   8.1 Dual benefit system 164
   8.2 Moving towards work 164
      8.2.1 Problems identified 164
      8.2.2 Possible approaches 165
      8.2.3 Bridge model 167
      8.2.4 In conclusion 171

Appendix A  Method and sample 173
Appendix B  Recruitment questionnaire 183
Appendix C  Copies of claimant letters 187
Appendix D  Topic guides 189
Other research reports available 199

LIST OF TABLES

Table 2.1 Total duration of claims 21
Table 2.2 Current working status 22
Table 3.1 Claimants’ illnesses and disabilities 38
Table 3.2 Largest categories of illness and disability 39
Table A.1 Contacts 173
Table A.2 Sample achieved - figures 179

LIST OF FIGURES

Figure 2.1 Number of claims transferring monthly from JSA to IB/ISS 20
Figure 2.2 Precentage of all monthly JSA terminations who move to IB/ISS 20
Figure 7.1 Real or perceived barriers to work 141
Figure 8.1 Current PCA model 165
Figure 8.2 Possible three-stream model 167
Figure 8.3 Bridge model 168
Figure 8.4 Bridge amplified 168
We are grateful to Jo Bacon and Vivienne Avery at DWP for their management of this project. We also thank their DWP policy colleagues for their many comments and suggestions about the report.

Thanks are also due to all those claimants and members of staff who took part in the study, and to the local office managers who helped set up the staff groups.

Finally we are indebted to all those who supported the research in many ways – by recruiting participants, transcribing tapes, checking reports, and so on.
THE AUTHORS

**Alan Hedges** has worked in and around the worlds of social and market research for over 40 years. Since 1971 he has operated his own independent consultancy, advising on and carrying out research (with a particular focus on qualitative methods). He has had a good deal of experience of qualitative and quantitative research in both the social research and the marketing worlds (mainly as a practitioner, but also as a user and adviser), and has worked for most government departments. He has written and lectured widely on research methods and applications.

**Wendy Sykes** has worked for 20 years as a social researcher, independently since 1988. Her experience covers both quantitative and qualitative methods and she has an established track record in research methodology. She is a Visiting Senior Research Fellow at the University of Durham and the City University.
This report is based on qualitative research carried out in the Spring of 2001 by Alan Hedges and Wendy Sykes. The study focused on claimants moving in either direction between Jobseeker’s Allowance (JSA) on the one hand, and Incapacity Benefit (IB) or Income Support for Sickness (ISS) on the other.

The purpose was to identify the characteristics of movers, their reasons for moving and their experiences while doing so. Until recently, very little was known about clients who move between JSA and IB or their experiences of claiming benefit and the labour market. This research was commissioned in order to help fill the gaps in the Department’s understanding in order that these clients might be better helped and supported.

The study involved individual interviews with 40 movers, and also conversations with 34 BA and ES staff members, mainly held in small groups. It was carried out in five areas chosen for high levels of movement and a diversity of area types.

The rate of movement between JSA and sickness benefits seems to have been falling rather than rising in recent years. DWP statistics suggest that flows from JSA to IB/ISS declined by 25 per cent between 1997 and 1999.

The benefits provided for people who are incapacitated on health grounds are poorly branded. Movers are not only usually confused about what is available, but often unclear about which benefits they were actually getting themselves during this phase. Most people still simply talk about ‘sickness benefit’.

It doesn’t help that people are sometimes confused by the stresses and changes that periods of incapacity often involve, but the main problems are that:

- They are normally expected to claim two separate benefits, IB and ISS, for reasons that they do not usually understand.
- Contrary to expectation neither of these titles involves ‘sickness’.

---

1 There is in fact no benefit which bears the title ‘Income Support for Sickness (ISS)’, but this term is used throughout the report to denote Income Support claims which are made on grounds of incapacity by those not eligible for Incapacity Benefit.
The word ‘Incapacity’ is not in common currency, and sometimes suggests serious disablement.

‘Income Support’ has other associations and is not connected with sickness in most people’s minds.

Having to claim two different benefits at once is not only confusing but adds to the hassle of claiming for both customers and staff. In some cases only one initial claim is made, which can cause delays when a second claim proves necessary. The intricate interface between the various agencies and sections involved also sometimes causes problems.

_Movers are by no means a homogeneous group – their characteristics, personalities, situations and needs vary widely. In particular they enter IB/ISS with a very wide range of ailments that have different implications for both their incapacity and subsequent employability. At one extreme people have health problems that are finite and short in duration, and from which they recover completely (like a broken arm). At the other extreme some people with (say) serious arthritis or asthma may be long-term sufferers who go on being affected by this health problem even when not completely incapacitated by it. Problems often arise with ailments that are variable in effect, episodic or difficult to test._

Mental health and substance abuse cases together form a large and problematic category of this kind – they can be very disabling, but are also intangible, and those who suffer from them are often not seen as good employment prospects by either ES staff or employers.

_Moves from JSA to IB/ISS among claimants in our sample mostly seem to have been appropriate, and were usually caused by the onset, recurrence or deterioration of a health problem._

Both BA and ES staff allege a range of situations in which this move is made inappropriately in an attempt to manipulate the system, but there were few signs of this in the research. Such cases no doubt exist and should be dealt with, but we suspect they may be fairly marginal in numbers.

A number of those moving from JSA to IB/ISS are returning after PCA failure – mainly successful appellants or people reapplying. Some movers are also tipped off JSA temporarily by the rules on short-term sickness.

Moves in this direction may be triggered by:

- claimants themselves;
- actions, decisions or advice from their doctors or Jobcentre staff; or
- the regulations (in the case of short-term sickness).
Moves from IB/ISS to JSA usually result from professional or official decisions (their doctors stop certificating them or they fail the PCA). In these cases some claimants do not agree they are now well enough to work. However some others decide for themselves that they are fit enough to go back without being told to. Recovery from the incapacitating ailment may be complete or partial.

Staff in both Agencies sometimes notice moves which appear to be manipulative, but there is no systematic monitoring of such cases, and typically no action to investigate them. Neither BA nor ES staff feel they have the responsibility (or even the right) to challenge them, nor the powers to do so. Sometimes ES staff are even relieved if ‘difficult’ or unproductive cases move to someone else’s desk.

A study like this is not able to measure the level of manipulative moves, but there is no evidence here that this is unduly high. Where it happens it seems more likely to affect movement from JSA to sickness benefits rather than the reverse direction.

Experiences in moving (Chapter 5)

Moving between benefits involves costs for both system and claimants. The latter usually hate filling in forms, and often find it confusing to deal with new benefits and new rules (and in this case a new Agency and new types of staff). They fear (and sometimes experience) delays – and payment delays can sometimes cause hardship. Moving consumes staff time, and can generate friction when it leads to problems or queries.

Movement is likely to be a special problem with sickness benefits, mainly because of the dual benefit structure, which is difficult to understand and administratively complex. Sometimes moves go smoothly, but there is also evidence of problems occurring – mainly delays in initiating or paying the new benefit. Such problems are aggravated by the fact that three different Agencies and sections (ES, BA(IB) and BA(IS)) have to exchange information and wait on each other’s decisions and actions.

Incidental disruption of other entitlements (like Housing Benefit) can be a serious problem. Closing an IB/ISS or JSA claim sometimes seems to trigger closure of HB/CTB even where someone is moving straight to the other benefit. This can lead to rent or mortgage interest arrears and to tiresome and unnecessary reclaims.

Various issues arise when people move to JSA after PCA disallowance:

- The timing of disallowance notices and termination of benefit can cause delays or even loss of benefit, because they arrive only after benefit has been stopped, and some people want to consult their doctors before deciding whether to claim JSA. Staff did not have consistent views about the scope for backdating JSA.

- Disallowance notices often come as a shock and are blunt and cold in tone.
Post-PCA claimant options are not properly clarified (notably in relation to the possibility of taking reduced IS while appealing instead of signing on for JSA). These options are in any case often considered unsatisfactory. Neither staff nor claimants feel comfortable about someone signing on while declaring themselves unfit for work, but the reduced IS option seems economically harsh.

ES advisers are often not sure what to do with former IB/ISS claimants who say they are not fit, and/or seem likely to be hard to place. Disability Employment Advisors (DEAs) are in short supply, and often not deployed in this situation (see below).

Advice and information about the benefits under study is not always sufficiently available. Some people feel if they ask staff they often get passed between people and offices, and end up with contradictory messages. Many seem unaware of official literature. The range of outside advice agencies is not usually well known.

Clients usually have a closer relationship with ES than with BA, because JSA claimants have regular face-to-face contact. This means that:

- ES tend to catch a lot of the queries, about IB/ISS as well as JSA;
- although sick people may in some ways need more personal support, they actually tend to get less on IB/ISS than they did on JSA.

This research was in no way designed to evaluate the Personal Capability Assessment (PCA), and we can only draw on second-hand accounts of its operation from people who are not themselves either fully informed or disinterested observers. However it is important to give an account of how it looks from their perspective.

The actual basis on which the system assesses medical incapacity is not well understood by claimants or many staff (ES officers especially), and their intuitive assumptions about what it ought to do conflict in some respects with current regulations and procedures. The PCA is designed to test someone’s ability to carry out a standardised range of everyday activities, but participants were often puzzled about why it does not relate more specifically to the kind of work they could do or the kind of health problem they have. This often leads to a mismatch of expectations when people contemplate the workings of the PCA.

Claimants also rarely understand the procedural structure into which the PCA fits. Rather than a normal routine they sometimes interpret it as a sign that they are personally suspected. Many are puzzled by the turn of events at this point, particularly the way their own doctor’s opinion suddenly seems to lose its authority.

The PCA tends to have an unsatisfactory image – not only among claimants moving between these benefits, but also among the staff who work with
them from both Agencies. This can only in part be put down to the inevitable discontent of those who have lost out, but also arises from:

- lack of knowledge about how and what the PCA is meant to assess, the role of the various medical advisers, such as the GP and the Medical Services’ doctor, and the way in which procedures operate;
- the mismatch of expectations described above, and the feeling that someone might not necessarily be well enough to go out to work even if they fail to meet the PCA criteria;
- a widespread assumption that the test does fail some people who are not really well enough to work. This is heard not only from some of those who fail it, but also from many staff – particularly ES advisers (who have to deal with the outfall) but also often from BA officers (including some Decision Makers);
- the fact that the actual PCA medical examination does not usually strike people as substantial enough for the decisions based on it and is often perceived to be brief and perfunctory in nature;
- concern arising from perceptions of the way the PCA assesses clients with certain types of ailment – mental illness, for example, or other conditions that may vary from day-to-day;
- some allegations about insensitive attitudes from medical officers, or even about misrepresentation in the PCA medical report of what actually happened at the examination;
- cynicism about supposed political manipulation of outcomes.

Post-PCA options are not well explained or understood, and both staff and clients find it unsatisfactory to give appellants a choice between claiming seriously reduced benefit and making what many would see as a false declaration that they are available for work. Claiming JSA when they don’t feel well enough to work seems anomalous if not dishonest to many claimants – and also to many staff, particularly since appeals fairly often succeed.

Although the PCA is not meant to concern itself with employability, both ES staff and claimants often feel that it is neither useful nor fair to fail people whose health gives them little chance of finding or keeping work, even if in theory they would be fit to do it. ES advisers say they would even be very doubtful about sending some PCA failures to see prospective employers.

*Moving towards work (Chapter 7)* Many movers would like a job if they believed they could get one, and could handle the work. Working is often seen to have many advantages – economics apart, the right kind of work can stop you getting bored, depressed or isolated, and improve your self image – even sometimes your health.
However, those moving from sickness benefit to JSA often face a range of obstacles – some imposed by their health condition, others by their own or their prospective employers’ perceptions of their capabilities and/or their prospects in the job market.

Some people therefore lack confidence and motivation when it comes to re-engaging with the world of work. This does not necessarily mean they are ‘workshy’, but leaving the security of sickness benefits and venturing on what can seem a very uncertain path towards work makes some nervous and negative.

The kind of work they should seek also often needs to be carefully chosen if it is not to aggravate their health problem and/or end in demoralising failure. But the supply of suitable jobs with disability-friendly employers is limited, and the mechanisms for finding the right kind of work are not always effective.

Re-training can be important in some cases, although there needs to be realism about how far some people with limited skills can effectively change course.

The implication of the above is that people in this target group sometimes need a good deal of support and encouragement to help them back to work. This support needs to recognise issues of confidence and emotional turbulence as well as skills and experience.

In principle this kind of support should be available from DEAs within the Jobcentre, but in practice most of our movers never got to see a DEA. Awareness of the role is poor, and pressures on their time considerable. Some people don’t feel they get much help from their Jobcentre in dealing with the barriers they face.

There seems a need to extend contacts between movers and DEAs, particularly at the point when they shift back to JSA (and even more so after PCA failure). And we argue below that the role could be further developed to provide a more effective bridge between sickness and work.

Possible ways forward (Chapter 8)

We have suggested two particularly important ways of moving forward, in addition to more detailed recommendations. These are further discussed below:

- Integrating IB and ISS as far as possible.
- New structures leading on from the medical assessment, designed both to handle borderline or contested disallowance decisions, and to provide a more effective bridge into work.

Conclusions

The conclusions below reflect the researchers’ ideas arising from the study. They are not tested or costed proposals, but possible directions for improvements which might help movers between JSA and IB/ISS. We realise that some of them may have other difficulties or policy implications.
a) The benefits available for sickness could usefully be simplified, clarified and rebranded. At the least it would be preferable to have a common claims gateway rather than having to make two claims, and ideally the two benefits could be combined under one umbrella, as happened successfully with JSA.

The Department has already taken some steps in this direction. ONE has piloted the use of electronic integrated claim forms – completed over the phone through a call centre. Findings from this part of the ONE evaluation have not yet been published – but it will be interesting to see how popular they were with IB claimants.

b) The system needs to be more obviously sensitive to a wide diversity of ailments, which may have differing implications for:
   • the way they are tested at PCA in terms of variability and ease of detection;
   • the kind of support and help people need, both while on IB/ISS and on moving to JSA;
   • subsequent job-finding needs and employment prospects.

c) Insofar as this study throws light on the level of manipulative moves between benefits it does not suggest this is a major problem. However, such moves do appear to exist, and if there is concern about them then:
   • they should be more positively identified, monitored and documented;
   • someone needs to be given responsibility for looking into them and powers to take appropriate action – perhaps through some kind of review mechanism, or through advancing the PCA in doubtful cases.

d) The rules about spells of short-term sickness while on JSA seem worth reviewing. Tipping such people off JSA involves a double move (to IB/ISS and back), which has costs for the system as well as for the claimants. There could be more scope for holding people on JSA if the illness seems genuinely short-term, while doing more to review these cases if abuse is suspected.

e) The procedures involved when people move between benefits should be reviewed in the interests of reducing the likelihood of delays or muddles. As suggested above, amalgamating IB and ISS at one level or another would help in this.

f) Steps should be taken to protect HB and CTB claims from accidental and disruptive closure when people move between JSA and IB/ISS.

g) It would minimise the risk of benefit hiatus if a short period of grace could be allowed between issuing a PCA disallowance notice and terminating benefit. If the rules on backdating JSA claims are already adequate to cover such cases then they need clarifying for staff as well as claimants. Disallowance notices themselves should be more clearly spelt out and more sensitively phrased, and should clarify the options open and the next steps to take.
h) Counselling and personal advice should be available within the system, particularly in disallowance cases. Claimants should also be given advice agency contacts.

i) As long as the PCA remains in its present form it seems useful:
   - to explain to claimants how it fits into the sickness benefit process – they need information both when IB/ISS is first claimed, and again when asked to attend the medical;
   - to clarify the nature and scope of the test itself, and the way it operates, both to claimants and to staff of both agencies (especially ES);
   - to ensure that Medical Officers are reminded of the importance of a friendly and reassuring demeanour;
   - to look at post-PCA options, including:
     - making it clear that disallowed claimants can ask for a case review as well as being able to appeal;
     - reviewing and clarifying support options and procedures once an appeal is lodged.

j) At a deeper level there seems to be a case for looking again at:
   - the conceptual basis of IB and the way medical incapacity is assessed;
   - the relationship between incapacity and employability.

k) It is important to recognise that some movers need a good deal of support, advice and/or retraining if they are to get back into work. This will sometimes need to include personal and social as well as occupational support to help build:
   - confidence and/or motivation;
   - personal and interpersonal skills;
   - basic skills like literacy and numeracy;
   - occupational skills.

These facilities are all likely to be available from the Jobcentre, but often do not seem effectively deployed for the movers that need them. Access to these resources and to DEA services could usefully be improved.

l) Other ways of handling those failing the PCA should be considered to give people:
   - better support during a difficult transition;
   - a chance to have their case and needs looked at in more depth;
   - a more positive attitude to and confidence in the possibility of working;
   - better preparation for work.

m) More efforts are needed to improve the supply of work opportunities which cater for (or at least tolerate) people who suffer from different types of sickness or disability, and to build more widespread disability-tolerance among employers. It seems unreasonable to increase the pressure on IB/ISS recipients to get work without taking more steps to ensure that there is reasonable access to jobs for those who are fit enough to take them. This sounds a substantial task.
n) Opportunities for appropriate therapeutic or voluntary work should be promoted more proactively, and attitudinal or procedural obstacles reduced, by:
  - stressing the value of therapeutic and voluntary work to IB/ISS claimants;
  - clarifying the benefit implications of these kinds of work, and making it clearer that engaging in them will not compromise benefit entitlement;
  - reviewing the routes and procedures for authorising access to therapeutic work, with a view to making it more (and more rapidly) available.

o) The roles, numbers, resources and titles of DEAs should be reviewed. They and their services need better promotion and improved access – but this probably implies considerably increasing their numbers.

p) Much of the pressure might be taken off the PCA if instead of a rigidly two-stream ‘sudden-death’ benefit decision a third interim option was introduced for people with borderline or contested incapacity – a process of further assessment, which looks more deeply at both their health and their employment prospects. This should be work-focused, but should contain the possibility of going back to sickness benefit where this seemed the fairest and most effective course. A more complete and satisfactory implementation of this idea would be for everyone moving from IB/ISS to JSA to enter a similar bridge process, designed to assess and support the individual, and to facilitate progress towards work where this is the right outcome.

Taken overall there is much to be said for encouraging IB/ISS claimants to seek work where this is a reasonable option for them, but simply tipping them back on to JSA in an unsupported way is not likely to be the most effective means of getting some people into jobs, particularly where they have genuine doubts about their own fitness, and little confidence about their chances of getting work. We suggest that the approach proposed above would be equally work-focused, less likely to have emotional repercussions, and more likely to result in positive outcomes for all concerned.

It does however have resource implications. But on the other hand the barriers faced by many people in this target group are not likely to be overcome unless the opportunities are there and they are given the help and encouragement they need to take them up. Exerting blanket pressure towards working without doing more to help people get suitable jobs is unlikely either to be productive or to seem fair to those involved.

Finally, the laudable desire to ensure that those who are capable do get into work should not be allowed to cause unreasonable stresses or pressures for those who really should be recognised as not well enough to work.
1. The study

The study was commissioned by the Department for Work and Pensions (DWP), which at the time was still the Department of Social Security (DSS). The purpose of the study was to explore moves between Jobseeker’s Allowance (JSA) and incapacity-related benefits like Incapacity Benefit (IB) or Income Support for Sickness (ISS):

- When and why do people move between these benefits?
- What kinds of claimant are involved in such moves?
- What experiences do people have when moving between benefits, and how do these affect them?

Until recently, very little was known about clients who move between JSA and IB/ISS or their experiences of claiming benefit and the labour market. This research was commissioned in order to help fill the gaps in the Department’s understanding in order that these clients might be better helped and supported.

The Department was aware that large numbers of people flow between these benefits. In the year to November 2000 about 110,000 claimants left IB and began a JSA spell within one month. In the year to April 1999 (the latest figure available) there were about 190,000 cases of claimants flowing from JSA to IB. The administrative data provided very little information about who these people were, why they were moving between these benefits, whether these flows were appropriate or whether these clients risked missing out on the additional help available to those who remained on either JSA or IB through the various New Deals. The Department therefore commissioned this and another complementary parallel research project to find out more about the characteristics, motivations and experiences of these clients.

1.1 Background and purpose

This report uses the new title, DWP, but verbatim quotes will often refer to ‘DSS’ (or even earlier titles).

1.2 Scope and coverage of study

The research has two strands:

- Claimants who have made at least one move between JSA and IB/ISS within the past few years.
- Members of staff, including both:
  - Employment Service (ES) staff working at Jobcentres in various capacities; and
  - Benefits Agency (BA) staff, working either at Social Security offices, or on secondment to Jobcentres.


1.3 Method and samples

Qualitative research methods were used, involving 40 claimants and 34 members of staff. Further details of methods and sample are in Appendix A, with an analysis of the claimant sample profile achieved. The topic guides are in Appendix D.

1.3.1 Claimant sample

The claimant sample was based on individual depth interviews with 40 claimants, normally carried out in their own homes.

Claimants were sampled from a database of movers supplied by the Department for Work and Pensions (DWP). Data showing people who had made one or more claims for both JSA and IB within a given time period (Feb 1999-May 2000) was extracted from the DWP’s records.

The data available on patterns of movement proved to be somewhat limited. Case records are not kept in a form which makes this easy to identify, and in particular there is some lack of longitudinal data about patterns of moves over time.

The original database contained 672 names. These were analysed, and a short-list of 303 was chosen to go into an opt-out process, designed to give listed claimants an opportunity to say they did not want to take part (see Appendix B). Opt-out letters (see Appendix C) were sent to this short-list. Twenty of those sent letters opted out (seven per cent).

Quota sampling methods were used, with the quotas set purposively as indicated below. In selecting the sample for the short-list and subsequently for interview we aimed to highlight relevant and interesting cases rather than simply to take a straight cross-section of the listed names. We tried to identify and include a number of cases where it seemed from the information available that inappropriate switching might have taken place, and we also supplemented important minorities like people who failed the Personal Capability Assessment (PCA, see 3.1), and those who had appealed about the result. We tended to exclude those where the move had an obvious purpose – for example maternity cases.

Fieldwork was done in two waves, with informal feedback and discussion between the waves. This enabled us to assess initial progress and adjust the focus of the remaining work in the light of early experience. The sampling criteria were modified on the basis of the first wave.

The kinds of factor considered in sampling included:

- type and direction of switch, patterns of switching and current benefit;
- type of sickness or disability;
- PCA failure and appeals;
- length of claim;
- sex and age.
Recruitment of claimants for interview was often difficult, but in general a good spread of types of case was achieved. This is further analysed in Appendix A. The claimant recruitment questionnaire is in Appendix B, and copies of letters used in Appendix C.

1.3.2 Staff sample

The staff interviews were mainly based on discussions with small groups. Six groups were held in all, with numbers ranging from three to nine participants.

The intention was to include some Disability Employment Advisers (DEAs) with the groups of Jobcentre staff, but in spite of our best efforts to have DEAs at the groups the arrangements broke down in all cases. We therefore subsequently undertook supplementary individual interviews with four DEAs. One of these was carried out face-to-face, but for reasons of timing and practicability the other three were completed by telephone.

This gave us 10 fieldwork sessions altogether with staff, involving 34 people. These were made up of:

• 14 BA staff working at Social Security offices;
• 20 Jobcentre staff (including some attached BA officers and four DEAs).

Staff were chosen by their office managements rather than sampled directly by the researchers. Managements were given a written briefing about the kind of staff needed, supplemented by a telephone conversation.

A good variety of roles was represented — including decision-makers, front-line staff, and a range of different types of section and function.

1.4 Timing

The main fieldwork was carried out in February/March 2001, although the last few supplementary DEA interviews were not finally complete until April (see 1.3.2).

1.5 Fieldwork areas

The study was carried out in five different areas in England and Wales. It was decided that we should exclude areas where ‘ONE’ or the New Deal for Disabled people (NDDP) were being piloted. This was decided for two main reasons:

• The sample size is too small to compare different types of service properly, as well as covering the different labour markets, types of illness and so on, which were the primary stratifiers for this study.
• ONE, NDDP and Capability Report all have separate evaluations which comment on this issue, and as a result clients in these areas were over-saturated with research at the time of fieldwork.

The study findings therefore relate to the majority of areas, which do not have the additional services or help that are available in the excluded pilot areas (like a Personal Advisor or the Capability Reports).
Areas with high levels of switching were chosen to give a good regional spread and a range of types of area. The data for the target population was analysed at BA district level to ascertain which districts had the greatest numbers of people who had claimed both benefits. Five areas with large numbers of relevant claimants were selected to represent different types of area. These will not be identified specifically in this report for confidentiality reasons:

- Northern city – former industrial city in a region of relatively high unemployment.
- Rural area – in a region with an ILO unemployment level about equivalent to the UK national average.
- Mixed urban and rural area – in a former industrial zone including a city, several towns and a fairly extensive rural (although ex-industrial) area.
- London – some areas of inner London were found to have high levels of switching between the benefits, despite a buoyant London job market.
- South coast town – relatively high level of unemployment despite the generally low level of the region. Several towns on the coast of Kent, Sussex and Hampshire stood out as having higher levels of switching than elsewhere in those counties.

1.6 Caveats and limitations

This was a substantial project of its kind, and the findings should be seen as robust and reliable. However a few caveats should be noted:

- Like all qualitative studies it is designed to generate understanding and insight into the way people think, feel and behave. It cannot provide statistical information. Words like ‘most’ or ‘few’ are sometimes used to suggest the general drift of opinion, but these are to be interpreted only as very broad indicators.
- Recipient understanding of events and procedures was often limited, and it was sometimes difficult to establish what had actually happened.
- Unless otherwise specified, the findings are based on what people said. The study does not provide objective assessment or verification of the statements made, although in drawing conclusions we have considered their consistency and credibility.
- There were some limitations in the database information provided for sampling. It was difficult to identify longitudinal switching patterns, and the numbers in some interesting categories were limited from a recruitment point of view.
- The sample design includes only people who have moved between JSA and IB/ISS – it does not reflect other non-moving claimants of these benefits. Moreover, in sampling we did not take a straight cross-section of the target population, but deliberately tried to include reasonable numbers of difficult or interesting cases – PCA failures, serial movers, etc. However the sample does contain a good range of types of case.
The report concentrates on problem areas, which is the most useful focus. This affects its balance, because things which already work well get less attention.

There are several benefits which can be claimed when people are incapacitated for work on health grounds. The main benefits are Incapacity Benefit (IB), and Income Support (IS)\(^4\). Because IS applies to many other cases than sickness we use the term ‘Income Support for Sickness’ (abbreviated to ISS) to refer explicitly to its role as a non-contributory alternative to IB.

Because there are different benefits for cases of incapacity, and because claimants rarely know or use their proper titles (see Section 2.4) we sometimes refer to them collectively as ‘sickness benefits’. This is a convenient term that follows popular usage, but is not currently in official use. We also sometimes use the term ‘IB/ISS’.

There is a lack of really suitable terms to describe the health problems which IB/ISS claimants suffer from. Words like ‘sickness’ and ‘disability’ only properly describe certain types of problem, and some people claiming sickness benefit do not identify with one or the other – although as noted in Section 2.4, most claimants think they get ‘sickness benefits’. In the interests of variety the report sometimes uses terms like sickness, ill-health, ailment and disability to refer to health problems, but these are all used generally unless the context implies a more specific meaning.

The following abbreviations are used in the report:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AWT</td>
<td>All Work Test</td>
</tr>
<tr>
<td>BA</td>
<td>Benefits Agency</td>
</tr>
<tr>
<td>CAB</td>
<td>Citizens Advice Bureau</td>
</tr>
<tr>
<td>CTB</td>
<td>Council Tax Benefit</td>
</tr>
<tr>
<td>DEA</td>
<td>Disability Employment Adviser</td>
</tr>
<tr>
<td>DLA</td>
<td>Disability Living Allowance</td>
</tr>
<tr>
<td>DM</td>
<td>Decision Maker</td>
</tr>
<tr>
<td>DPTC</td>
<td>Disabled Person’s Tax Credit</td>
</tr>
<tr>
<td>DSS</td>
<td>Department of Social Security (Now DWP)</td>
</tr>
<tr>
<td>DWP</td>
<td>Department for Work and Pensions (formerly DSS)</td>
</tr>
<tr>
<td>ES</td>
<td>Employment Service</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HB</td>
<td>Housing Benefit</td>
</tr>
</tbody>
</table>

\(^4\) There is also Severe Disablement Allowance (SDA), but this is only for some long-term and heavily disabled claimants, and was about to be phased out at the time of the study. It was not much mentioned in discussion. Statutory Sick Pay is a short-term benefit for those already in work. It was also not much mentioned here, because our emphasis was on movements involving JSA.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>IB</td>
<td>Incapacity Benefit</td>
</tr>
<tr>
<td>IS</td>
<td>Income Support</td>
</tr>
<tr>
<td>ISDP</td>
<td>Income Support Disability Premium</td>
</tr>
<tr>
<td>ISS</td>
<td>Income Support for Sickness</td>
</tr>
<tr>
<td>JSA</td>
<td>Jobseeker’s Allowance</td>
</tr>
<tr>
<td>JSAg</td>
<td>Jobseeker’s Agreement</td>
</tr>
<tr>
<td>NI</td>
<td>National Insurance</td>
</tr>
<tr>
<td>PCA</td>
<td>Personal Capability Assessment</td>
</tr>
<tr>
<td>SDA</td>
<td>Severe Disablement Allowance</td>
</tr>
<tr>
<td>SE</td>
<td>Self-employed</td>
</tr>
</tbody>
</table>

1.8 Verbatim quotations

Verbatim quotations are used to illustrate the way people think and talk. Quotations should be read in the context of the surrounding text – the presence or absence of quotes does not denote importance, and some important points cannot be illustrated in this way.

Each quote is preceded by ‘M’ or ‘F’, showing whether the participant is male or female. ‘I’ denotes remarks from the interviewer. Quotes are followed by a label showing the characteristics of the session it came from:

- **Type of participant**: ‘Claimant’ or ‘Staff’.
- **Area type** (see 2.5 above for key): ‘London’ = inner London, ‘Northern city’ = northern city, ‘Rural’ = rural area, ‘South coast’ = south coast town, and ‘Urban/rural’ = mixed urban and rural area.
2 THE BENEFIT BACKGROUND

Key points

- Awareness and understanding of the benefits available for incapacity is very limited even among those who receive them.
- Recipients of IB and ISS\(^5\) often don’t know which they get.
- The dual IB/ISS benefit structure is confusing and causes hassle for both claimants and staff.

2.1 Benefit structure

Anyone who, due to sickness or disability is, or becomes, unable to fulfil the JSA conditions of being available for and actively-seeking work may make a claim for Incapacity Benefit (IB)\(^6\). JSA claimants are entitled to claim IB as soon as they become incapacitated. To cover short spells of incapacity while on JSA, current rules allow claimants to continue to receive JSA for up to two spells of two weeks’ sickness in any 12 month period. During this time they are treated as meeting JSA conditions of entitlement. For periods of longer than two weeks or if they are incapacitated on more than two occasions in the year, clients are required to terminate their claim for JSA. Most will then claim IB and/or IS on the grounds of incapacity. Those receiving these benefits are exempted from the obligation to seek work.

IB is a National Insurance (NI) contributions benefit. As well as proving incapacity, in order to receive payment of IB, a claimant must have paid the appropriate contributions. This is checked by the Benefits Agency when a claim for IB is made. Claimants deemed incapable of work\(^7\) who do not satisfy the IB NI contributions conditions for entitlement may be entitled to receive NI credits.

After the first seven days of incapacity, which are self-certified, access to IB requires medical evidence (such as a medical certificate from the

---

\(^5\) There is in fact no benefit which bears the title ‘Income Support for Sickness (ISS)’, but this term is used throughout the report to denote Income Support claims which are made on grounds of incapacity by those not eligible for Incapacity Benefit.

\(^6\) IB was introduced in April 1995 to replace Sickness Benefit and Invalidity Benefit as the main long-term contributory benefit for people incapable of work because of an illness, or bodily or mental disablement.

\(^7\) ‘Deemed incapable of work’ is used here as shorthand to describe those who reach the threshold of incapacity at which entitlement to a benefit does not depend on availability for work.
claimant’s GP) to be supplied to a BA Decision Maker (DM). For someone who has previously been working full-time, the GP certifies them as sick, depending on whether they can do their usual job. This is valid for up to 28 weeks before people may have to take the PCA to test their capacity for a wider range of tasks.

The first step in the PCA process is to check for potential ‘exemption’ from the test for those with certain prescribed severe conditions. This may be apparent from information already held – for example, where the claimant receives the highest rate care component of Disability Living Allowance. In other cases where the claimant could have a severe condition further information is sought from the claimant’s GP. In most cases of severe illness the DM will obtain advice from an IB approved Medical Services doctor before deciding whether the person should be exempted from the PCA.

If not exempt, the claimant fills in a questionnaire about her/his incapacity and is asked to obtain form Med 4 from her/his GP, which gives fuller information about the condition than standard certificates. The Medical Services doctor advises the DM on the basis of all the written evidence. If the doctor is unable to do this, the case is referred for examination.

Following examination, the approved doctor sends a report to the DM, who determines whether the claimant meets the qualifying threshold of incapacity for benefit purposes on the basis of the PCA report and all other available evidence. If the threshold is met, a review date is set for further assessment, based on advice from the examining doctor. Those who do not meet the threshold of incapacity will have their award of IB or credits terminated. These people might then make a claim for JSA.

In areas where the ONE⁵ and New Deal for Disabled People schemes are being piloted, the PCA includes an additional element, the Capability Report, which is for the use of the client’s Personal Adviser (PA). This report is completed by the IB-approved doctor at the same time as the medical examination and is an assessment of what the client can do, in spite of her/his illness or disability. The PA uses it as part of a wider assessment of the client’s employability.

If the claimant is unhappy with a decision to withdraw benefit or credits following application of the PCA, s/he may ask for the decision to be reviewed by a different DM. If the decision is confirmed, there is a right of appeal to an independent appeal tribunal. During these stages, the

⁵ ONE is a new service for people of working age being piloted in 12 areas of the country. ONE brings together the ES, BA and Local Authorities at a single point of contact. New claimants for certain benefits, including JSA and IB, are allocated a Personal Adviser, who guides them through their jobsearch and/or their claims for benefit.
claimant may provide further evidence for the DM or tribunal to consider, for example from her/his GP or specialist. Cases that go to tribunal can take six to eight months to be resolved, during which period the client can claim JSA or IS. IS, however, is then payable at a reduced rate.

**Severe Disablement Allowance (SDA)** is for people who have been incapable of work for at least 196 consecutive days and cannot get IB because they do not meet the contribution conditions. If the claimant is aged over 20 years, s/he must have been incapable of work and assessed as at least 80 per cent disabled for at least 196 consecutive days in order to be entitled to SDA. Only one claimant in the study sample was getting SDA, which was closed to new claims from April 2001.

There are a number of routes onto **IS for sickness (ISS)**. Essentially, claimants deemed incapable of work can get IS based on incapacity. ISS is income-related, so a claimant’s income must fall below a certain amount for benefit to be payable. ISS cannot be paid to anyone who has more than £8,000 capital.

Although there is no legal requirement to do so, usually a person who is or becomes incapacitated will make a claim for both IB and ISS. The main reason for this is that if it is found that the client does not fulfil the contribution conditions for IB, her/his entitlement to IS will run from the day of her/his initial claim for that benefit, provided s/he meets the eligibility criteria for ISS mentioned above and is deemed incapable of work. If the client waited to hear the outcome of her/his IB claim before claiming IS, there would be a period of time for which s/he would not receive benefit. It is likely, however, that the claim for IB would remain active on a credits-only basis, in order that the claimant has NI contributions paid on her/his behalf and that her/his incapacitation can be monitored.

Claimants receiving ISS for 12 months are entitled to the IS Disability Premium (ISDP). In addition, people in receipt of certain other benefits, including SDA and Disability Living Allowance are entitled to ISDP after 28 weeks of incapacity.

**Jobcentre Plus**: The government has announced its plan for the future shape of the ES and BA, called Jobcentre Plus. This will combine the functions and services of the ES and the working age parts of BA. Offices for these functions will be located on the same site and staff will no longer be working for two separate agencies. New claimants for a range of working age benefits, including IB and IS, will be invited for a discussion with a Personal Adviser to talk about work. The Jobcentre Plus development was not discussed with participants, but could have considerable implications for some of the issues reported.
2.2 Trends in level of flows  DWP statistics suggest that the level of flow from JSA to IB has actually been reducing over recent years. The figures in the chart below are taken from the quarterly five per cent snapshot samples of management information (from which the study sample was also taken). The average number of monthly JSA to IB/ISS moves for the last three months of the period shown is 25 per cent down on the average for the first three months.

Figure 2.1 Number of claims transferring monthly from JSA to IB/ISS

Figure 2.2 shows that the proportion of those leaving JSA who move to IB/ISS has also diminished slightly over the same period.

Figure 2.2 Percentage of all monthly JSA terminations who move to IB/ISS
Whether these trends will continue is not clear from these figures, and it would be interesting to review them over a longer span. At the time illustrated in the charts, however, the level of flow from JSA to IB/ISS seems to have been abating rather than increasing.

Analysis of the database of 638 people who had made at least one move between JSA and a ‘sickness benefit’ shows the following patterns of benefit receipt at the time the list was compiled:

- Forty-four per cent of them were claiming IB/ISS, 23 per cent were claiming JSA, and 33 per cent were claiming neither.
- In their last spell on sickness benefit 41 per cent were getting IB itself, and 58 per cent were getting IB credits – ie they were deemed to be receiving IB for purposes of NI credits only, and were basically getting ISS.
- The 41 per cent getting IB proper divided as follows: 24 per cent had been getting the lower short-term rate (first 28 weeks), 11 per cent the higher short-term rate (29–52 weeks), and only five per cent the long-term rate (over 52 weeks).

In 286 cases (45 per cent) the claimant had made a net movement from JSA to IB/ISS over the period. In another 193 cases (30 per cent) the net movement was in the direction of IB/ISS to JSA. The remaining 159 (25 per cent) had moved from one of these types of benefit to the other and back again. Among this latter group 117 (18 per cent) had had one spell of IB/ISS sandwiched between two spells of JSA (JIJ), and 42 (seven per cent) had had a JSA spell sandwiched between two IB/ISS spells (IJI).

The total duration of claims is shown in the following table. This includes the sum of any spells active within the three-year period, not just the last spell. These spells were not necessarily contiguous. Apart from switches to the other benefit type they were sometimes interspersed with periods of work, claims for other benefits, or periods of inactivity where they neither claimed nor worked.

### Table 2.1  Total duration of claims

<table>
<thead>
<tr>
<th></th>
<th>IB/ISS</th>
<th>JSA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 6 months</td>
<td>54</td>
<td>48</td>
</tr>
<tr>
<td>6 months to 1 year</td>
<td>31</td>
<td>24</td>
</tr>
<tr>
<td>1 to 2 years</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Over 2 years</td>
<td>8</td>
<td>14</td>
</tr>
</tbody>
</table>

By the end of the period reflected in the sample database (May 2000) 15 people were currently claiming IB/ISS, eight were claiming JSA, and 17 were claiming neither – mostly working, but some claiming other benefits or completely inactive.
By the time of interview (Feb/Mar 2001) the 40 claimant participants were reporting their current working status as follows (actual numbers):

Table 2.2  Current working status

<table>
<thead>
<tr>
<th>Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sick/disabled</td>
<td>15</td>
</tr>
<tr>
<td>Seeking work</td>
<td>14</td>
</tr>
<tr>
<td>Working</td>
<td>9</td>
</tr>
<tr>
<td>Not seeking work</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>40</td>
</tr>
</tbody>
</table>

Among the nine ‘Working’ cases five were in full-time work, two part-time, and two self-employed.

If we compare this with their status at the end of the database period we see that:

- of the 15 people who had been claiming IB/ISS when the database was compiled, ten were still sick or disabled, two were in work, two were seeking work, and one was inactive;
- of the eight people who had been claiming JSA three had moved into work, and five were still looking. None had gone back to IB/ISS;
- of the 17 people who had not been claiming either type of benefit seven were seeking work, five were back on IB/ISS, four were in work, and one was inactive.

This shows a fair amount of movement, but no net increase in the number on IB/ISS.

2.4 Awareness and understanding of benefits

Claimant participants in the study were often vague, hazy or confused about a range of benefit matters. They were often unsure about:

- which benefits they get, or have had in the past, and what these are called:

  M: ‘Well I’m on the sick now at the moment — it’s not Incapacity it’s — er — Jobseeker’s-based Income Sick is it? There’s two different types of sick you can claim, see, and I can’t remember which one it is though.’

  (Claimant, Urban/rural)

- the history of their claims, and the sequence or timing of events;
the benefits which are available, and their various purposes:

I: ‘What sort of people get Income Support?’

M: ‘Oh, I don’t know. Well I think it means if you haven’t got enough to live on.’

I: ‘And Incapacity Benefit, what’s that for, who would apply for Incapacity Benefit?’

M: ‘Umm – don’t know. Haven’t got a clue on that one.’

I: ‘OK. And have you heard of something called Severe Disability Allowance?’

M: ‘Yes. That’s if you can’t do things for yourself and need someone to look after yer.’

(Claimant, Rural)

M: ‘At the end of the day I don’t know what I’m entitled to, that’s the bottom line. Because something I found very confusing, I was over the Social Security about three weeks ago. And he was going through my claims and everything, and he said to me, ‘Oh, you’re claiming Disability for your partner’. Or Mobility. Not Mobility, Incapacity. And I said, ‘No I’m not’. So he phoned up. And I was.’

(Claimant, Urban/rural)

- the rules governing different benefits, including:
  - eligibility criteria;
  - the distinction between contributory and non-contributory basis that exists within JSA, and also determines eligibility for IB;
  - the position about National Insurance (NI) credits for benefit claimants, and the credits-only concept for people not otherwise entitled to IB;
  - the existence of short- and long-term rates for benefits like IB.

M: ‘I didn’t know there was any different rates. They just said this is what you’re entitled to, this is what you get, and that’s it. They didn’t say what rates they were.’

(Claimant, Northern city)

- which agency they have been dealing with about which benefits.

Such vagueness is commonly found in benefits studies, but seemed particularly marked for IB/ISS.

M: ‘You’re pretty much in the dark, especially when you go along this path for the first time.’

(Claimant, Urban/rural)

F: ‘To be honest with you, I don’t understand half of it.’

(Claimant, South coast)
"I don’t know how many times I try and take it in, don’t know what it all means."

(Claimant, Rural)

"I’m sure we’ve all said if people outside knew the half of it they would be astounded, the complexity of it. It’s Byzantine, the whole thing is fantastic."

(BA/ES staff, Urban/rural)

This is probably because health-related benefits are intrinsically more muddling:

- There is an intuitive perception that there is one thing called ‘Sickness Benefit’, but there are in fact several, and none of them bears this title. The name ‘Incapacity Benefit’ isn’t widely familiar at all.
  
  M: ‘The benefit, I just call it sick pay, it was Sickness Benefit, I think. Do you call it Incapacity? Sickness anyway.’

  (Claimant, Rural)

- The different benefits concerned are poorly differentiated and opaque in the minds of claimants, and their structure is complex and arcane. The basic distinction between IB and Income Support for Sickness (ISS) is that IB is contributions related, but this is not widely understood.
  
  F: ‘I did have a form for Incapacity Benefit, but I wasn’t on it long enough to get the Incapacity Benefit. It was just the Sickness Benefit.’

  (Claimant, Rural)

- Although this report uses the term ‘ISS’ for clarity, in fact it is just called ‘Income Support’ (IS) in official documents. This means that there is nothing to associate it with sickness in the public mind, because ‘Income Support’ has other types of association – it is a multi-purpose benefit which covers a lot of other things, and is not often connected with sickness in people’s minds. For example, one woman in the study has claimed IS in three different capacities at different times – as a single parent, as incapacitated for work, and as a carer for her disabled son. Her local office itself got confused, and kept reassessing her eligibility and the basis for her claim.
  
  F: ‘All it’s called on this letter here is Income Support, but I have a feeling it – well it has to have something to do with Sickness Benefit, doesn’t it, otherwise they wouldn’t be wanting medical notes every six months?’

  (Claimant, South coast)

F: ‘I didn’t know there was Income Support for sickness. My understanding of Income Support is you’ve got some sort of income but it’s not enough, and Income Support will kind of bring you up to a certain level.’

(Claimant, London)
• When they fall sick they have to claim both benefits – and can in fact end up getting elements of both, which is a further source of confusion (see 3.5).

   F: ‘On different papers they’ve called it Income Support, another one they called it Incapacity Benefit.’

   (Claimant, South coast)

• The health condition itself is sometimes stressful and/or confusing, which further fogs some people’s understanding and memory of what happened.

   F: ‘I found it difficult having come out of hospital, still feeling fairly ill, being weak, very, very convalescent for a long, long time.’

   (Claimant, Rural)

M: ‘To be honest I think I’ve chosen not to remember a lot of things, it was so bad.’

   (Claimant, Rural)

   F: ‘I’m a bit hazy on it, because I was on a lot of morphine and painkillers.’

   (Claimant, London)

• Sickness benefits sometimes involve several moves between benefits, sometimes for short periods which are easily overlooked when trying to remember the sequence of events.

Few people seemed to understand (or even know about) the concept of ‘premiums’ under IS – even though some were getting disability premium.

   M: ‘I don’t know if I’m getting a premium, it just says on me book ‘Income Support’’

   (Claimant, Urban/rural)

On the whole there seems better understanding of JSA than IB/ISS. The role and terms of JSA seem comparatively clear, at least on a general level. The contributory/non-contributory distinction is not widely understood, but this seems less confusing for JSA because it is handled within the one benefit, rather than obliging people to claim different things. There is also a good deal of face-to-face contact with Jobcentre staff, so that things tend to get explained – but dealings with BA over IB/ISS tend to be handled at a distance through the post (see Section 5.3).

Therefore Jobcentre staff are often asked about benefits because they tend to have closer face-to-face relationships with their clients, who sometimes turn to them when they are thinking of moving to (or have just come from) sickness benefits (see 5.1.1).

2.5 Dual benefits, dual claims

People switching to sickness benefits are usually advised to claim IB and IS simultaneously. Normally they are informed about this by BA or ES, and given or sent both sets of forms. However staff say that not everyone
is told this, and that people therefore occasionally only make one application and then have to be sent the other for completion.

F: ‘Though they’re told about claiming IB they aren’t always told about IS. They may be under the impression that they’ll be paid straightaway as soon as they get their claim form in. That happens a lot.’
(BA staff, Northern city)

Some BA staff said that ES do not always tell people about the dual claim. Conversely some ES staff said that BA sometimes only send one set of forms when claimants ring up to enquire about claiming a sickness benefit. This may well only apply in a minority of cases, but it seems worth clarifying the procedures involved.

M: ‘I think it’s a minefield, the forms. I mean the Jobseeker’s Allowance form is all in one – there’s a bit for Contributions and a bit for Income-based. Now a lot of people go sick, fill the Incapacity Benefit form in, they’ve not got the contributions on. Then they get a letter saying, ‘You’ve not qualified for Incapacity Benefit’. So then they come in here saying, ‘I claimed Sickness Benefit and I’m not getting anything, do I need to sign on so I can get some money?’. And all they needed to have done was claimed Income Support along with the Incapacity Benefit to receive the benefit.’

F: ‘If you just ask for an SC1, they (BA) don’t ask you if you might need – if you rang there they just take you exactly what you’ve asked for, an SC1, they wouldn’t take the trouble to inquire what your circumstances were or whether you needed that additional form so that you claimed both from the same date. And of course if you do ask for Income Support, say a week later, somebody tells you, ‘Oh you needed that’, and Income Support will only date that from your date of contact. So you might have lost some money there. And BA don’t take the trouble to ask you. We would here. We give a better service here.’
(ES staff, Rural)

F: ‘They might come back to us (IB) and we’ll say, ‘It may be worth your while to claim Income Support’, and we would advise them to do that, send the forms out to them. We hope our counter staff are advising that when they bring the forms in to check.’
(BA/ES staff, Urban/rural)

Whether or not the process is explained to claimants, it is apparent that their awareness of the dual claim is very patchy, and their understanding of it is usually very poor. They often have only a confused and incomplete memory of the claims process. Some remembered making a dual claim, but others were not sure whether or not they had done so.
I: ‘I’ve got a note here that you had Incapacity Benefit at some stage, in the early stages of last year.’

M: ‘I applied for it, but I didn’t get it. I can’t remember why I applied for it really. Trying to think, I had two forms, applying for two benefits and I can’t remember why, I think one were like Jobseeking, the other one I can’t remember why I applied for it.’

(Claimant, Rural)

M: ‘I was a bit puzzled why they gave me that form for Incapacity, ‘cos I read through it and thought, ‘I don’t understand this’ – so I just sent ‘em both off and got Income Support.’

(Claimant, Rural)

M: ‘They sent me a letter saying I’d filled in the wrong form, so I had to go back up there then, ‘cos I haven’t been paying my national insurance – so I go back up and get the other sick form then. That’s less money every week.’

(Claimant, Urban/rural)

Making a dual claim is often confusing in itself. To begin with the concept is unfamiliar, and the rationale for it rarely well understood. People have a notion that they need to claim ‘Sickness Benefit’, and are not usually at all clear why they are then asked to claim two different benefits instead, neither with the expected title (see Section 2.4).

F: ‘I’ve put in the forms for Income Support and – I don’t know if it’s Incapacity, I don’t know what they call it. I think it’s Incapacity Benefit, I’m not sure.’

(Claimant, Northern city)

It is not clear from this research whether the problem is that the situation is not well explained to people, or whether it is just intrinsically hard to understand.

I: ‘How do you explain it to people if they’ve got to fill in two claim forms?’

F: ‘We just have to say that our benefit is contributory-based and it’s different rules altogether – it’s a separate benefit altogether, with separate qualifying conditions, and they have to make two separate claim forms.’

(BA/ES staff, Urban/rural)

F: ‘They still have to apply for Incapacity Benefit even though they won’t get it, because we need it on Income Support, we need to have a decision from Incapacity Benefit.’

(BA staff, London)
Where claimants do remember how it was explained to them, two main kinds of notion seem to have come through:

- The most common recollection is that they have to claim both because it is not clear which they are entitled to, and hence a dual claim saves reclaims and delays.
- Less common but occasionally heard is the argument that it is to do with making sure they get the maximum amount of benefit they are entitled to – they might be entitled to different amounts, or might get some money from each.

Where people have either of these stories in their heads the process of dual claim tends to seem a bit less pointless and arbitrary – although it still strikes some as an oddly complicated system that makes this necessary.

Sometimes people had erroneous explanations in their minds – for example that one of the benefits is long-term and the other short-term.

F: ‘Was it Sickness Benefit or Incapacity Benefit – it took me seven weeks to get that, ’cos I had to fill in two forms, ’cos you have to apply for both, Incapacity Benefit and Sickness Benefit as far as I can remember – and they give you whichever is the larger, which is nice of them. Although Incapacity Benefit is supposed to be something permanent, I believe, that you’re never likely to work again, as opposed to Sickness Benefit which has an end in view. I honestly can’t remember, it might have been Incapacity Benefit.’

(Claimant, Rural)

M: ‘Think I did, yeah, if I think back, think I did fill in two forms, and then they made the decision.’

I: ‘Did they explain why that was?’
M: ‘Think it’s a points system in it?’

(Claimant, Rural)

The comparison is compounded by the fact (as noted in Section 2.4), that people usually don’t know which two benefits they are actually claiming, what they’re called, or how they relate to each other. They often don’t realise there’s more than one type of ‘sickness benefit’ – and don’t usually know the difference between them.

The further fact that the contributions rules are different for JSA and IB is an added barrier to claimant (and occasionally ES staff) understanding. Getting JSA(C) does not necessarily mean you would qualify for IB, although both are contributions-based.

The kind of information people get about the IB/ISS even once the claim is determined is in itself hard to understand, and does not help people get a clear grip on what benefits they are getting.
F: ‘If you’re receiving Incapacity Benefit of say £50 a week, we would take the £50 a week into account from your Income Support. What that means is that if your Income Support is £52 a week we will take off £50 a week because you’re already getting it on Incapacity Benefit.’

(BA staff, London)

The idea of having to claim two benefits in this way is in itself usually unpopular. Apart from being confusing, it involves filling in extra forms, and more hassle.

F: ‘They have to fill in two sets of forms, one Incapacity and one for Income Support.’

I: ‘How do they react to that?’

F: ‘Oh God, awful! Most of the time we try to help them, but we’re all out of the office more now, it’s become impossible.’

(DEA staff, South coast)

F: ‘I had to fill in two lots of forms. I found that an unnecessary amount of paper and felling of trees.’

(Claimant, Rural)

The fact of making dual claims sometimes seems to cause interface problems within BA, because the dual claim involves passages between IB and IS staff. This can cause delays if either section doesn’t complete its work quickly (see Section 5.1.2).

F: ‘My involvement (IS section) would be when they’ve signed off JSA and they’ve come here to claim either Incapacity Benefit and/or Income Support. I get the Income Support claim form, and then I can’t proceed with the Income Support claim until Incapacity Benefit have put their claim onto the system. I need information from Incapacity Benefit before I can proceed with the Income Support.’

(BA staff, London)

It also adds a further layer of confusion, because claimants don’t understand who they should be talking to.

F: ‘The claimants when they’re signing on (for JSA) know where they stand. When they come to claim as sick they don’t always know — and even we don’t know, we’re waiting on this person, that person’s waiting on that person — and there’s a lot of grey areas, a lot of confusion. And of course the claimant, he’ll end up like pig in the middle, whether he’s genuine or not he’s still the pig in the middle — and he’s waiting to hear from anyone, and it’s when they don’t hear from anyone that the frustration kicks in, the anger kicks in.’

(BA staff, London)
M: ‘I don’t know whether there’s a line down the floor and Incapacity is that side of it and Income Support is that side of it, and they don’t pass the files across, or there’s a little grille that they pass them through at the end of it, but unless you get the information for yourself, when you ring ’em up the next time, you sit and wait, because the person might say, ‘You’re now dealt with by office B’, but it might take three weeks for your papers to get there. You’re three weeks without money, you can’t do anything – and then you get it in a big wad.’

(Claimant, South coast)

Some staff in these two sections said they got irritated when claimants rang up and blamed them for delays caused by the other section. For example, callers would say they had already provided the requested information, but it had in fact been given to the other section and not passed on. Staff often do not seem to realise how little the public understand about these internal structures, and how unreasonable it seems to them to have to have separate dialogues with different parts of the system. They tend to assume it’s ‘all on the computer’.

F: ‘We put them through to IB and they just come right back to us, and they say to me, ‘Right, you’ve put me through’ — and they’ve been told to come back to you. Why? It’s not the claimant’s fault because he’s stuck between two sections. It’s an Incapacity Benefit query, I’ve explained to them what their Income Support position is, ‘cos I personally think it’s rude just to say, ‘Oh well you’re IB’, just throw them over there. Explain the situation to them, then put them through to Incapacity Benefit — but Incapacity Benefit just bounce it right back at us and we’re like, ‘This is nothing to do with Income Support, why have you put it through to us?’’

(BA staff, London)

IS staff also sometimes expressed resentment at being buttonholed by claimants about failing the PCA – such conversations can sometimes be difficult or acrimonious, and staff feel they are catching the flak for Medical Services decisions which lie outside their own domain.

Both BA and ES staff sometimes agreed that the two sickness benefits should be amalgamated on the lines of JSA, with the contribution condition handled within the one entity.

F: ‘JSA came in a couple of years after Incapacity Benefit, and it was all sussed out. I thought what a brilliant benefit, the first time they’ve done something right — why didn’t they do it for us (IB).’

(BA/ES staff, Urban/rural)
Possible action points

• While the present benefit structure remains it seems important:
  - to find better ways of explaining it to claimants;
  - to clarify claiming procedures;
  - to clarify benefit communications in relation to the benefits received.

• There seems a strong case for harmonising the different sickness benefits:
  - at least a single gateway to sickness benefit – for example a single joint claim form even if the benefits remain separate;
  - preferably amalgamating the benefits on the JSA model, retaining the contribution/income basis within one consolidated benefit.

• Since most people talk about ‘Sickness Benefit’ and many don’t recognise ‘Incapacity Benefit’ it seems worth considering reverting to the former title.
3 WHO ARE THE MOVERS?

Key points

- Movers are not a homogeneous group – their characteristics, personalities, situations and needs vary widely.
- In particular they enter IB/ISS with a very wide range of ailments, which have different implications for both their incapacity and subsequent employability.
- Problems often arise with ailments that are variable in effect, episodic or difficult to test. Mental health and substance abuse cases together form a large and problematic category of this kind – and are often not seen as good employment prospects by ES staff or employers.

3.1 Characteristics of movers

Analysis of the database of movers prepared for sampling purposes shows the following patterns:

- Seventy-two per cent of the listed movers were men, 22 per cent women. In the study sample the proportion of women was boosted to 40 per cent.
- Movers were well spread along the age range –18 per cent were aged 16-24, 25 per cent were 25-34, 23 per cent 35-44, 19 per cent 45-54 and 15 per cent 55+.
- Thirty-nine per cent of movers had no listed phone number. It seemed from recruitment experience that some of these unlisted cases did actually have telephones, but many did not. Some come from segments of the population with whom it is not easy to communicate – in terms either of physical accessibility, or educational level and proficiency with written communications.

Movers are not by any means a homogeneous target group. The study interviews showed a great diversity of situations, types of sickness, personalities and attitudes (see case histories in Section 3.4).

Some people showed an almost stoical fortitude in the face of sometimes considerable problems, and resolve in trying to overcome them. They tend to be anxious to lead a ‘normal life’ and not to be dominated by their disability. Conversely others seemed less resilient and more weighed down by their troubles. Where they feel particularly damaged by their experiences some try to minimise contact with the world outside. These attitudes often relate not only to their health problems, but to their employment prospects, social life, and so on.
Some movers have been on benefits for long periods – either on account of long-term health problems, or for other reasons (lone parents, long-term unemployed, etc).

F: ‘Every time my sons were ill, I’d have to give up working, summer holidays. I didn’t have anybody to look after ’em for six weeks so I had temporary work. All my jobs seemed to end in the summer, and then I’d look for work at the end of the holidays. So it was many years till they grew, off benefits – in and out of work – I always tried to work. Sickness Benefit at one time. That went on for a few months. I feel as if I’ve had a life history of benefits. In and out, it just never ended.’

(Claimant, Urban/rural)

At the other extreme there were some whose recent experience of IB/ISS and JSA was their first experience of the benefits system.

### 3.2 Types of sickness

The sample database classified the different types of ailment from which IB/ISS claimants were suffering under three headings, as:

- physical ailments (70 per cent of cases);
- mental health problems (27 per cent);
- alcohol/drug abuse (three per cent).

**a) Physical ailments:** This is by far the largest category. The physical ailments in the sample were extremely varied in nature and effect. Some (like broken legs) were generally likely to be of finite duration, while others (like chronic arthritis) were likely to be enduring and sometimes permanent problems. Some people in the physical category also had secondary mental symptoms (see Section 3.3).

**b) Mental health:** This is a fairly large and difficult category, which staff feel is also hard to deal with. Such cases are intangible by nature, and often not easy to demonstrate or test objectively. In the nature of things it can be hard for someone to prove to a sceptical observer that they have a genuine and incapacitating mental health problem – and equally difficult for the observer to prove that they do not.

Conditions like depression, anxiety and agoraphobia are sometimes seen by staff as among the health problems which are sometimes feigned by people who simply want to avoid having to seek work⁹. Sufferers are sometimes aware of this, and the feeling that they are suspected of malingering can aggravate their problems.

However, mental health problems can be extremely disabling. Sometimes they seem to arise in response to serious life events, sometimes they do

---

⁹ These impressions are generally based on perceptions and anecdotes, rather than hard evidence of fraud. As noted in Section 4.3.2, such suspicions are rarely investigated.
not have such an obvious cause.

F: ‘I've always been a very strong person, but because of various things happening, and my daughter having a very severe accident and things, suddenly it hit me and I went into a very deep depression, which is something I thought I’d never suffer from. And living on my own obviously I went to see my doctor, and he was wonderful and he said that he was not surprised — over the years things hit you and it just sort of all built up. And I really felt quite ill. I had actually thought I’d had enough of life. My daughter had a dreadful accident, and the partner I had for 13 years walked out and left me absolutely nothing financially, he’d just gone. And you try to cope with different things, and I know I suffered from a bit of a lack of confidence — as time went on and you couldn’t get a job you do begin to feel demoralised. And then with her accident — and she was terribly ill and not able to work, she lost her flat, she couldn’t pay the mortgage there, so I had her here for a short while — and with one thing and the other I just went down the pan. My family insisted I went to see the doctor because I thought, “I can work it off, I can get out of this” — but it didn’t work. And I went to see him and he said, ‘Why on earth haven’t you been before, you need help, you’ve got to the stage you’ve got to have help’. And that’s when they put me on the sickness thing, and then I don’t honestly — it’s such a muddle, I can’t remember exactly how long you’re on this sickness thing.’

(Claimant, South coast)

M: ‘I’m just depressed, I’m not motivated, I feel empty, and I have bouts of crying and I need the tablets — I have to take three at night.’

I: ‘And that started while you were still working?’

M: ‘Yeah, and then I just couldn’t work — well, I wasn’t fit to work any more, the depression was when I was working, and I just couldn’t cope any more.’

(Claimant, London)

M: ‘When I was made redundant from my previous job it was a major blow. Unfortunately, my mother died at the same time of cancer and I nursed her through that. My son ended up in prison at the same time and mother-in-law wants to commit suicide ‘cos she’s got schizophrenia. I found me auntie dead in bed, we had a car crash, my daughter was in hospital and me wife was on the edge of a breakdown. You name it, it was going on. And I took a friend home one night just up the road and I killed a dog. Oh! Everything I touched went wrong — it was a nightmare!’

(Claimant, Rural)

Some mental health problems also come and go to some extent. There may be periods of remission and relapse, which can alternate on short-term and/or long-term cycles. At any particular moment a sufferer’s mood and level of incapacity may be reasonably good or very poor.

People also often find it difficult to admit publicly that there is something
wrong with their mental health. It tends to be assumed that employers would not want to take on people with mental problems.

F: ‘I would tell anybody anything rather than say you were depressed, it’s too embarrassing. It’s still stigmatised. And nobody will employ you. ‘What do you suffer from?’, ‘Depression’. You don’t put that down! You dare not write that down. ‘Have you ever suffered?’. I lie, I do, and put ‘No’. If somebody offered me a job tomorrow and they asked me, ‘Do you suffer from depression?’, I’d put ‘No’. I’m sorry. ‘Cos you won’t get the job. It’s terrible. I’ve been offered good jobs, until they’ve given me the form. And I know they can check with my GP, so I can’t lie. So I’ve not applied for ‘em. So that’s why I’ve been kept in a spiral of low-paid work, because you dare not expose it.’

(Claimant, Urban/rural)

Some ES staff also tend to think that mental health cases are likely to be difficult to place. They often feel it would be pointless to send someone exhibiting mental health symptoms for interview – employers would react badly, and the claimant’s failure might actually worsen their condition.

M: ‘Sometimes I go a bit funny and I shout, so they said, ‘He’s definitely not well, so put him on the Income’ – ‘cos I blow up sometimes, when you’re trying to get through to someone and it’s like talking to a plank of wood.’

(Claimant, London)

F: ‘An example of very severe depression, and I thought he’d signed off sick – and I saw him in the office last week and I was thinking, ‘Oh no, don’t tell me he’s back!’ . And that would have been someone that just sits here like this and hasn’t worked for 15 years, and couldn’t cope with the day-to-day pressures of working. I thought we’d persuaded him to go back onto Incapacity Benefit – but perhaps not.’

(ES staff, South coast)

Evidence from the ONE employer’s research\textsuperscript{10} found that employers were less willing to take on people with mental health problems than with physical disabilities. While 62 per cent of employers said they would be likely to take on people with physical disabilities within the next two to three years, only 37 per cent said they were likely to take on people with mental health problems.

Mental problems can also reduce claimants’ confidence and motivation in the job market. Self-esteem may be low, and people may have difficulty in presenting themselves positively. They also sometimes have coping worries – their mental problem might make it impossible to do the job,

or working might make their problem worse.

Staff say that certain types of mental health case can be hard to handle, and potentially violent.

M: ‘I certainly know of a guy with mental problems, that if you say to him, ‘Go and see your doctor’, he says, ‘If I go and see me doctor they’ll take me away’. So he’s caught between the two benefit systems. And they would take him away as well, he once went to sleep in the foyer. So in the end he comes in here. You’re never going to send him to an employer, he probably isn’t genuinely looking for work, but you think, ‘Hang on, what do I do with this guy?’. Do we say, ‘Right we’re stopping your money’ – and he’s potentially violent?’

I: ‘If he was genuinely looking for work would he find it?’

M: ‘No. No, an employer wouldn’t touch it, he’s got mental problems and he’s potentially violent as well. He refuses to go and see his doctor, so what do you do? And you carry on paying him’

(ES staff, Rural)

M: ‘They can be quite touchy if you say, ‘Go back to the GP’.

F: ‘They could flip any time.’

M: ‘Are you saying I’m insane?’, all these come out. You have to sometimes basically just go through an interview, and just let them continue signing on.’

F: ‘Because you’re dealing with someone that’s all right one day, and the next day they come in and say, ‘You haven’t seen me, I haven’t been here’. They could be fine one day, but when they come in to sign it’s a different person. You think, ‘How did they get through the system?’’

(ES staff, London)

Some people refuse to acknowledge that they have mental health problems at all.

F: ‘There are a lot more people with mental health problems, and most of them refuse to accept the fact that there’s something wrong with them, and won’t claim Sickness Benefit – they refuse to claim it.’

(BA/ES staff, Urban/rural)

c) Alcohol/drug abuse: We had few of these in the sample – they formed only three per cent of the sample list. They proved very difficult to recruit, so we were not successful in boosting the numbers.

In some ways people with alcohol/drug abuse problems have similar characteristics to mental health cases. Problems may again be more or less apparent at different times. In addition some staff said that people with substance abuse problems sometimes under-report their condition – they may need to earn to support their habits, and may want to seek work even though not really fit to do so.
F: ‘It’s notorious with people who are alcoholics, they deny they’ve a problem and nobody can help them until they want to help themselves. This particular case I’m thinking of, according to his family he goes along for the test and according to him everything is fine, and he just lies – and he fails the test, scores nothing. But all he wants to do is have money for drink – and completely unemployable.’

(BA/ES staff, Urban/rural)

Again, ES staff tend to be reluctant to send substance abusers to employers.

M: ‘I’ve had ones who’ve been on drug rehab programmes, alcoholics.’

I: ‘How would you feel about sending them for interviews?’

M: ‘Well I wouldn’t. I just think they just wouldn’t be able to start work, they’re just not in a position – and then you start sending them for interviews and they get knocked back, that’s going to drag ‘em down even further, they’re already at a low stage when they come in.’

(ES staff, South coast)

M: ‘Once again I think you just sign them on and – ’

F: ‘Ignore them!’

(BA/ES staff, Urban/rural)

The sample database also lists claimants’ illnesses and disabilities in more detail. Here it is notable that the ‘Mental, Behavioural’ category is larger than any specific group of physical ailments.

Table 3.1  Claimants’ illnesses and disabilities

<table>
<thead>
<tr>
<th>Category</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental, behavioural</td>
<td>30</td>
</tr>
<tr>
<td>Musculoskeletal and connective</td>
<td>18</td>
</tr>
<tr>
<td>Other symptoms, signs etc</td>
<td>18</td>
</tr>
<tr>
<td>Injury, poisoning, external causes</td>
<td>17</td>
</tr>
<tr>
<td>Cardio-vascular</td>
<td>3</td>
</tr>
<tr>
<td>Digestive system</td>
<td>3</td>
</tr>
<tr>
<td>Respiratory</td>
<td>3</td>
</tr>
<tr>
<td>Endocrine, nutritional</td>
<td>1</td>
</tr>
<tr>
<td>Genitourinary system</td>
<td>1</td>
</tr>
<tr>
<td>Neoplasms</td>
<td>1</td>
</tr>
<tr>
<td>Nervous system</td>
<td>1</td>
</tr>
<tr>
<td>Skin, subcutaneous</td>
<td>1</td>
</tr>
<tr>
<td>Other or unclassified</td>
<td>1</td>
</tr>
</tbody>
</table>

1 This includes people with obvious symptoms (like pain) the cause of which has not yet been diagnosed.

The table also hints at the very large array of different kinds of problem people have – some of the larger categories in themselves contain many different types of ailment. There is a yet more detailed classification in the database that lists 105 different types of sickness or disability. It is not worth quoting these in detail, but below are the dozen largest categories, all those accounting for two per cent of cases or more.
### Table 3.2 Largest categories of illness and disability

<table>
<thead>
<tr>
<th>Category</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive episode</td>
<td>15</td>
</tr>
<tr>
<td>Back pain</td>
<td>10</td>
</tr>
<tr>
<td>Pain, other</td>
<td>7</td>
</tr>
<tr>
<td>Unknown, unspecified causes</td>
<td>7</td>
</tr>
<tr>
<td>Other anxiety disorders</td>
<td>6</td>
</tr>
<tr>
<td>Other spine, trunk injuries</td>
<td>5</td>
</tr>
<tr>
<td>Fracture of upper limb</td>
<td>3</td>
</tr>
<tr>
<td>Reaction to severe stress</td>
<td>3</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>2</td>
</tr>
<tr>
<td>Other arthritis</td>
<td>2</td>
</tr>
<tr>
<td>Other arthrosis</td>
<td>2</td>
</tr>
<tr>
<td>Other neurotic disorders</td>
<td>2</td>
</tr>
<tr>
<td>Surgical treatment</td>
<td>2</td>
</tr>
</tbody>
</table>

It is notable that ‘depressive’ episode is the largest single element (15 per cent), followed by ‘back pain’ (ten per cent), and ‘pain, other’ (seven per cent). ‘Other anxiety disorders’ (six per cent) also comes high.

In talking to our sample of IB/ISS claimants and staff various other relevant ways of classifying health problems suggested themselves. The main concepts are listed below:

- **Acute or chronic**: Some problems are of finite and sometimes brief duration, with a prospect of a full recovery. Others are more enduring ailments, which may even be permanent in some cases.

- **Stable, versus periodic or remitting**: Some ailments are relatively stable while they last, others come and go, with periods of remission and relapse. Assessment of the latter can be difficult, since on any given day patients may be (or appear to be) considerably better or worse than on other occasions. These variations may be short-term or long-term in effect.

  *F: ‘Drug and alcohol dependency and mental health issues – and those are the three most difficult areas really, because they’re so fluctuating. Those people for example who have a broken leg or a broken arm generally find work quite quickly because it’s something which has happened, it’s gone away, it’s not a recurring problem.’*
  
  (ES staff, South coast)

  *M: ‘It was a viral infection. You have good days and you have bad days. And there are some days I would get up, go downstairs, have a cup of tea and all I wanted to do was to go back to bed ‘cos I felt absolutely lousy. And there were other days when I felt I could have gone and run the marathon.’*
  
  (Claimant, South coast)
• **Prospect of improvement**: Some types of problem are likely to improve or cease in due course. Others are not likely to improve – and some may be terminal.

• **Objective observability**: Some illnesses or disabilities are relatively easy to observe or demonstrate, others are more intangible, and hence easier to ‘fake’, and harder to test. It is interesting that the two forms of sickness listed at the top of Table 3.2 are both hard to demonstrate or test objectively – and are also the two examples most often talked of by staff as likely choices for anyone who wants to feign illness in order to claim sick.

  F: ‘Back pain and depression tend to be the most popular ones, because you can’t prove someone hasn’t got depression, you can’t prove someone hasn’t got back pain.’

  (BA staff, London)

  F: ‘It’s much easier proving that you haven’t got work and that you’re looking for work than it is proving that you find it difficult to go outside and function in the real world, unless you’ve been to see a psychiatrist or have been sectioned recently. And I think it’s more difficult to be on Incapacity Benefit really – and that’s another whole like psychological issue. You’re being asked to prove that you’ve got problems. And it’s not pleasant to have to say to somebody, ‘I’m having really bad flashbacks, I’m looking at a bus and I’m getting freaked out’. ‘Oh really? Can you prove it?’ Does that make sense?’

  (Claimant, London)

• **Effects on capabilities**: Different illnesses are more or less limiting for people’s activities or capabilities. The kinds of process someone can carry out will depend on what is wrong with them, as will the kinds of situation or activity which trigger attacks.

• **Barriers to employment**: Different disabilities provide different kinds or degrees of barrier to employment, including acceptability to employers as well as ability to do the job. For example health problems like epilepsy are said to have an off-putting image, although someone with well-controlled epilepsy may be capable of a wide range of work (see Section 7.2.2).

Some of our participants were having trouble getting a clear diagnosis of what was wrong with them.

  M: ‘For the last four years I’ve been getting really bad cramps and pains and spasms in my legs as well as my back. At first I was told it was kidney stone problems, then I was told it was circulation problems, then I was told it could be a heart problem, but last year I eventually had an MRI done on my back which showed a slipped disc which was eroding, so it had been out for a while anyway. I don’t know how long I’ve had the slipped disc, which I’m being treated for at the moment.’

  (Claimant, London)
3.3 Multiple problems

Some people suffer from multiple health problems, which can affect their capacity to work, and/or their employability (see Section 7.2.2) – for example:

- A woman with asthma also had ‘flat vertebrae’.
- A man who has both seriously arthritic knees and also club feet finds that the latter condition aggravates the former, because it affects the way he walks.

Sometimes we can divide these into primary and secondary problems. The primary problem is what makes the individual incapable of working. Secondary problems are not the main cause of incapacity, but they can in themselves affect someone’s fitness for work or employability. Secondary problems are often (but not invariably) mental in character.

Secondary health problems (mental or physical) can arise either:

- directly from the primary source of incapacity; or
- indirectly from employment difficulties or other consequences of the incapacity.

For example someone who is in a lot of pain and sees little prospect of improvement can sometimes get depressed on that account. This depression may be mild, but could in some cases reach serious clinical levels, which might in themselves be incapacitating. In other cases a secondary depression may arise not from the pain itself, but from the effects the primary ailment has on employment prospects, social life and so on.

M: ‘Well I do get down on days, to be honest with you. I just try and put it behind me, like. I mean I’ve just come out of hospital after an operation. I got high counts of white blood cells in my body and they’ve got to try and sort that out as well. I don’t try to think about it – just take a day as it comes.’

(Claimant, Urban/rural)

From the employment point of view health itself is often not the only issue. There is a range of other types of problem – limitations in education, qualifications, vocational skills or work experience, deficiencies in personal or social skills, and so on. Some of these may have been caused by long-term illness, but conversely in other cases the illness might have been triggered by multiple deprivation – or the two sets of problems might be quite unrelated. Whichever is the case they can have an additive effect as obstacles to employment (see Section 7.2.2).

M: ‘I’ve always had problems, I missed a lot of school because of it, I never got to do any exams because of the illnesses.’

(Claimant, London)

Multiple problems can also occur with older people. The cause of incapacity may or may not be age-related, but age is sometimes a factor.
in someone’s employability, or in their confidence in being able to find work.

3.4 Some case histories

The best way of understanding the kind of people who make switches is through looking at a range of individual cases in the round. Below is a short series of brief accounts, selected to illustrate the diversity of people and experiences.

Case A

This man in his early 50s, formerly a senior local authority personnel officer, was suddenly made redundant late in 1998. He had previously worked all his life. Since redundancy he has taken a series of temporary and part-time jobs, interspersed with JSA spells and one period of self-employment, which didn’t produce a viable business.

His redundancy happened to coincide with a series of crises in his personal life. This put him under a lot of stress, but he signed on with JSA and looked for work, even though he wasn’t sure he could handle a job if he got one. Eventually he got a viral respiratory problem combined with depression, and was given a note by his doctor which caused a move to IB. He recovered from this and went back on JSA.

He seems keen to work – and is now working again, but in a temporary job, supported by New Deal 50+ (about which he is enthusiastic). He seems to have been active in looking for jobs, but has had little success – and at his age is becoming increasingly doubtful. He is slowly and reluctantly lowering his sights about the kind of work he is looking for.

Case B

This 30 year old man has a recurrent back problem stemming from a childhood accident. When his back is bad he can’t dress himself or sit up. For the last seven months he has been on IB/ISS because he has been having a bad time with his back. Before that it was less of a problem and he went on JSA. However the only jobs he is really qualified for involve physical tasks which he can’t do because of his back. He is unable to read or write properly, although he has taken some local courses in basic literary skills. He has not actually worked for more than ten years. The Jobcentre encouraged him to claim sick.

Case C

This young man (25–34) is now on JSA. He has had several spells of JSA and work, with one three-month period on IB for a depressive illness following marital breakup. He seemed vague and fairly confused about his benefit and work history – probably genuinely foggy, not just evasive. He misremembered the length and timing of his illness. He says he wants to work, but seems to have low motivation – and perhaps naively
high expectations relative to his lack of qualifications and experience (and apparently limited intelligence).

**Case D**

This man in his early 30s is an A level qualified clerical worker. During the monitoring period he spent a total of 54 days on JSA in two spells. He had only nine days on IB when he had a short period with a ‘bad back’. He was working at the time, but (for some reason he didn’t understand) did not get SSP. He went briefly back on JSA at the end of his illness (which he had expected to be very short), and then got a job, which he still has. Other than these two JSA and one very short IB/ISS spell he seems to have worked more-or-less continuously – and expects to stay in work.

**Case E**

This is a former civil servant, who took early retirement at 50. He hoped to get other employment but has found it hard to get a suitable job that pays enough. Because of his pension he only qualifies for JSA credits, and has to pay for his own training courses. He has been on JSA for nearly four years since retirement, apart from three months on IB when suffering from cellulitis.

He doesn’t understand why the State actually pays him when he is ill but not when he is seeking work.

He is very reluctant to claim sickness however, although he is beginning to think he will never work again – the longer he is out of work the more difficult it is to find a job. But some of his friends in similar circumstances have ‘retired’ on to IB, and he feels some pressure from his associates to do likewise – which he has so far resisted.

**Case F**

This is a black woman in her 50s. She used to work as an accountancy assistant. She had five children and lost her job after maternity leave 19 years ago, so decided to look after the children until the youngest was at secondary school. She suffers from long-term high blood pressure and worries about her health. She gets dizziness and headaches if she bends down. She was on IB/ISS for a period until she failed the PCA since when she has been on JSA. She has done a number of office skills training courses but has not managed to find a job – she thinks because of her employment gap, age and health. Her spoken English is hard to understand. She seems desperate to work, but has little hope of finding anything. She thinks the Jobcentre don’t have much time for her, and feels a bit let down.
She was terrified and unnerved by the disallowance letter following her PCA failure. Her GP feels she is unfit for work but says he is unable to help her now the PCA verdict has gone against her. She seemed stressed and emotional during the interview and clearly feels trapped and powerless.

**Case G**

This divorced woman in her late 40s has two teenage children. She became unemployed in 1998 when her company started laying off people, and initially went on IS as a lone parent. She decided to take a word processing course to improve her skills. When her son reached 16 she could no longer get IS, and she then claimed JSA. The Jobcentre said at first that she couldn’t carry on with her training because she would not be available for work, but then decided she could because it was only a part-time course. Before completing the course, she developed a gynaecological problem that led to a hysterectomy. She told the Jobcentre when she started experiencing difficulties, and they advised her to go to her doctor.

She was off sick for about six or seven months in all. She then signed on again and was on JSA for about another nine months. The Jobcentre were generally helpful, but hardly ever had suitable vacancies. When she first went back she said she could not lift heavy weights, but she didn’t think the staff took much notice. There was a ‘sort of jobclub’ which she found useful – more sources of jobs, and help with CVs etc. Eventually she found her own job as a clerical assistant through the paper, and she is still working at this.

**Case H**

This man in his late forties has had arthritis and ‘crumbling of the bones’ for the past eight years, giving him severe back pain. During the interview he had to keep shifting his seat, and was clearly in a lot of pain.

His last job was shelf-stacking in a supermarket, but five years ago he got to a point where he could no longer do this because of the bending involved. He signed on for JSA, and tried to find a job that didn’t involve bending. He thought that delivery driving would be a possibility, but couldn’t find anything suitable. He had the idea of retraining to do book-keeping, which he had had some experience of a long time ago. He has found the Jobcentre staff friendly, but not at all useful in finding work.

He then had to go for hospital tests, and his doctor said he should give up trying to find work. His condition had got a lot worse, and the hospital said it would continue to deteriorate.

A year before the interview his doctor gave him a letter. He took this to the Jobcentre, and signed off. He had previously been on JSA for about 16 months. He then got what he calls ‘disability’, and is still getting this.
Case I

This man in his late 50s used to be a Civil Service HEO, but had to take compulsory early retirement about five years ago. After a couple of years attempting self-employment his business did not succeed, and he signed on for JSA.

He has had problems with his feet all his life, and latterly began to develop arthritis in the knees. His condition began to deteriorate rapidly, but at first he continued to look for work. His Jobcentre adviser suggested non-clerical posts like supermarket shelf-stacking but he pointed out that he couldn’t bend his legs or kneel. He was referred to the DEA. He found her ‘most helpful’ in approach, but she seemed mainly interested in retraining. Since he was experienced in clerical work (which would have been ideal) this did not seem necessary but he couldn’t get suitable clerical jobs. His condition worsened, and finally his doctor gave him a sick certificate.

Having been in the Civil Service all his life with few spells of illness he knew little about the benefit system, but is used to dealing with forms and literature. He took his sicknote to the Jobcentre, who explained the procedures and gave him forms to fill in.

He is now waiting for an operation on both knees, and has been signed off work until that happens – probably in a couple of years. He has had a PCA, which confirmed he was not capable of working. He seems to be in severe pain, and cannot walk more than 50 yards without stopping. He now gets ‘Mobility Allowance’ at the second application. There is no question of his returning to work until after his operation – by which time he will be 60.

Case J

This woman in her mid 40s has suffered from cyclic depression for the past 20 years – starting when her marriage broke up in her early 20s, leaving her to bring up two small children. She was prescribed Valium at the time, and became dependent on it until she was finally able to give it up.

She has been in and out of work periodically through her life, although working at the time of interview. She says she prefers to work – she dislikes being on benefits, and was ‘brought up to work’ by her father. Her spells on and off work were partly determined by her depression, partly by being a single parent, and partly by a perceived benefit trap – she can usually only get low paid work, and by the time she has lost HB and CTB she finds she cannot pay her way. She says this can make you ‘dependent’.
She had a long spell on ISS in 1999, again caused by depression. While the depression is bad she is unable to work, but she says that having had depression also makes it much harder to get work – she feels it is stigmatised, and a major obstacle to being taken on. She doesn’t now admit to having had it on application forms and interviews.

She is currently working as a care assistant. This has been her main line of work, because she ‘loves working with people’ – but it is poorly paid.

Case K

This young woman is aged 22, partnered, with one child. She last worked on an assembly line, but she stopped work when she had to have an operation. She had three PCAs, one every two months. The first two confirmed that she was not fit for work, because the operation ‘hadn’t healed’, but the last said she was fit. She was not surprised at this – she said she was expecting it, and agreed with the verdict. She then got a letter, which said she had to go back on JSA, which she did.

Case L

This woman suffers from depression and anxiety – serious enough that sometimes she is afraid to go out. She was working when she became ill. She says she enjoyed her work as a catering assistant, but she got to a point where she could no longer ‘cope with people’. After a spell on SSP she had to claim ‘Sickness Benefit’ – this is how she refers to it, but she knows it is called ‘Income Support’. She’s had two PCAs, six months apart – passed the first, disallowed the second – but won her appeal and is now back on sickness benefits.

She feels satisfied with her treatment by the benefit system, and found BA staff polite, friendly and helpful. She says she had no problem with her claims.

Case M

This woman in her early 50s has been suffering from epilepsy for 30 years. She was on JSA for a while a couple of years ago, since when she has been getting ISS. She has been on sickness benefits for a long time, with brief spells in work or unemployed.

The jobs haven’t lasted because of her epilepsy. Although she describes this as ‘only minor’ she finds it loses her jobs. She has tried telling employers in advance (in which case she doesn’t get offered the job), and not telling them (in which case she sometimes gets the job, but loses it as soon as she has an attack).

She seems very keen to work, but has more-or-less given up hope. For ten years she has been doing voluntary work a couple of days a week at
a local charity shop, mainly just to keep active and get her out of the house. Otherwise she finds she gets depressed, and time hangs heavy. She feels the Jobcentre and Benefits Agency are sympathetic to her voluntary work, and have not suggested this might affect her benefit status. She had to get letters saying she wasn’t being paid anything, but that was all. The voluntary work is ‘the only thing that keeps me going’, and ‘gives me a reason to get up of a morning’. She feels it is good for her – but doesn’t seem familiar with the concept of ‘therapeutic work’.

She was originally an office worker, but for medical reasons connected with her epilepsy can’t work with computers (according to advice given at the hospital), which limits the range of office jobs open. In practice she has been looking mainly for retail work. The Jobcentre staff were ‘nice’, but didn’t give much actual help in finding job vacancies. ‘They have a lot on their hands’, with ‘queues out of the door’. She is convinced that employers don’t want people with disabilities.

She passed her PCA, and thinks she is now permanently signed off. But she still feels able to work if she could get something suitable from a more epilepsy-tolerant employer. She feels epilepsy has a stigma, and that employers think she is much worse than she is. She says that it is other people rather than herself who find her disability a problem. Although not now signing on she still keeps her eyes open for suitable work. A part-time job would now suit her best.

Case N

This man in his early 40s has a serious anxiety disorder. He had mainly been doing hotel work, but has had a long spell of about five years on JSA. He had developed anxiety symptoms, and when eventually offered a job as a barman he said he couldn’t do it. The Jobcentre said he was on the wrong benefit, and rang up BA on his behalf. He has now been on ISS over a year, and passed his PCA.

He is receiving counselling and group therapy for his mental condition, and is on ‘sleeping tablets’. He also gets arthritis, although this is not why he can’t work. He says he has had death threats – I cannot tell whether these were real (and may have contributed to his mental state), or are just paranoid delusions arising from his illness. He describes himself as ‘traumatised’ by the experience, and says he has ‘lost confidence’. He says it was because of these threats that he couldn’t take the bar work.

He is slow of speech and thought and his manner seems strange (it was not clear whether this is because of medication or because of his mental state). Even if he was fit for work it seems doubtful that he would be employable in his present condition.
**Case O**

This man in his late 30s was a successful manager when he fell ill. He is a graduate, and seems fairly ambitious. His doctor took blood tests and after a while he was diagnosed as having glandular fever, and therefore unable to work for at least a year. He had been working for a small firm who were unable to keep him on.

After a period on IB he was told he had to go for a medical test. He was feeling much better and anxious to resume his career, although not sure he was fit yet. But his doctor was concerned about a relapse – which could be serious with glandular fever, particularly at his age. The GP advised that he needed another couple of months – but predicted that the AWT would probably judge him fit, because it looked only at immediate capability, not at stamina.

After the medical he got a letter saying he was assessed as fit for work. He consulted his doctor again, and was told he must appeal. The GP offered to represent him, but he was told that the time (or even the day) could not be guaranteed, and he did not feel he could ask the doctor to ‘go and sit about’. The GP therefore wrote a letter, and he appealed in writing. He thinks on reflection that this was a mistake. He is positive he was not told the result of the appeal, and that when he asked for a copy of the judgement it did not arrive – he had to chase it up. At all events his appeal failed.

His doctor agreed that in the circumstances he would need to get a job, but suggested something less stressful than his original management post. He therefore went to sign on, and asked for JSA backdated to the date when his IB was stopped, on the grounds that he had not been told the outcome of the tribunal. He signed on and off on the same day, because he had found himself a ‘stepping-stone’ job at half his original salary. He subsequently found himself another management position, which he still holds.

He seems motivated and ambitious, and there is no indication that his IB claim was anything other than appropriate. The precise point when someone should start work after a debilitating illness like glandular fever must be difficult to determine, but he seems to have acted according to his doctor’s advice. He says he had to learn at earlier stages to curb his impatience to get on with his life, and to let the illness run its course.

**Case P**

This young man is a former labourer with back pain. He had several different labouring jobs, all short-term, interspersed with JSA spells. Because he was getting pain in his back he was given forms to fill in for IB. He was then told that the form was ‘the wrong one’, because he hadn’t paid enough NI, and had to fill in other forms – he couldn’t
remember the name of the other benefit, but when he checks his book it’s Income Support.

After about a year he had a medical test, which declared him fit for work. He thought this medical was unfair, but he didn’t appeal, because he thought it a waste of time to do so.

He went to the Jobcentre, and was asked if he was indeed fit. He said he thought he could do some work, but not the kind of heavy jobs he had done originally. He says that the kind of jobs he was shown were not suitable. His qualifications, skills and experience are very limited, and he does not seem very bright or communicate well. He began to come under more pressure from the Jobcentre staff, and says at one point they threatened to stop his benefit. After about three months he went on New Deal, which he thought was good, and gave him more options. He was planning to take retraining, but then finally got a job.

However by then his back was getting worse, and the new job involved a lot of bending, so he ‘had to pack it in’. At this stage he says he ‘lost interest’, and felt there was ‘no help for him’, so he stopped claiming altogether, and was simply supported by his family for about three months. Although he doesn’t use the word it sounds as if he got depressed. Eventually he claimed sick again, and now awaits another ‘medical board’.

It is impossible to tell whether he is as he presents himself (someone with a genuine health problem who has not been very well treated by the system), or whether he is simply unwilling to work. Back pain is a classic excuse for not working, and staff at both BA and ES have clearly felt they needed to apply pressure. On the other hand he does seem to have a real back problem. He is seeing a specialist, and is now to go for MRI scans. He was obviously a fitness enthusiast, and comments that it is hard not to be able to be like a normal 24 year old – he talks, for example, about having had to cut down the length of walks with his dog.

It is quite possible that he could do some work if it didn’t stress his back, but because of his limited qualifications and skills he has not been offered anything suitable. He has not seen a DEA, and is not aware of their existence.
Possible action points

- The system needs to be sensitive to a wide diversity of ailments, which may have different implications for:
  - the way they are tested at PCA in terms of variability and ease of detection;
  - the kind of support and help they need;
  - subsequent job-finding and employment.
Key points

• Moves from JSA to IB/ISS:
  - Among claimants in our sample these moves mostly seem appropriate, and were caused by some kind of deterioration in health.
  - Staff allege a range of situations in which moves are made inappropriately in an attempt to manipulate the system, but these were not much apparent from the research. Such cases no doubt exist, but are probably fairly marginal in numbers.
  - Some people are tipped off JSA by recurrent short-term sicknesses, and the mechanics of this would be worth reviewing.
  - A number of moves from JSA are caused by people returning to IB/ISS after PCA failure – mainly successful appellants or people reapplying.
  - Moves in this direction may be triggered by claimants themselves, by actions, decisions or advice from their doctors or Jobcentre staff, or by the regulations in the case of short-term sickness.

• Moves from IB/ISS to JSA:
  - The most common reason for moving from IB/ISS to JSA is because of complete or partial recovery from the incapacitating ailment. Claimants sometimes decide this themselves, but it often arises from professional or official decisions – their doctors stop certifying them or they fail one of the two tests of incapacity (see Section 6.1). In these latter cases claimants sometimes do not agree they are now “fit for work” (see Section 6.5.2).

• There is no evidence that the level of manipulative moves is unduly high, but where it happens it seems more likely to affect movement from JSA to sickness benefits rather than the reverse.

• Staff sometimes notice apparently doubtful movers, but there is no systematic monitoring of these cases, and typically no action to investigate them. Staff do not feel they have the responsibility (or even the right) to look into such cases, nor any powers to do so. Sometimes they are even relieved if ‘difficult’ or unproductive cases move to someone else’s desk.
‘Moving’ means moving in either direction between JSA on the one hand and IB or ISS on the other. Moves from JSA to IB/ISS are considered first, then moves in the opposite direction.

Moves should take place when people’s circumstances change so that they either become incapacitated or cease being incapacitated on grounds of health. That is an ‘appropriate’ move. Moves made in other situations we describe as ‘inappropriate’.

Why do people move from JSA to IB/ISS? We can divide the reasons presented into four broad groups:

1. ‘Appropriate’ reasons, where people have behaved more-or-less as they should have done in switching to a sickness benefit.
2. ‘Systemic’ reasons, where the move was initiated by the system or the regulations rather than by claimant action.
3. ‘Doubtful or manipulative’ reasons, where on the face of it claimants seem to have made the move in an attempt to manipulate the system to their own advantage.
4. Misunderstandings, where people move inappropriately because they don’t know what they are supposed to do.

This classification is clearly a matter of judgement in particular cases. We are going only on the general impression made in the interview, and without any direct access to medical information. We make no claim to know the ‘truth’ of particular cases.

1. ‘Appropriate’ reasons for moving from JSA to IB/ISS: Most of our claimant participants who had made such moves seemed to fall into this category. We have classified this kind of move as ‘appropriate’ if it occurred because someone came to the point where it was felt that they could not or should not any longer work or seek work on health grounds. This usually happened when they became sick or disabled, but sometimes because a pre-existent disability worsened or recurred, or was identified and recognised for the first time.

2. ‘Systemic’ problems: Sometimes people who have recurrent bouts of short-term sickness are tipped off JSA by the fact that their pattern of sickness exceeds the limits set by JSA regulations. These say that claimants are treated as meeting JSA conditions of entitlement for up to two spells of two weeks’ sickness in any 12 month period, but they cannot continue on JSA if they are sick for longer than two weeks or on more than two occasions in the year.
F: ‘Dealing with new (IB) claims, what we (BA) find, people are coming off JSA claiming sick with flu, tonsillitis – off for ten days, something like that. I’ve never seen a section 50A case where they sign an agreement where they know they’re going to be short-term sick and so they stay on JSA – I’ve never seen one and I’ve been on new claims for four years. Who should be advised when they’re phoning the Jobcentre saying, ‘I can’t come and sign, I’m sick’ – instead of them saying, ‘Is it going to be a long term sickness?’; or, ‘Is it just the flu? What’s the matter with you?’’

F: ‘They do get asked. We (ES) do issue quite a lot of them.’

F: ‘You might find it’s the people who are on their third period of sickness, you’re only allowed two periods of 14 days, so if it’s third period they have to sign.’

F: ‘We just don’t know that, when it comes to us (BA) we don’t see that.’

F: ‘Because there’s no indication for us, and it seems this poor guy is off for ten days, he’s lost three waiting days with us – and I’ve always felt that we were letting them down and not advising them. But if they’ve already had two bites at the cherry, there you go, that’s the reason why.’

M: ‘But then that is quite rare – very, very rarely we’ll have a person going sick three times in a year.’

(BA/ES staff, Urban/rural)

It is clearly important to have a mechanism to limit the scope for some people to abuse the system by using repeated or extended short-term sickness claims to evade their responsibilities under JSA, but it seems questionable whether the present regulations are too rigid. Genuinely short-term illnesses could easily take people across the defined boundaries in a given year. It may also be that officers do not always take sufficient advantage of such flexibility as they are allowed. Some BA staff suggested that ES do not always enquire closely enough into the likely duration of an ailment before telling people that they should go and claim sick.

I: ‘How well do you think the system handles people who are on JSA who have periods of short-term illness?’

F: ‘Well not very well, because they’re only allowed a two week period of being ill, and therefore their claim has to end and they have to claim Incapacity Benefit. Well when you’ve got a normal employer they allow 20 days a year, possibly we should be looking in line with that. Because it has its effect at the Jobcentre, possibly we should be looking to increasing that to try and stop the to-ing and fro-ing, and make it easier on the client.’

(DEA staff, South coast)

Switching people arbitrarily at some point from JSA to IB/ISS makes work and hassle both for officers and for claimants. It does not save taxpayers money because the levels of sickness benefit are similar in many cases, and if the illness is genuinely finite and short-term then people soon have to move back again to JSA, involving further hassle and cost. It also takes people further away from the job market and the pressures and disciplines which JSA is intended to apply.
It seems to us that there should be scope for holding people on JSA as long as their illnesses seem genuinely short-term, and that they should only be moved to IB/ISS if the problem seems likely to be extended enough for a move to be efficient either for claimant or system. In order to keep abuse in check there should be mechanisms for reviewing cases where the sickness starts to look excessively frequent or extended, or where there are other grounds for questioning the genuineness of the sickness periods. Sanctions should be available in cases where someone clearly abuses this provision.

F: ‘If you’ve got someone who’s got a recurring illness, they’ve only got two periods in which they can be sick in twelve months, and for someone who genuinely has got something which flares up every now and then, it’s not very generous, is it?’

(ES staff, South coast)

The system also triggers quite a large number of moves to IB/ISS where those failing the PCA win their appeal after having (usually reluctantly) claimed JSA in the interim. This therefore causes two fruitless moves, to JSA and back. Since something like 40 per cent of appellants win their case (about one disallowance in eight) this generates quite a lot of hassle for both staff and customers. It would seem sensible to review the benefit arrangements pending appeal (which seem unsatisfactory on various grounds, see Section 5.1.3), and to consider holding people temporarily on their sickness benefit until the appeal is determined.

Those who do not make or win an appeal also often reapply for IB/ISS. This is perfectly legitimate, but again increases the number of switches made. A number of BA and ES staff told us that disallowance cases are only allowed to reapply after six months, unless they are claiming for a different health problem, although we understand that this is not the case. Staff who thought there is a six-month rule sometimes suggested that this facilitates serial moving – by the time pressures have built up on JSA claimants are entitled to apply for the sick again.

3. ‘Doubtful’ or ‘manipulative’ reasons: The following analysis of why people may move inappropriately from JSA to IB/ISS in order to manipulate the system to their advantage comes mainly from staff reports. We found little evidence of this happening from our claimant participants, although such situations might not always necessarily be apparent in an interview. Staff reports were anecdotal, and officers could not say how common such events are – as noted in Section 4.3.2, no one seems to monitor or record cases like these. However the anecdotes were sometimes vividly related, and at the very least there is a lively staff folklore that such things do happen. Estimating the incidence properly would call either for a different kind of research, or for better monitoring and record-keeping.
The list of instances below is fairly long, but our net impression is that the situations presented are probably not very common.

M: ‘There are a lot of genuine people. Obviously we’re talking about extreme cases.’

(ES staff, Rural)

a) Escaping from pressure: Some Jobcentre advisers say that an important motive is to escape from pressure to find work. If Jobseekers are not thought to be making a proper effort to find work then officers start to apply more pressure, which could culminate in sanctions and loss of benefit. ES staff suggest that when certain claimants reach ‘crunch-points’ of mounting pressure they are apt to claim sick, since those receiving IB/ISS are not subject to pressures of this kind.

M: ‘I asked him to write down what he’d done to look for work and he couldn’t write anything down. So I said, ‘Right, we can’t pay you for the fortnight that you’re signing for because you haven’t been looking for work, we’ll have to refer it to a Decision Maker to decide whether you’ve done enough to look for work’. The next day he’s come in with a sick note straightaway. So as soon as we said we’re going to stop his money he’s been to the doctor and got a doctor’s note. And at the end of the day, you think, ‘Well, he’s off’.

F: ‘He’s out of my hair.’

(ES staff, Rural)

Having to go on a compulsory New Deal can have this effect, particularly when clients reach the options stage. This is often applied to young people, although not exclusively so.

F: ‘To avoid having to do what they’ve got to do. I had one client who’d come to the end of his New Deal – what we call Gateway, which is the four-month period of interviews. He was 19, 20, he was at the point where he had to start an option – and he kept telling me he had a bad back, but every time I saw him walking round the town he was walking with a jaunty step, nothing wrong with him whatsoever. I told him he’d got to start this option on Monday and he came back to me on the Friday with a three-month sick certificate – and to me that’s the main reason why a lot of people go onto Incapacity Benefit.’

(ES staff, South coast)

F: ‘The Restart process is fairly easy to avoid in a way, it’s an interview once every six months. It’s when people are over 25 they join the Jobfinder, at 18 months unemployment they would be seen by an adviser once a month, and then the pressure starts to build – and then when they get to New Deal at two years I see them once a week. Generally that’s where the crunch again hits with older clients of 25+ when they hit New Deal again.’

(ES staff, South coast)
Even if there is no specific pressure, claiming sick saves the hassle of having to sign on every fortnight – although having to renew and present sick notes can also seem onerous.

M: ‘It was the same (as JSA), but I didn’t have to spend any money looking for jobs. Because if I’m on JSA obviously I have to go looking for jobs, and if I’m not on it I don’t. And there’s no pressure.’
(Claimant, Northern city)

F: ‘It is easier for a customer to be on IB than JSA, because they go to the doctor and the doctor gives them a couple of weeks sick, and they don’t have to do anything else for that period of time. Whereas if they go down to the Jobcentre and sign they have to show what they’ve been doing to get work. So our customers would rather be on Incapacity.’
(BA staff, Northern city)

b) Working illicitly: Some staff argued that people working illicitly “on the black” while claiming JSA may find conflicts between their work and their obligations to sign on and seek work. If they find this difficult it might seem convenient to move to IB/ISS, where they would not be compelled to sign on or engage in other activities.
M: ‘People that are working as well, and it interferes with them having to come to our interviews. They would go possibly to Incap, working and signing. We can ask them to come for an interview at any time, or they’re given a letter on signing day saying I want you to come in. Now that could interfere with their work pattern.’
(ES staff, Rural)

c) Brief claims: A few BA officers said they had noticed some people moving for short periods – too short for the PCA to kick in while on IB/ISS, or for sanctions pressures to build while on JSA. There was also mention of “seasonal claims”, or holiday periods, where a short spell on sickness benefits would solve the problem of not being available to sign on11.

d) Disillusion: Some people are thought to become disillusioned with the prospects of getting work. Some of these may initially have been keen Jobseekers, but as time passes hope of getting work fades, and in that context continually having to sign on and go through the motions of seeking work can come to seem a pointless chore. Signing sick is one way out.

e) Early retirement: Shifting from JSA to IB/ISS could be used as a kind of ‘early retirement’ by someone who has reached the age where work begins to seem no longer available or no longer desirable. Staff reports of this were patchy. It was not usually one of the main categories they mentioned, but some talked of it as a matter of course. Others felt they did not see this happening – they suggested that older people are less likely to abuse the system, having grown up with a more work-oriented ethic.

11 Self-employed people were also sometimes said to use IB/ISS for short holiday periods, but these would not have moved from JSA. The self-employed are entitled to claim IB/ISS, but not JSA.
I: ‘Do some people of 55+ use Incapacity Benefit as a sort of alternative to early retirement?’

F: ‘No, I wouldn’t say that, would you?’

M: ‘No, no, in fact because I find most of the older client group more willing.’

F: ‘More willing to work than the youngsters, yeah!’

(ES staff, South coast)

F: ‘Years ago I can remember when I was working in the Jobcentres, all the doctors used to sign men 50 odd on Incapacity – ‘It’s easier, blah blah blah’.’

I: ‘It still happens?’

F: ‘No I don’t think it does so much now.’

(DEA staff, Rural)

F: ‘Not in general, it isn’t the norm. They’d still have the Personal Capability Assessment to get through, and a medical to get through – and they’re quite stringent, so they’d have to have some kind of incapacity to keep them on the books.’

(BA staff, Northern city)

The fact that people over 50 often doubt that they will find jobs no matter how hard they try may encourage this practice. On the other hand it was also sometimes suggested that New Deal 50+ is providing an attractive counterbalance for this age group.

F: ‘If you’ve worked for 30 years in the yards and you’re in your 50s, and suddenly the job isn’t there any more, and you get a sick note to say you don’t have to look for another job, that must be easier. Plus the likelihood of getting another job isn’t very high.’

(BA staff, Northern city)

F: ‘It’s too much hassle, I don’t want this, I’m going to go sick. A lot of them can be very negative, ‘You’re not going to find me a job, who’s going to employ me, there’s no point’.’

(BA/ES staff, Urban/rural)

There were clues that in some areas of high unemployment this notion of early retirement may have become part of the culture. For example in one such area a man said that this almost seemed to have been expected of him – some friends had taken this course, and urged him to abandon his scruples and follow suit. We found clues in areas of high unemployment that:

- pessimism about the prospects of getting work tends to encourage staff to be more flexible in their approach, sometimes to the point of bending the rules to suit the situation on the ground;
similar pessimism on the part of claimants also sometimes encourages them to feel that it is legitimate for them to bend (or even break) the rules;

* there are more advice agencies (sometimes more streetwise and aggressive), which can encourage some clients to look for ways of getting round regulations which appear too harsh for their context.

One factor which may perhaps have encouraged some people to use IB for early retirement is in the fact that it has treated occupational pensions differently from JSA. Someone with an occupational pension might therefore have been better off under IB. However most of our participants did not know enough about the benefit structure to be aware of this. We understand that these differentials have been adjusted since the fieldwork took place.

M: ‘I think the element that we’ve seen that are perhaps reaching retirement age are the people with pensions. Because I’ve certainly seen people that when I’ve told them that it’s going to wipe out their Jobseeker’s Allowance, they’ve asked me directly, ‘Does it affect Sickness Benefit?’, and I’ve said, ‘No it doesn’t’. And then lo and behold they say, ‘Right I’ll go and see me doctor’. And they’ve just finished work. They’ve been working and they’ve come in to see you within a few days and then all of a sudden they’re ill. Amazing!’

F: ‘But obviously that will change from April because they’ll lose some.’

(ES staff, Rural)

F: ‘Well that’s what this occupational pension thing is all about now, taking that into account against IB – that’s brand new, because there’s this body of people like police and firemen and so on who take early retirement and come onto IB. Now some of them of course will be genuine, but others, they’ve retired early with these handsome pensions.’

(BA/ES staff, Urban/rural)

However, we found few signs of this ‘early retirement’ motivation from the claimants interviewed, although we had nine people aged 55+ in the sample. Some of these older people seemed keen to work, and frustrated by their inability to do so. They often felt unable to get jobs on age as well as health grounds.

*f) Differential benefit rates: It had been suspected that some people might have been induced to move because of differential benefit rates between JSA and IB. This was only occasionally suggested as a motive by staff, and again there was little sign of this being an important switching factor among claimants in our sample.*
To begin with, claimants often seemed unaware of or hazy about differentials. Again there was typically very little knowledge of the way the different benefits work, or of the amounts involved. We found most claimants unaware of the different rates payable at different stages of IB.

Disability premiums payable under ISS can also make a difference – but again we found very low awareness of these.

Claimants usually thought that changing from JSA to IS (or back again) made little difference to them financially – either the money was thought to be the same, or any difference was remembered as marginal. Nor had they generally expected it would make much difference – and it would probably be expectations rather than actualities that would motivate moving.

F: ‘Well I did come off the Social and went onto the Sick Benefit to see how that went, to see if it’d help me any other way, but it didn’t, I still got the same amount of money as what I was signing on.’

(Claimant, London)

Some claimants argued that the disability money ought to be higher, because sickness and disability tend to increase costs.

F: ‘I was a bit stunned to find it was less money than the then Unemployment Benefit. And this made no sense at all to me, because if you’re too ill to work, you are likely to need better food – and more warmth.’

I: ‘This time was it less, or about the same, or more?’

F: ‘About the same, I really can’t remember.’

(Claimant, Rural)

M: ‘I got less on Sickness Benefit than I did on JSA. There’s 49 quid and I was getting 51 on JSA. So I have all this stress and anxiety and upset, I literally could not walk across the room, my immune system had gone – and I lose two quid a week. Oh dear!’

(Claimant, Rural)

Apart from differential rates there could also be financial differentials in the way other income or capital are treated which might make IB (but not ISS) more attractive to some people. This might well be a factor in certain cases – but once more it did not show up much in our sample. Awareness of these differences again generally seems very limited, and (as noted in Section 2.4) we did not find many customers who were at all clear about which benefits are means-tested – or even knew which benefit they were actually getting.

There may well be a minority of unusually savvy or well-advised individuals who do understand the financial implications of moving but who did not happen to show up in our sample. However, in the general case this does not seem to be a significant factor in causing flows from JSA to IB.
g) Former lone parents: When the children of lone parents reach 16 they have to sign on. This was occasionally said to precipitate a sickness claim.

h) Change of illness: As noted above, it was sometimes (incorrectly) believed by some staff and claimants that people who have failed the PCA and been forced to claim JSA have to wait another six months before being able to reclaim IB/ISS. It was alleged by some of these members of staff that claimants sometimes present a different illness in order not to have to wait. Some such switches might of course reflect genuine changes in health, but staff suggested that in some cases this may be an attempt to beat the system. In one big-city area it was described as a common occurrence – but again we did not pick up such cases in our sample.

i) Exaggeration of problems: Some people may have real but minor problems whose effects they are said to exaggerate.

F: ‘The thing is you have got your very small minority of people that have perhaps niggly ailments, perhaps niggly asthma – but they make it bigger.’

F: ‘Bad backs, that sort of thing.’

(ES staff, Rural)

4. Misunderstandings: It appeared from comments made by some ES staff that claimants occasionally move to IB/ISS because JSA was claimed mistakenly in the first place. Some people are said to come and sign on as Jobseekers in spite of having an incapacitating disability – either because they think that’s the right thing to do if you want benefit, or because they are keen to work and therefore underplay their incapacity. Such cases should normally be picked up at the reception stage before they actually claim, but it seems that they sometimes get through the net, and their sick status only becomes apparent at a later stage when the claim is already logged.

F: ‘There are a few people with learning disability, and they don’t understand the forms or the system, and if there’s no adviser to help them they get lost in the system and they don’t know which benefit they should really be on – and they don’t understand it.’

(DEA staff, South coast)

4.1.2 Triggers for moving from JSA to IB/ISS

Moves from JSA to IB/ISS for the reasons described above may actually be initiated by a variety of individual decisions or triggering events:

- Often the impetus comes from the claimants themselves, who may decide to move for various reasons – typically arising either from a change in their state of health, or growing signs of their incapacity, but sometimes from a desire to escape from the demands of JSA and signing on.
- Sometimes it is the patient’s own doctor who triggers the move by advising them to stop working, and issuing a certificate which ‘puts you on the sick’.
F: ‘I think that was down to the doctor. I don’t remember ever saying to anybody, ‘Right, I’m coming off, I want to go on something else’.’

(Claimant, South coast)

- Sometimes the trigger comes from Jobcentre advisers suggesting that a client should claim sick – either because it becomes apparent that they shouldn’t be working, or because staff sometimes despair of being able to place someone whose symptoms make them seem virtually unemployable (see Section 6.5.3). This sometimes happens when they sign on; sometimes after repeated attempts make it seem that they cannot get a job or shouldn’t start work; and sometimes when their health seems to deteriorate.

F: ‘I’m saying to them every time, ‘This is the kind of job I can do’. So they say, ‘In that case you’re not fit to do any rough job, or any other job, you need to apply for disability’.’

(Claimant, London)

F: ‘I’ve persuaded several clients to claim Incapacity Benefits, but it’s predominantly been those with mental health issues who don’t have the motivation. They’re quite happy to plod along on JSA, and because of the mental health issues, depression and things like that, they don’t want to face the decision to change from one benefit to another. And really with those clients it’s gentle persuasion, it’s talking to them, explaining the benefits – and you can persuade clients to change to Incapacity Benefit who you feel really mentally are not capable of working.’

(ES staff, South coast)

- Finally it is sometimes the regulations that trigger moves from JSA to IB/ISS – notably in the case of someone having a series of short illnesses while on JSA.

**Possible action points**

- Look at the financial structure of these benefits to minimise incentives to move inappropriately to IB/ISS.

- Review the way short-term sickness is handled within JSA to minimise very brief switches.

- Consider holding post-PCA appellants on IB/ISS pending the outcome, to minimise unnecessary moves.

- Keep careful watch for signs of incapacity when people are about to make a new JSA claim.
4.2 Moving from IB/ISS to JSA

4.2.1 Why people move from IB/ISS to JSA

Why do people move from IB/ISS to JSA? Again we can cluster the reasons broadly into ‘appropriate’, ‘systemic’ and ‘doubtful’ categories.

1. ‘Appropriate’ reasons: The most obvious reason for moving off IB/ISS is when claimants recover from the illness or disability, or their condition improves sufficiently to allow them to look for work again. Either the person decides for themselves that they are better, or sometimes their doctor tells them it is now OK for them to get a job. In some cases the doctor stops certificating them.

In certain cases it is simply a case of feeling well enough to work, but with some types of illness the issue is also when it is medically advisable to return to work, and professional opinion is then important. For example one young man with glandular fever began to feel that he was nearly ready to go back to work, but was advised by his doctor that he should leave it for a few more months to minimise the risk of potentially serious relapse.

Another important reason for moving is simply PCA failure, and in cases where this is based on a correct assessment it can be classified as an appropriate move. Statistically about a third of those who move from IB/ISS to JSA do so because of PCA failure, but it was notable that this often seemed the main reason in the minds of ES staff. It is probably salient in conversations between front-line staff and clients because people who find themselves in this situation are likely to comment or ask advice, whereas if they have simply recovered from their ailment they may not feel it necessary to mention this.

2. Systemic problems: It was not the aim of this research to validate the PCA, and the kind of evidence we collected does not enable us to make judgements about the objective validity of the PCA process. However, it seems to us inevitable that there may be some unreliable results, because the assessment of incapacity is intrinsically difficult. Various issues (discussed in Chapter 6) were also raised about the way the PCA approaches it.

Whether PCA failure is classified as ‘appropriate’ or ‘inappropriate’ depends logically on whether the assessment of incapacity is or is not soundly-based in a particular case. There was evidence to suggest that there are cases where the PCA result is at least open to question:

- Appeals are made by 28 per cent of all those failing the PCA, and the judgment is overturned in about 41 per cent of those cases. This is not necessarily proof that the original decision was wrong, but suggests at least that the outcome was subject to different interpretations (see Section 6.6).
• In a number of cases the claimant’s own doctor is said to disagree with the result (see Section 6.5.2)\textsuperscript{12}.

• There is widespread suspicion about the reliability of PCA judgements among both BA and ES staff (see Section 6.5.3), and also among many claimants (see Section 6.5.2). This suspicion is again not necessarily evidence that PCA judgements are in fact often unsound, but it constitutes at the least a credibility problem.

• The PCA outcome seemed somewhat surprising in a number of the cases we talked to, and many ES staff say that they often find themselves dealing with people turned down at PCA who do not strike them as being fit for work (see Section 6.5.3).

It would seem reasonable to conclude that there must be some cases where the result of the PCA is in some material sense incorrect, and that an inappropriate move to JSA is therefore made. There is no clear evidence about how frequently this might happen, but the appeals evidence suggests that it is probably not just a rare occurrence, and staff suspect that it is a problem.

3. ‘Doubtful’ or ‘manipulative’ reasons: Where manipulative moving behaviour was alleged by staff this normally related to moves from JSA to IB/ISS rather than the other way about. It is less obvious why someone would choose to move inappropriately in the other direction. Only two possible reasons emerged which might be classified under this heading.

Staff occasionally suggested that certain people move back to JSA because the PCA is in the offing, and they want to avoid it because they expect to fail. This is the mirror image of the pressure-motivated move from JSA (see Section 4.1.1), when people are said to dodge across to IB when faced with compulsion. On this view some people skip backwards and forwards, timing their new claims to avoid the PCA on one side, and compulsion or sanctions on the other. It may be that this does happen, but it was not apparent in our claimant interviews, or in our analysis of the database supplied for sampling.

Finally there are occasional clues that some people come off IB/ISS because they want to work, and feel capable, even though in the judgement of ES advisers they are not really fit to do so. If staff are right about this then such people are moving inappropriately, albeit for positive and work-oriented reasons.

\textsuperscript{12} Technically the GP has a different perspective, which relates to the initial ‘own occupation’ stage (see Section 6.1). But in practice some GPs were quoted as maintaining that certain disallowed claimants were ‘not fit for work’ in a general sense – and this is certainly how it is often interpreted.
4. Misunderstandings: Again there are some cases where people move because they do not understand how the system works or what they are supposed to do. There is no evidence that this is a very widespread problem, but one instance is that some people do not understand their post-PCA options, and think they are obliged to claim JSA (see Section 5.1.3).

The most common cause of closure is ‘Closed certificate’ – 47 per cent of the 313 database cases where the most recent IB/ISS claim had been closed. This presumably means that the doctor had stopped providing the certificates necessary for pre-PCA eligibility. This will generally imply that the patient has recovered sufficiently not to need to stay off work any longer – although occasionally claimants alleged their doctors had changed their minds about certifying even though they themselves didn’t think their condition had improved.

M: ‘She says, ‘Well, I think you should have another two weeks off’. Fair enough. And that went on for six weeks, and then she says, ‘I think you’re fit enough to go back to work and try it’. So I says, ‘OK’, and went back.’

(Claimant, Northern city)

The other very common trigger when moving from IB/ISS to JSA is simply failing the PCA. Statistics from the sample database provide two measures of this. These are not quite consistent, but both make it a major factor. One measure is the recorded reason for terminating IB on the last occasion. This gives PCA failure as the cause in 33 per cent of cases of IB/ISS closure. On another measure 40 per cent of those whose net movement over the period was from IB/ISS to JSA were listed as having failed the PCA.

So the trigger for moving from IB/ISS to JSA, in the great majority of cases, is a professional or official decision that brings entitlement to an end. But there are also some cases in which claimants themselves decide they feel better, or that they want to work.

A few people disqualify themselves by not completing questionnaires or attending medicals. Sometimes this may be because they know they have a weak case, but our interviews suggest that it can also be due to misunderstanding, confusion, lack of personal organisation, or fear of official processes. Occasionally there seem to be good reasons for non-compliance, which claimants do not always communicate well.

4.2.2 Triggers for moving from IB/ISS to JSA

There may well be some recording errors in both sets of figures, although the general picture they present seems to be true. We understand from some of our staff interviews that reasons for termination may be entered as a separate clerical process after the event, working from the papers and not direct from interview, and perhaps completed by someone other than the staff on the case. PCA failure data also seems incomplete, since some people are recorded as having appealed without being listed as having failed. If movement between benefits is seen as an important policy issue there is a case for upgrading aspects of the recording process.
4.3 Manipulative moves

4.3.1 Level of manipulative moving

A key focus of the project was to look at the level and nature of moves between JSA on the one hand and sickness benefits (IB/ISS) on the other. One issue is whether the level of flow is higher than it needs to be. How far do people switch when they need not (or should not) do so, particularly where there seems to be some manipulative intent?

There is little evidence from this study to suggest that the level of manipulative moves is unduly high, although clearly some such moves are made, particularly from JSA to IB/ISS (see 5.1.1).

Claimant evidence: As far as the claimant interviews go it is sometimes difficult to be sure whether a particular move was or was not appropriate. Apart from the limited database information we can largely only go on what they told us. Their recollections are sometimes fuzzy, and anyone who was deliberately trying to manipulate the system might of course not be frank about this.

It is also possible that anyone who was taking advantage of the system might have declined to be interviewed. If this was the case then some manipulative movers might have been excluded. However, the drop-out rate was not very high. Only 23 people (seven per cent of those mailed) actually opted out. Only 11 of those contacted were unwilling to take part, and only three of those who agreed to take part did not finally do so. There is moreover no evidence that those who did not participate were ‘harder’ cases. For example only five of these 37 drop-outs were listed as having failed the PCA. This works out at 14 per cent, compared with 16 per cent for the sample database as a whole.

Having made these reservations however, we did not find many signs from the customer interviews that suggested inappropriate moves, in spite of the fact that in selecting the sample we tried to lean towards cases where this seemed likely. Most of the people we talked to appeared to have done broadly the right thing in moving as they did. In a few cases it was perhaps debatable whether the move might have been made earlier or later than it was, but in general any such adjustment would probably have been minor.
There was only a small handful of cases where the interviewer felt there might conceivably have been some underlying manipulative intent although, on the face of it, the move had been correct and justified.

**Staff evidence:** We heard quite a lot of anecdotes from staff about ‘doubtful’ cases where moving seemed inappropriate, and even of ‘serial movers’ who frequently switch back and forth between JSA and IB/ISS for what are suspected to be inappropriate reasons. These are further described in Sections 4.1.1 and 4.2.1, and staff’s response to them is in Section 4.3.2.

M: ‘We’ve got people that’ve never worked for years because they’ve just swapped from one benefit to the other. Now that happens because they come up to the bit where we start trying to apply a bit more – perhaps pressure is the wrong word, but if we don’t think they’re doing enough to look for work and we want to see some sort of movement from them – what have you applied for, are you going to this interview? And as soon as that happens they go back onto Incapacity Benefit. They’ll get it probably for six months. They come up to the All Work Test. They’re found fit for work, then they come back to us. And perhaps six months, they’ll get an interview from us and we’ll say, ‘You’ve not done anything’ – and they can claim Incap again six months after the All Work Test.’

(ES staff, Rural)

F: ‘There is always a hard core of regulars that you know their names. You do get the ones you’re continually telling are fit for work, and they go and sign on for a few weeks and then they feel, ‘I’m losing money here, I’m better off on the sick’. Then they’re off down to their doctor’s again, and they’re back on – and it’s a vicious circle.’

F: ‘They’re the ones who really don’t want to work. There’s nothing wrong with them, but they don’t want to work. They’re all sorts.’

(BA staff, Northern city)

F: ‘They’ve failed the All Work Test because on the day they had their test perhaps they were a bit more together than they would be on other days, because it changes. And then six months down the line they’re hitting the Restart counsellor, they’re being put forward to matching, they’re being put forward to this, that and the other, and it’s crunch time again. And then the six months have elapsed, and they can go back again after six months. So six months later they go back for a little while – and then they fail the All Work Test again.’

I: ‘Can they go on doing that forever?’

F: ‘Technically, yeah – nothing to stop them.’

(ES staff, South coast)

But although many staff members had anecdotes of this kind to relate these were not usually presented as a major problem in terms of being a substantial proportion of movers. Staff do not monitor these ‘doubtful’
cases systematically, nor does the system make it easy for them to make numerical estimates.

Moreover they were not clearly visible in the database or claimant sample. We made considerable attempts to analyse the data in ways that would show up cases of inappropriate moves, but with very limited success. Some staff said that we would easily be able to spot some people moving backwards and forwards frequently in the records, but what we found was as follows:

a) There were not many of these serial movers on the database of cases provided for sampling. Painstaking preliminary analysis of the patterns of moving was made, but it was quite difficult to find enough cases for recruitment purposes where the patterns suggested the likelihood of serial moving. During the three-year period for which the database was compiled we found that only 16 out of 638 people (three per cent) had made as many as two complete pairs of moves (IIJI or JIJI). No-one had made more than this. By far the largest group was the 359 people (56 per cent) who had made only one move (IJ or JI). Insofar as regular serial moving exists it seems to apply at most to a very small percentage of cases.

b) Multiple moving patterns did not often prove an effective way of identifying cases of likely abuse. There generally seemed to be good reasons why a series of movements had been made.

There were clues from some of the staff interviews that there may occasionally be problems with under-moving as well as over-moving – in other words some people don’t move when perhaps they should. Examples of this would include:

- Someone who hangs on claiming JSA although not really well enough to seek or get work – whether through ignorance, a misplaced determination to get into work when their health makes this inappropriate, or unwillingness to come to terms with their sickness.

  M: ‘To be honest I should have gone on Incapacity Benefit sooner, ’cos I knew I was struggling, I knew had I got a job I would have struggled to have done it – but I thought, ‘I'll struggle on, struggle on’ – and I thought, ‘Well this is silly’. ’

  (Claimant, Rural)

M: ‘This was a chap who should never have been signing on, he had all kinds of health problems, but he was absolutely adamant that he wasn’t going to go back on the sick because he was losing out, and yet he was one of these who would have been very close to unemployable.’

(DEA staff, Urban/rural)
F: ‘This person came in to see me, and to look at him you would think this person is fit to work. But there were certain things in the interview that made me doubt that he was fit to work. And I actually requested a medical report, and the doctor wrote back to me on headed paper saying he couldn’t disclose why but this person will not be fit for work in the foreseeable future – there was something very serious there. That person was actually on Incapacity Benefit and he had come in because he wanted to look for work, but he wasn’t actually fit for work.’

(DEA staff, London)

- Someone who stays on IB/ISS even when their health begins to improve to a point where they might be able to find work again.

M: ‘I would say it is more your very long term unemployed that do that. Once they get into the cycle of being on benefits.’

(ES staff, Rural)

There were clues that what may seem to officials as a fraudulent attempt to get round the regulations can appear legitimated in some people’s eyes if the system itself seems to be behaving unreasonably and unfairly. For example, where claimants regard the PCA as unfair (see Section 6.7) they may think that taking steps to subvert its decisions is not so much a fraudulent act as a restitution of natural justice.

4.3.2 What happens in ‘doubtful’ cases?

It was clear from discussions with both BA and ES staff that officers do sometimes see people making moves which look as if they might be manipulative rather than genuine – for example, repeated moves, claiming sick when the Jobcentre starts to exert pressure, or changing illness after PCA failure. What do staff do when they see such apparently suspicious signs?

The answer clearly and almost universally from both BA and ES staff is that they generally do nothing. There seem to be various reasons for this, as follows:

a) Lack of monitoring: No-one feels responsible for identifying ‘serial movers’ or doubtful moves. It is apparent from the accounts in Section 4.1.1 that staff do sometimes see what they feel are transparently manipulative moves, but that is just a passing reflection, not something they feel they need to record or draw attention to. Movers simply shift to someone else’s jurisdiction, and even in the most dubious-seeming cases staff do not generally seem to pass on their suspicions to the receiving agency. And although they may sometimes happen to notice suspicious patterns, no-one is specifically charged with the task of looking out for these, or of analysing claims data to monitor or highlight possible problems. One consequence of this is that reports of doubtful moves are almost entirely anecdotal, and staff have no systematic evidence about incidences or types.
b) **No clear responsibility:** Nor does anyone feel they have a duty or responsibility to take action about such cases, and it seems that no action is in practice normally taken, even where manipulation is actively suspected.

To begin with there is a feeling that it is GPs (and then subsequently the PCA) who are the gatekeepers of incapacity, not the BA or ES staff who are routinely dealing with cases. It was commonly perceived by officers that they not only had no duty but no right to interfere in this process – on the contrary they argued that customers have a right to claim IB/ISS if they have a doctor’s certificate, and it would be high-handed if staff tried to impose their own opinions. Moreover this would challenge the professionalism of the doctors involved. It is therefore seen as the duty of staff to process claims and ensure that non-medical eligibility criteria are satisfied, but the medical criteria are someone else’s responsibility.

> F: ‘My concern is, ‘Do you meet the criteria to get the benefit?’ How they manage to do it is not my concern, what I think of it is not my concern – so long as it meets criteria set down in regulations is my concern.’

(BA staff, London)

In any case ES staff in particular tend to feel they have more important responsibilities than pursuing cases like these.

c) **Lack of powers:** Furthermore, even if staff thought they ought in principle to be acting as watchdogs over the verification of medical ailments, they often say they actually have no powers in practice to do anything in advance of the PCA. The wheels must turn as they will – and ultimately the PCA is there to test whether people are in fact entitled to be regarded as incapacitated for benefit purposes.

> I: ‘If you suspect that pattern to be true in a particular case, what do you do? Is there anything you can do about it?’

> F: ‘No.’

> F: ‘No, we haven’t got time to get involved.’

> F: ‘Well you can’t. What can you do about it? We’ve got no power to stop them doing that.’

> F: ‘No, if their doctor signs that they are sick.’

(ES staff, Rural)

> F: ‘They can’t do anything about it. They give them the paper and because they’ve got that certificate they’ve got a legitimate reason to make a claim and we can’t say, ‘You can’t claim’, you’ve got to accept a claim.’

(BA/ES staff, Urban/rural)

d) **Lack of incentive:** In some ways staff are often relieved to get rid of troublesome cases, who are thereby unloaded on to someone else’s desk. This particularly applies to ES officers, who have to deal regularly with their clients. It is not merely a question of reducing hassle, but is also presented as enabling them to spend their time on more productive cases.
M: ‘At the end of the day if they’ve gone on Incap they’re out of your hair. I know that’s perhaps the wrong way of looking at it. They’ve not really been looking for work, they’re wasting your advisory time when it could be better spent with somebody who genuinely wants a job.’

(ES staff, Rural)

The upshot is that staff in practice generally seem to take a laissez-faire attitude to cases where people appear to be claiming sick for inappropriate or manipulative reasons – not because they are neglecting their duties, but because that is what the system seems to require them to do.

There seems an interesting contrast here with other kinds of manipulative claimant behaviour. For example, if someone made inconsistent declarations of the numbers and ages of their children in support of an IS claim this would be investigated, and their claim would then be disallowed if the facts did not support it – with the possibility of fraud proceedings if deliberate misrepresentation was involved. In this case of course the presence of children is a matter of verifiable fact, whereas incapacity is a matter of medical judgement which can often only be supported to a limited extent by objective evidence. However issues like cohabitation would also be investigated, although these are less objectively clear-cut.

This implies that the possibility of ‘fraud’ seems in practice to be virtually ruled out in relation to incapacity, although if staff hunches are right there may be some cases where people’s sickness claims were no less fraudulent in intent than someone who invented a family with children.

One obvious possibility would be to advance the PCA where moves seem doubtful. Some decision-makers said this would be possible, but it does not often seem to happen – if only because such cases are not routinely being detected and brought up for scrutiny. Some IB staff also seem to operate on a fixed tariff system, whereby the PCA date is determined by the nature of the ailment rather than by whether it is a suspicious case.

F: ‘We can’t do that, we cannot do that (advance the PCA). We have to treat each and every claim individually no matter what. You can look at previous history to get information that will help the current claim, but you cannot allow previous claims to influence the current claim.’

I: ‘It would be wrong to do so?’

F: ‘Absolutely.’

(BA staff, London)

The PCA may not in any case be the best instrument for looking into these cases. It might need some kind of pre-PCA review procedure which looks at the medical evidence and establishes dialogue with the client’s doctor.
Possible action points

• Provide mechanisms for:
  - identifying, monitoring and recording cases of ‘doubtful’ movement, where the context or patterns of claim give rise to reasonable doubt about whether someone is genuinely incapacitated;
  - looking into such cases with a view to disallowance if the moves are shown to be purely manipulative.

• This could be done either by:
  - advancing the PCA in these cases;
  - providing scope for some other kind of pre-PCA review.

• Do more to identify JSA applicants who should claim sick, and provide an assessment facility.
Key points

- Moving between benefits can be a hassle for claimants at the best of times, because it involves more forms, new rules and the possibility of delays. It also makes more work and aggravation for staff.

- This is likely to be a special problem with sickness benefits, mainly because of the dual benefit structure (see Section 2.5), which is difficult to understand and administratively complex.

- Sometimes moves go smoothly, but there is also evidence of problems occurring – mainly delays in initiating the new benefit. These are exacerbated by the involvement of three different agencies and sections – ES, BA(IB) and BA(IS).

- Incidental disruption of other entitlements (like Housing Benefit) can be a serious problem.

- Various issues arise when people move to JSA after PCA disallowance:
  - The timing of disallowance notices and termination of benefit can cause delays or even loss of benefit.
  - Disallowance notices are cold in tone and often come as a shock.
  - Post-PCA claimant options are not properly clarified (notably in relation to the possibility of taking reduced IS while appealing instead of signing on for JSA).
  - The options are in any case often considered unsatisfactory. Neither staff nor claimants feel comfortable about someone signing on while declaring themselves unfit for work, but the reduced IS option seems economically harsh.

- ES advisers are often not sure what to do with former IB/ISS claimants who do not consider themselves fit, and/or are likely to be hard to place.

- Advice and information is not always sufficiently available. Some people feel if they ask staff they get passed from person to person and often end up with contradictory messages. Many seem unaware of official literature. The range of outside advice agencies is not usually well known.
• Clients usually have a closer relationship with ES than with BA, because JSA claimants have regular face-to-face contact. This means that:
  - ES tend to catch a lot of the queries about IB/ISS as well as JSA;
  - although sick people may in some ways need more personal support they actually tend to get less than they did on JSA.

5.1 Effects of moving

What effects does moving between benefits have – on claimants, on staff or on the system as a whole?

5.1.1 General effects

Effects on claimants: Moving between benefits can be a pain and a hassle for claimants, even if nothing goes wrong with the process. It involves form filling, and often uncertainties about dealing with new and unfamiliar benefits – and in this case also new people in different offices, since moving between JSA and IB/ISS also means moving between ES and BA offices.

People are also often concerned that something may go wrong – for example the change may involve possible delays, or a hiatus in payments, and it may be difficult to sort out any problems that arise.

M: ‘I've always found when you go on to a new claim, that's when you get the problems. It can last up to two months.’

(Claimant, Urban/rural)

In practice some of our participants reported that their moves went smoothly, but others said there had been problems. These usually did involve delays – for example in determining the claim, or getting into payment.

The delays were often stressful – sometimes financially where payments were delayed, but often psychologically, because people felt they needed to chase things up or get problems sorted out. In doing this they did not always get clear answers, and some complained of being passed from person to person or section to section when trying to get information or action. This can be confusing and frustrating, and tends to create the impression of an inefficient, if not deliberately evasive, organisation.

---

14 Recent proposals for ‘Jobcentre Plus’ would remove this problem by combining the agencies.
M: ‘The worst thing what I found was phoning up, and if you’re not specific about what you want you phone up one department and they’ll pass you onto someone else.’

I: ‘Do you feel you know quite clearly what it is you’re asking about?’

M: ‘You go round the houses, it’s two hours on the phone, you end up speaking to people in Newcastle, and eventually they pass you onto someone else, and then you don’t know who you’ve spoken to and you end up speaking to the same people again, and you end up having to explain the whole thing. It is frustrating with them. Unless you know specifically what you want, it is really hard to get it.’

(Claimant, London)

M: ‘They say, ‘Sorry, I’ve got to go through all this again because I can’t find it, I can’t get it whatever’, and all I think is, ‘Well if you’re a business you’ve been taken over or you’ve gone bust’.’

(Claimant, South coast)

M: ‘The impact on (ES) staff is that people become irate in the office, and at times it’s not the most pleasant thing. If they believe they’ve been given the run-around, or been to that office and we’re telling them here, ‘You have to go back’, they’ll say to you at reception, ‘Look, I’ve been here, I’ve been there, been here, can someone clarify something?’’

(ES staff, London)

It makes it worse when claimants get contradictory information from the various people they are referred to.

F: ‘If you go into a Jobcentre and ask somebody you’ll get told one thing. If you ring up you’ll get told another thing. If you speak to somebody from the Benefits Agency you get told another thing. It’s like which is the true thing? Am I filling out the right form? Have I filled out all the forms I need to or just part of them? Is that worse than not filling any in at all? And it is quite confusing. ‘Go and have a look at leaflet SL57’. ‘Where do I get that?’ ‘I don’t know, ask at reception’, ‘I don’t know, I’m the receptionist’.’

(Claimant, London)

M: ‘Half the time they don’t give the right answers anyway – because half the time they don’t even know the answers themselves. They’ve just been on the computers for a couple of weeks themselves.’

(Claimant, Northern city)

Claimant understanding of the structure of the agencies concerned is often rudimentary at best, particularly where IB and IS sections within BA are concerned. It can be particularly difficult where these latter sections are housed in different buildings, as in some of the areas we visited. In one case new IB/ISS claimants found themselves dealing with three different BA offices in as many different towns, with little clue who
they should correspond with about what. Telephone calls can be transferred, although people find it frustrating to keep having to explain themselves to new people without seeming to get to the person they really need to talk to. But it is more of a problem if correspondence goes to the wrong address – and even more if people actually visit the wrong office and have to trek off to another place.

One very important consequence for some claimants is that moving between JSA and IB/ISS sometimes disrupts other benefits – notably Housing Benefit (HB) and Council Tax Benefit (CTB). These are administered by local authorities, and commonly have a notorious image of being difficult to claim. It seems that when a claim for IB/ISS or JSA is closed down during a move to the opposite benefit this sometimes triggers a closure of HB and/or CTB, so that these have to be reclaimed from scratch – often involving much more hassle than the original move, and sometimes causing arrears where the problem only becomes apparent some way down the track.

F: ‘The main stumbling block for that is our local Housing Benefits department, because when they stop claiming Jobseeker’s Allowance we input the dialogue which closes their claim down, that automatically transmits information to Housing Benefits, ‘We’ve stopped their claim to JSA’.’
I: ‘Even if they go straight on to Incap?’
F: ‘Yeah. They have to reclaim Housing Benefit – and if you had our Housing Benefits you would not want to reclaim it, because it takes them months to get it right in the first place, and then to have to stop it and claim it again is just a nightmare. I’d’ve thought a system which allowed them to keep it in suspension for a couple of weeks pending them claiming another benefit would be far more suitable.’
F: ‘Well us that sit on the front line downstairs, we don’t know anything about Housing Benefit at all so we don’t know how that part of the system works, they find that out themselves when their Housing Benefit stops, and they come in firstly to us and say, ‘My Housing Benefit has stopped because you’ve closed my claim down, why is that?’ We don’t know because we don’t have that access.’
I: ‘How do you answer them then, do you say, ‘We don’t know’?’
F: ‘Go to the council!’
F: ‘The major problem is the council is now privately run, and ever since it’s become privately run, the service has been abysmal.’
F: ‘Housing Benefit across the country is in a dreadful state.’
F: ‘Yeah, and that’s one of the major factors why people will not take things like temporary jobs on. So you have someone who has perhaps been on Incapacity Benefit, is offered a temporary job – and anyone’s reluctant to take it because of this need to stop and start, and stop and start again.’
M: ‘All the hassle of doing the forms!’
(ES staff, South coast)
Effects on staff: Flows between benefits also affect staff and workloads. There is inevitably extra work involved in opening and closing claims, assessing eligibility and entitlement, fielding queries from new claimants, and putting the new claim into payment.

There were clues that these effects are sometimes exacerbated in the case of moves between IB/ISS and JSA by various problems relating to communications across departmental and sectional divides.

Since JSA can’t start till IB/ISS is closed (and vice versa), a new claim cannot be actioned until the other agency has closed its original claim.15 There were fairly frequent grumbles on both sides that an attempt to open a new claim is blocked by failure to close the previous claim. This means the agencies have to communicate with each other, and the sending agency then usually seems to have to contact the claimant if they do not already have notification from them that the claim is terminated. The fact that they have made a claim for the new benefit is not taken as evidence of a desire to close the old one, although the two sets of benefits are mutually exclusive. This sometimes causes a certain amount of time-consuming to-ing and fro-ing, and holds up progress on the new claim until it is resolved.

F: ‘I can’t actually stop the JSA claim until I’ve got a claim for Income Support and IB have received a claim for IB, so I send her out the claim forms, and when it comes back if JSA is still live then I’d have to send out a proforma which I’d fax to them asking them to close the claim down. Although we do send the claimants off to close the claim down it’s actually for us to do that, ’cos the transition between signing on and claiming sick should actually be quite smooth, and they shouldn’t actually have any gaps between their benefit dates.’

F: ‘But it happens and people do lose out money. With IB it’s OK because we can claim from any date and we can backdate it three months, but with IS it’s the day received.’

(BA staff, London)

When this happens the receiving agency often grumbles at the sending agency for not doing its job properly. In turn both sometimes grumble about claimants who have not reported that they are terminating their claim. The fact is that claimants sometimes tell the sending agency that they are making a move, but they sometimes go straight to the receiving agency if they feel they know where to go and what to claim. Either course can seem to them a perfectly proper and logical process, and it is not obvious to them that they ought to notify both agencies about the move.

15 It was occasionally said by staff that simultaneous claims can sometimes be open for IB/ISS and JSA, because of limited dialogue between BA and ES systems.
F: ‘I had the same little scenario on Tuesday. A young girl came in, she’d put in an Incap claim four weeks ago and not heard anything. I rang them up and they said they were waiting a decision from Social Security. I rang Social Security and they says, ‘I’ve got to find the papers’. An hour later they ring back – ‘Oh it’s because we haven’t had a statement from her to say she wants to claim from last May 17th’.

F: ‘But they never seem to write to customers to say what they want. The customer seems to have to like guess what they might want. And you often say, ‘Why is this claim still live, when I’m trying to get a Jobseeker’s Allowance claim on the computer and your Incapacity claim is still live? Why haven’t you shut it down?’ ‘We’re waiting for them to write to us to say they don’t wish to claim anymore’. ‘Well have you told them that?’ ‘Well no, but they should know to let us know’. But it’s just not on. There should be a letter go out explaining what’s required of them, because they’re not seen, they’re like invisible to BA, Incap customers are.’

(ES staff, Rural)

This affects not only transactions between ES and BA offices, but also to some extent between the IB and ISS sections within BA. As noted in Section 2.5, the dual claim structure involves an intricate interplay of information and decisions between these two in order to determine whether a claimant is entitled to either or both, and how much they should get. As we have seen, claimants don’t usually understand this, and don’t know who they ought to contact about what. Some IS staff said they end up catching a lot of the queries, perhaps because their benefit is better known than IB. In practice it may depend on who enquirers are put through to when they ring up and ask about their ‘sickness benefit’ claim.

Many claimants are in any case inclined to assume that messages can be fed into any part of the system, and will automatically be available to staff in any other part of the system if they need to know about them. They often assume that ES and the various sections of BA are just different gateways to what is basically the same organisation.

Staff tend to see it differently – they are very aware of structural boundaries, and some get quite irate if information they are supposed to be actioning is given to some other agency or section. Some feel that customers ought to report everything relevant to the claim direct to them, and that they are just being lazy or inefficient if they fail to do so. In this situation both sides fail to understand how the world looks to parties on the other side.
F: ‘Ours (IS) doesn’t take as long it appears as it does for Incapacity Benefit, but I think they (claimants) just don’t realise that there are three separate benefits and three separate sections, three separate procedures.’

F: ‘As far as they’re concerned they think we are the same, so why are we hassling them.’

F: ‘It should be the same – ‘If I told you, you should know’.’

(BA staff, London)

Some of these problems arise from (or are aggravated by) the dual claim aspects of the system (see Section 2.5).

Malfunctioning systems can also add to delays.

I: ‘So how quickly do you get their contribution record?’

F: ‘If it (the system) is working it could be the next day or the day after, but all of a sudden you might have it go down for a couple of days and all the requests you make on one day might not come back for a week, or you might have to re-request them. But generally speaking now it’s more often than not next day or the day after. It’s not too bad now, it’s just the odd hiccup.’

(BA/ES staff, Urban/rural)

F: ‘One thing that nobody’s mentioned yet but I’m sure everyone will agree is about the appalling software that we’ve got.’

F: ‘Oh God, yeah!’

F: ‘Now whether this is because the system is so complex that nobody can design software to cope with it – but we’ve got dialogues that don’t talk to each other, and the outcome is that you get massive overpayments and incredible things happen, because one thing that you input doesn’t register somewhere else. You end up with the right hand not knowing what the left hand is doing.’

F: ‘You can feasibly have an Incapacity claim and a JSA claim running side by side if you’re not careful, ‘cos the systems don’t talk.’

(BA/ES staff, Urban/rural)

Delays, breakdowns and misunderstandings are frustrating for staff as well as customers, and tend to generate friction between the parties. Some customers are inclined to blame the system rather than the staff – they may even feel sorry for staff, coping with deficient computers, complex systems and changing regulations. But staff tend to catch people’s irritation nevertheless, since they are the customer’s normal interface with the system.

5.1.2 Effects when moving from JSA to IB/ISS

So far we have considered the general problems of moving between benefits. What happens when people specifically move from JSA to IB/ISS?
In some cases the transition was reported to have been smooth and trouble-free.

F: ‘I thought they were good. I took the doctor’s paper down and you fill in all – it’s just the forms, once you get through them, it’s not too bad then.
I’m not saying it isn’t an ordeal, but I think all benefits are an ordeal.’
(Claimant, Urban/rural)

However in other cases difficulties or uncertainties had arisen. These consequences are reviewed below.

1. Delays: Any change in claim can involve delays, and these were sometimes reported. Indeed delays seem to be expected by some, so that apprehensions sometimes exist even where things, in practice, turn out to go smoothly and without a hitch.

Where delays occurred these may sometimes have been due to random administrative hitches, but the administrative set-up in this case is unusually intricate.

- The Jobcentre sometimes issues forms if the client is talking to them about the possibility of moving. Some BA staff complained that ES do not always date the forms handed out – this is needed in order to backdate payment. This is reported as a diminishing problem, but is still sometimes said to happen.

- Customers claiming sick are supposed to make simultaneous claims for both IB and IS (see Section 2.5). This usually happens, but it seems they are not always advised to do this straightaway by ES, or not always sent both sets of forms by BA. Delays can occur where successive claims have to be made.

- IB and IS sections within BA need to liaise and co-ordinate their activities, and neither can finally determine the claim until the other has completed their work – which (as staff sometimes admitted) creates further potential for delay. In some of the areas visited these sections are physically housed in different locations.

F: ‘There’s two offices in the town, who do talk to each other, but depending on whether you’re getting Incapacity Benefit or Sickness Benefit, it goes to a different place – and the whole thing was an horrendous muddle and I got very tight-lipped and actually threw a wobbly on the phone.’
(Claimant, Rural)

- Those moving to IB/ISS have three ‘waiting days’ before payment starts. This does not apply to those moving in the opposite direction.
M: ‘I was so annoyed, I had to wait three days, I moved from JSA to Sickness Benefit and I had to wait three days, ‘waiting time’ they call it. And I got nothing, and I said, ‘Tell me why’. And they said, ‘Oh that’s the laws, you’ve gone from one benefit to another therefore you have to wait’. I said, ‘Well I’m still unemployed, I’m still waiting for money, I’m skint’, and they say, ‘Oh no, those are the rules’. But, when I come to the end of my sickness and I go back onto JSA I didn’t wait three days. Now that’s weird!’

(Claimant, Rural)

One woman told of repeated problems in getting her new IB claim into payment. IB and IS are handled by different offices in her area, and she says there was a muddle between offices, and problems with computers. This took seven weeks to resolve. She kept asking why she wasn’t getting any money, meanwhile BA kept sending her automatic letters saying she hadn’t filled in forms – which they agreed she had sent when she rang or went in. The problem was still not resolved when she came out of hospital, and she had to try and sort it out while trying to convalesce. Staff were very helpful, but the system seemed a mess, and they couldn’t sort it out quickly. Once in payment she got all her back IB paid, and had no further problems.

2. Confusion, uncertainty: The feelings of uncertainty or confusion which are often experienced when changing from one benefit to another can be exacerbated in the case of moves to sickness benefits because:

- people who have become ill or disabled enough to stop them working sometimes feel unwell or mentally dislocated. The change in their state of health in itself precipitates them into a new and sometimes worrying situation, and gives them new problems to deal with;
- on top of this they are having to grapple with new and usually unfamiliar benefits. This is generally an unsettling process at the best of times, and when you have just fallen sick it is not a good time to be trying to take on board complex new information;
- the particular benefits involved are not only unfamiliar to many movers, they are also fairly complex in detail and blurred in image (see Section 2.4).

M: ‘I find with the Jobcentre, you go up and you say you want to put a claim in, and I find it easier to get – with the sick there’s more details like, there’s more information that you’ve got to give out, with the dole it’s more straightforward, they interview you personally like. With this it’s more like writing down.’

(Claimant, Urban/rural)

- the fact of having to make dual claims and fill in two sets of forms (for IB and ISS) can be a further source of puzzlement and hassle (see Section 2.5).
3. More forms: Claiming a new benefit inevitably means filling in more forms – and many people find forms difficult and unpleasant. IB/ISS forms usually seem to be thought worse than JSA forms – and again there are two lots of forms to complete.

Those intending to move from JSA to IB/ISS got their forms by various routes. Sometimes they contacted the BA office direct, in which case they were either sent the forms or collected them in person. In other cases they spoke to the Jobcentre about it. In that case JC staff:

- either gave them the necessary forms; or
- rang up BA on their behalf to ask for these to be sent; or
- just referred them to BA and left them to get their own forms.

In any event problems can arise if:

- people don’t know which forms to ask for;
- they don’t get sent both IB and ISS forms;
- the forms aren’t properly dated.

4. Changing agencies: Changing agencies can cause further uncertainties. There is a different set of people to deal with in a different place – and (less obviously) a different modus operandi and a different kind of ethos. Moving from ES to BA can be particularly disorienting because the interface is more remote – the Jobcentre operates largely on a face-to-face basis with regularly programmed contacts, but dealings with the Benefits Agency about IB/ISS are often handled through the post (see Section 5.3).

5.1.3 Effects when moving from IB/ISS to JSA

What happens as a result of moving specifically from IB/ISS to JSA?

In most ways the effects are similar to those for people moving in the reverse direction (see Section 5.1.2). Again there are sometimes payment delays, particularly where people go straight to the Jobcentre to make their new claim, and don’t first tell BA. This means that they don’t get signed off IB/ISS, so the new JSA claim can’t be initiated.

Some say that it takes too long to initiate a new JSA claim.

M: ‘It takes seven to ten days when you are going back to JSA and you lose a week’s money. I don’t know why, but I would like to know. They say it’s because it has to go through the books, but you still shouldn’t lose any money. It only takes a few minutes to punch it into the computer.’

(Claimant, Northern city)

However, where moves from IB/ISS to JSA are triggered by PCA failure various significant issues also often arise. Some of these relate to the impact of the failure and its implications for needing to declare themselves available for work – matters which are reviewed in Section 6.5.2.
However, we also found two more functional problems, discussed below.

1. **Post-PCA timing**: Customers normally have to wait for the outcome of their PCA – a couple of weeks or so seemed fairly common from what people said, although some memories were a bit hazy. In some cases there were said to be longer waits.

Some claimants said they were not informed of the result at all and had to chase it up, which annoyed them. BA staff sometimes said they get quite a lot of calls from people complaining that they hadn’t had the letter, or that it had been seriously delayed. In these circumstances they were often unsure whether the claimant was being evasive, or whether something had actually gone wrong (either at BA or in the post). Some are inclined to see it as claimant prevarication.

*M: ‘I didn’t receive notification of the verdict of the tribunal. I actually had to ring and ask for it. ‘What happened, has it been held?’ ‘Yes it has. We’ve upheld what our doctor said so you can’t claim anything. You should have been claiming Jobseeker’s Allowance from this date’. ‘Well that’s not my fault if you don’t tell me’. They said, ‘Well you should’ve got a report’, I said, ‘Well, can I have a copy of it, can I have the verdict or the judgement or whatever they call it?’ Didn’t get it – so I had to chase that.’

(Claimant, South coast)

F: ‘Sometimes – quite a lot actually – where they don’t pass their test I’ve had claimants call me up again, ‘I don’t know what’s happening with my claim, I’ve not had any letters’. And then I have to go right back to the beginning now and walk through, see what’s happened so far – when they made their claim, how they’ve been claiming and if they’ve had the test. And by now it really shouldn’t even be a claim for Income Support.’

(BA staff, London)

ES staff often pointed out that disallowance notices do not arrive until after IB/ISS claims have been stopped, giving rise to a likely payment hiatus. The claim seems to be terminated as soon as the decision is made, but it inevitably takes a few days for the letters to arrive in the post. Even if recipients go straight to the Jobcentre they are therefore liable to be several days’ benefit adrift by that point.

F: ‘We quite often have clients who receive their letter after the day they were expecting to go and cash their order book and rather than stopping their benefit from the day that it would be reasonable to expect that client to receive the letter, they stop it from the day the doctor makes the decision and there can quite often be quite a difference between the two dates.’

(ES staff, South coast)

There may also be various reasons why they do not go straight to the Jobcentre (see below). Some who are disallowed but are unhappy about signing on because they feel they are not fit (see Section 6.5.2) want to
consult their own doctor before deciding what to do. It often takes quite a time (several days, sometimes more than a week) to get an appointment. Uncertainty or confusion about whether they should be signing on at all can also delay matters.

F: ‘I think it was about a month, I had nothing at all to live on, not a penny, when all this hassling was going on as to whether I should be signing on. And then they said I shouldn’t, and this, ‘Would you accept £41?’.
‘Yes, I’d accept anything’, I said, ‘I’ve got nothing at all’. My mother, who’s on a pension, was bringing me in food parcels, I mean I didn’t want to eat, I lost three stone in a short time with nerves and so on. It’s a tight living, but when you had nothing at all and you feel your life is pretty worthless to start with, it didn’t help.’

(Claimant, South coast)

There is thus the likelihood of at least a short payment hiatus – and the risk of a longer gap. Even if they eventually got money paid for the gap period this could cause cashflow problems for some people.

F: ‘It’s just lucky that my mother was around to help me out financially. I’m not exactly sure why that was, and it was kind of basically having to ring up, crying on the phone, saying I’ve got no money, I can’t really leave the house. That was really difficult.’

(Claimant, London)

And it seems that in some cases they probably do not get it back. It was apparent that different staff make different assumptions. BA offices sometimes assumed that JSA could simply be backdated to the point of IB/ISS termination, but ES staff gave varying accounts. Some were firm that it could only be dated from the point when people had declared themselves fit for work, and signed on to this effect, others thought they had powers to backdate it – but only through more forms.
F: ‘We can then do a backdated (JSA) claim – and that is more than likely allowed if there’s documentary evidence to show they came in as quickly as they could – but it’s a lot of palaver, a lot of unnecessary forms – especially if you’re not well.’

(ES staff, South coast)

I: ‘I just wondered what that experience was for you?’

M: ‘I hadn’t received no money for two weeks, it was just coming up to my next payment, and I got this letter. I was expecting a payment and I couldn’t believe this, and I thought, ‘Well, what am I going to do now?’ because I’d signed on about four years ago, and I know it takes about two-and-a-half to three weeks for any money to come through. I explained this to the Incapacity Benefit people and she goes, ‘Well, if you’ve got to go and sign on, you’ll have to sign’, I goes, ‘What am I supposed to live on, I’m due another payment now, they’re not going to give me a payment next week?’ So I went down and I explained to the people in the Jobcentre when I was claiming Jobseeker’s, so I had to fill in a back-dated form for Jobseeker’s from the period of time from when I was last paid. Well from that it took about just over two weeks before I got any money.’

I: ‘And what did you do in that middle period?’

M: ‘It was terrible, I had no money – well very little, I’d put by a few pound coins and I lived on that, I hardly ate anything.’

(Claimant, London)

2. Post-PCA options: Post-PCA failure options are generally not made clear, and in many people’s eyes do not seem satisfactory once known. The disallowance notice does not deal at all with claimants’ options pending appeal. Instead of signing on for JSA, appellants are entitled to claim IS at the reduced rate of 80 per cent of their normal benefit (about £42 a week for a childless individual aged 25+), but this is not mentioned at all in the letter. Many claimant participants were unaware of this option – including some of those who had actually appealed. Occasionally they were told of this option by a member of staff – often at the Jobcentre rather than by Social Security – but in some cases they said no-one had told them at all.

F: ‘They are not made aware that they can claim reduced Income Support and so on whilst they’re appealing, they’re told to come straightaway to sign on – and they aren’t made aware of the reduced rates.’

(DEA staff, South coast)

Although news of the reduced IS option tended to come from the Jobcentre (if at all), some ES officers seemed unclear or uncertain about this – for example, some thought it would apply only to those claiming IS rather than IB.
If they are not otherwise entitled to IS the lack of this option obliges them to claim JSA or go without money altogether. In several cases within our sample people had felt so unable to declare themselves available (and hence fit) for work that they stopped claiming altogether for a period, and were effectively kept by their families.

In those cases where people had heard about the reduced IS option they were not aware that if they chose this route they would forfeit their NI credits during the appeal period if they lost the appeal. The implications of this need to be spelled out, because some people are muddled about NI, and it is a material fact that should be made clear so people can make an informed choice of option.

F: ‘Unless they’re very clear about the credit situation there will be a gap in their record.’

I: ‘And do you suspect they are always clear about that?’

F: ‘No.’

F: ‘Oh no!’

F: ‘No, definitely not, no – and when they are disallowed I mean that really doesn’t come into it, they’re just more annoyed of the fact they’re being disallowed.’

(BA/ES staff, Urban/rural)

One BA group suggested that a Class 3 credit could be issued to all appellants, safeguarding pension rights but not entitling them to short-term benefits.

When participants were told about the reduced IS option (either by the researchers or previously) they did not usually see the choices open to them during appeal as at all satisfactory:

- On the one hand claiming JSA can seem highly inappropriate to people who genuinely believe themselves to be unfit for work. Signing to declare themselves available for work in these circumstances can be quite disturbing. It seems dishonest (some even described it as a ‘fraudulent’ declaration), and it also seems to compromise what people believe should be their incapacitated status.

One BA Decision Maker pointed out that the appeals regulations say that signing a Jobseeker’s Agreement in which people declare themselves available for work must not prejudice the tribunal’s judgment about whether they should be regarded as incapacitated. However this is not apparent to claimants, and is not what many would naturally assume. We did not put this point to them, but we suspect that some claimants would be very sceptical about it.
On the other hand the reduced IS option can seem penal – quite apart from the possible loss of credits, an income of £40 or so a week simply strikes many as extremely low, and inadequate to live on. Some said this is not an option they could have taken up even if they had known about it.

F: 'I'm very lucky that I have a family who love me and help support me. On £41 a week you can imagine there were weeks there wasn't much in the cupboard.'

(Claimant, South coast)

Staff are sometimes confronted by angry and confused people, which in turn causes aggravation for them.

F: ‘This is what infuriates us as well on Income Support because no-one – and no-one – explains this to the claimants, and it’s left to us to do it – and this is where we do get wound up because we have to explain a system we don’t know – we do not know IB, we only know Income Support, so then we have to explain to the claimant that you failed your test – and they’ve called us in the first place because they’re saying they had a test and they do not know the result, they’re saying that they haven’t received their letter. Once that’s been established as to what the situation is with the test they say we’re not really concerned with the letter, we’re concerned with the test. It’s then down to us to in a way explain to them that number one they didn’t pass that test – which, as far as I’m concerned it’s not for us to do, but as it is we have to do it. And then we have to explain to them their options, because the letter that they get, all it tells them is that they can appeal, doesn’t tell them they can go and sign on, doesn’t tell them they continue on Income Support but with a deduction. So we have to go through the process now, ‘You can stay on Income Support but you’re gonna get 20 per cent deduction’. They go through the ceiling. ‘Or you can sign on’ – they go through the ceiling. Either way we end up with the brunt of it. If they choose to go and sign on that’s it, they go off Income Support, the claim gets closed down by change of circs, then goes to Unemployment Benefit office. If they choose to put an appeal they still sign on or they can stay on Income Support but with that deduction – but nobody explains that to them until they get to us, and a lot of the times, the claimants will say to us, ‘Why didn’t somebody tell me? Why didn’t somebody tell me?’’

(BA staff, London)

The issue of options pending appeal is aggravated by the fact that appeals often take a long time to be heard. Staff often commented about this. It routinely takes several months to determine an appeal, and some officers said that waits of six months or more are not uncommon. This means that the options pending appeal are more than a nominal choice – appellants have to live with them for some while. The length of the appeals process also stretches out the anomalies of the interim period (see Section 6.6).
M: ‘I think the efficiency of the appeal should be a little quicker and the fact that you have to wait quite a long time between the appeal – and finding out whether you’ve got it or not, it seemed to take a tremendous amount of time to send these letters out when you need the information.’

(Claimant, Urban/rural)

**Possible action points**

- Review moving procedures to ensure that things go as smoothly as possible and that the risk of problems or delays is minimised. Inter-agency procedures for opening and closing claims should be improved where possible.

- If staff want customers to report things to the proper place they will need to put more effort into making sure that claimants understand how things work and what they are supposed to do:
  - Communications about moving need to be clarified. Such clarification might improve the situation, although it seems unlikely to make the problem go away altogether.
  - But however much the responsibilities are clarified there will probably be a residual failure to report, so there also seems a need to look at the systems for making sure that information ends up in the right place, and that the procedures for closing claims are not unduly cumbersome.

- Seek ways of ensuring that there is no interruption of HB or CTB claims during transitions between JSA and IB/ISS.

- Strong case for a single sickness benefit gateway (see 3.5).

- Review and clarify (to both staff and claimants) the rules governing benefit entitlement and payments during post-PCA transition from IB/ISS to JSA:
  - Consider a period of grace after IB disallowance to allow time for the letter to arrive and a new JSA claim to be instituted, so that the sickness benefit runs on for a few days during the move. Alternatively there could be clearer discretion for exceptional backdating of JSA in the aftermath of PCA failure.
  - Reconsider, and clarify options pending appeal.
5.2 Help and advice

Here we consider the kinds of help and advice given to claimants – firstly by staff and then by others. This is an important issue because:

- the system is complex and aspects of it are hard to understand;
- claimants in general do not know or understand much about the way things work (see Section 2.4).

I: ‘How well do you feel you understand the benefits that are there for people who have health problems of one form or another?’

M: ‘I haven’t got a clue – it’s only what I’ve been told by word of mouth, from my brother mostly, who fell off a roof and broke his back 12 years ago. Basically no-one tells you.’

(Claimant, London)

The common folklore suggests that the system will not perform for you unless you know exactly what questions to ask.

M: ‘Well the things that I get from Income Support is, the money for me and for the children, I get Child Benefit, I get rent rebate and council tax paid for us. And that’s it. Well as far as I know that’s all I can get. There’s no-one informed us saying, ‘Oh you can get this, you can get that’. I think you have to ask them what you can have, you’ve got to go in and say, ‘Can I claim for this, can I claim for that?’ And they will tell you. But you’ve got to know what you’re asking for. They don’t volunteer what you can claim for.’

(Claimant, Northern city)

Claimant reports of staff helpfulness vary considerably. Some found the people on the other side of the desk very helpful and forthcoming, others complained of indifferent, unhelpful or even rude behaviour.

M: ‘The person I dealt with in the Jobcentre, who was a lady who looked after me, she was brilliant. She was actually brilliant! She said, ‘Right, OK then. You need to do this, you need to do that. Right, sit down’. ‘Oh, right’. ‘You need to write that there, you need to write that there. You need to know’. In inverted commas she steered me through it.’

(Claimant, South coast)

F: ‘I was scolded on the phone by one of the women, ‘Well you should know better!’ And I said, ‘But I don’t know anything about the system’. And she said, ‘Well we rely on people’s awareness, they should know these things’. And I said, ‘But I don’t go out the house’ – I went through one of these awful things when I couldn’t go out and I didn’t want to see people. And of course my family know nothing about the system, and you ring them to ask, and that’s what you get. ‘Public awareness and talking to other people’, she said to me, ‘Then you’ll know how to claim’. And so I thought, ‘That helped me no end, I wouldn’t want to ring you again.’

(Claimant, South coast)
F: ‘I remember one and it was embarrassing — a younger lady, and she said to me something like, ‘Oh you’re not in the real world’. I said, ‘Yeah I would like to be in the real world, but at the moment due to problems I hope you never have, I’m not’, and she looked a bit embarrassed and I didn’t see that particular lady again. But when people are down and they’re kicked, it’s a hell of a feeling, ‘cos your pride is shot anyway.’

(Claimant, Urban/rural)

People usually seem to prefer to turn to ES rather than BA for help — they have a more frequent face-to-face relationship with ES, who tend to have a friendlier image (see Section 5.3).

However, while ES generally seems a valuable (and valued) source of advice, ES staff themselves sometimes seem to have limited understanding of the details of benefit regulations. The rules are complex, and it is not primarily their job to offer expertise of this kind. There were a few cases where claimants seem to have been misinformed about benefits by well-meaning advice from ES. For example one woman described being sent backwards and forwards between ES and BA offices in different towns, because they were giving her different advice about what she could claim while appealing against her PCA ruling. The advice from ES turned out to be incorrect.

F: ‘There isn’t anything that’s concise and easy to read that gives you the information. And I think when you ask people — if they’re frontline Jobcentre, they’re signing you on, they’re not Benefits Agency people. They may not know all the things that you need to do, so they may give you misinformation, like unwittingly. Obviously they don’t mean to confuse you, but it is quite confusing when the people who are giving you the information are themselves confused.’

(Claimant, London)

Jobcentres do have BA staff on secondment, but they are not always called on to advise clients — and in any case they tend to specialise in JSA (which is what they normally deal with), and sometimes seemed hesitant about more detailed aspects of IB/ISS.

Staff are sometimes inhibited from giving people advice by:

• pressures on their own time — particularly where they are asked to advise about something which is not their responsibility (eg Jobcentre staff fielding a lot of queries about benefits claims), and may be seen as getting in the way of achieving their own proper goals and targets.

I: ‘Do they ever come in clutching the (IB) forms and say, ‘Can you help me fill these in?’

F: ‘They do, but we refer them back to the Benefits Agency if they do that, or CAB. There’s one reason for that and one reason alone, and that’s called targets — and if we’re helping someone fill out a sick benefit form, we’re not helping someone else into a job.’

(ES staff, South coast)
a sense that people know more than they actually do – and that if they don’t it is their responsibility to find out. Staff often underestimate how difficult it is for outsiders to get to grips with what someone called the ‘Byzantine complexities’ of the benefits system.

F: ‘There are all kinds of leaflets – which are out on our counter section which are out on the Jobcentre, which are in doctors – saying if you claim sick what happens. And I’ve read those when I’ve been in my own doctor, it tells them about the test, it tells them what happens if they pass, it tells them what happens if they fail – so at the end of the day as far as I’m concerned the claimant has absolutely no reason to turn round and say he didn’t know, ’cos the information is there.’

(BA staff, London)

There seemed to be generally low awareness of official BA and ES literature for sick or disabled claimants. Many participants did not remember seeing this, or even recognise it when shown – and few recalled having been given any. The researchers found that it was not always obvious on the racks in Jobcentres or BA offices.

Staff scenarios: During the staff interviews a set of ten scenarios was used to help explore the kinds of action and advice that would be deployed in a range of different cases and situations. These scenarios were intended to stimulate discussion rather than as a basis for formal assessment, and they were not all used in every staff session. The scenarios are reproduced in turn below, with some comments about the kinds of response they tended to produce.

**Scenario 1**

A former factory manager, early 50s, made redundant a year ago, is claiming JSA. He has entered an ND and has just begun a work trial. He becomes sick with a back problem (recurrent), and doesn’t know if he will be well within two weeks. He does not want to sign sick but indications are that he will be incapable for longer than two weeks. **What advice would be given by ES staff?**

There was a mixture of reactions to this. Some ES staff said that he would just have to sign sick. It was sometimes argued that his back condition meant that he would not be job-ready, and therefore should not be dealt with by ES – the remarks of some advisers suggested they would be relieved to get this kind of case off their desks. Others would advise him to see his doctor, who would decide on fitness for work. There seemed some reluctance to give advice, other than to see the doctor or claim IB/ISS. The issue of how to treat potentially short-term sickness was not usually gripped in the discussion.
M: ‘There is a form called a JSA28, where they can be sick and remain on Jobseeker’s Allowance for a two-week period. I would give him that option, I would let him have the two weeks on the JSA28 form, and then at the end of the two weeks I suppose it depends how he feels at that stage. If he wasn’t fit for work he would have to go and see his doctor.’

(ES staff, Rural)

F: ‘If he says at the outset that he thinks it’s going to be for longer than two weeks we should advise him to sign off and sign on Incapacity.’

M: ‘Yes – see his doctor anyway, get some sort of medical.’

(BA/ES staff, Urban/rural)

Scenario 2

A long term IB-only claimant is found fit for work. He is sent a letter telling him to register for work, which he doesn’t want to do. He wants to appeal. What advice on the benefit options would be given by BA and ES?

As noted above, we found that claimants were usually very unclear about their options after PCA failure, and tended to feel that these had not been explained to them (see Section 5.1.2). Staff responses to this scenario were often hesitant or incomplete, and few did lay out the options clearly.

There was some uncertainty among ES staff about the full range of options. Some were unsure about the reduced IS option – particularly about whether this would apply to an IB-only case.

F: ‘He’s IB only so he’s not going to get anything if he wishes to continue to claim sick, because he’s not got any Income Support – so his only avenues are either to choose to sign on and appeal, or choose to sign on and not appeal, or not choose to sign on. Those would be his three scenarios – and run through what we would do, whilst he’s appealing we’d be perhaps sympathetic and be a bit more lenient, but if the appeal were heard and it went against him then we would be expecting him to fulfil all the criteria required for someone signing on.’

(ES staff, South coast)

Some ES staff said they would explain the claimant’s job-seeking responsibilities if they claimed JSA, although others said they would expect to apply these leniently during an appeal (see Section 6.6).

Some ES officers would actively urge this claimant to appeal, but others were careful to say they would be neutral on this point.
Scenario 3

A 57 year old man, unemployed for over two years, enters ND (over 25) and is found a job which he considers unsuitable, and doesn’t match up to his experience or previous earnings. He refuses and is threatened with a reduction in benefit. He subsequently claims to be sick and suffering from stress. How do ES/BA staff deal with this? How would it differ if the job does appear suitable?

The basic response here is that the man would be entitled to claim sick, and that his eligibility would initially be determined by his doctor, not by staff. If the man said he was sick they would advise him to see his doctor. Staff would not see it as their business to discourage a sickness claim, even if they thought the man was malingering. It would not be right to try to block it – and they have no powers to do so (see Section 4.3.2).

F: ‘Have to accept it.’
F: ‘Yeah.’
M: ‘And I’d be keen to tell him to go to his doctor and get a medical certificate before he progresses with any signing off.’
I: ‘And you’d tell him to go on what the doctor says?’
F: ‘Well, we have to really.’
(BA/ES staff, Urban/rural)

M: ‘If he went to his doctor then so be it.’
F: ‘You couldn’t really dissuade him from claiming Incapacity.’
M: ‘No. I couldn’t say to him, ‘Look, I think you’re putting it on’.’
(ES staff, Rural)

F: ‘If there’s a crunch time and they say, ‘Well I’ve got this bad back, I really can’t do that’, and we would say, ‘Why don’t you get a doctor’s certificate, sign off and say you’re unfit for work’, ‘cos if they genuinely feel they can’t work and we feel there’s nothing we can do for them – .’
(ES staff, South coast)

In any case, if he does successfully claim sick that solves a problem for ES staff, and some would even be disposed to encourage him to do so on that basis.

F: ‘Well I advise him if he’s sick then he can go and claim sick, because I suppose at the end of the day it’s one less client for me to deal with. One less off the register is in a way our attitude – sorted, that’s gone, next one to deal with.’
(ES staff, South coast)
The issue of the sickness claim was largely seen as unrelated to the suitability of the job. Some ES staff bridled at the implication that they might be sending people to unsuitable jobs. ‘Suitability’ is said to depend on the Jobseeker’s Agreement. Some said that they would refer this case to a Decision Maker on grounds of refusal of employment.

M: ‘I hope I wouldn’t send someone that was unsuitable to the job in the first place … He thinks he’s unsuitable, but if the job met the criteria on his Jobseeker’s Agreement then I’d have to go down the refusal of employment road.’

(ES staff, Rural)

Scenario 4

A woman JSA claimant (mid 40s) becomes a carer and claims IS. She eventually ceases caring and no longer feels able to work full-time, because it is a long time since she last worked. Should she claim IB or JSA? What advice would be given by BA/ES? What difference would it make if she claimed to be suffering from stress that would make it difficult for her to get a job? What possible barriers to work might she face?

The general feeling here is that if the woman was fit for work she would have to sign on for JSA, and that she should be told she needed to get a doctor’s certificate if she felt she was not fit.

Advice about the full-time issue seemed variable. Some staff just said that to claim JSA she would need to be available for 40 hours a week, but others said that although she would need to be prepared to work full-time there would be nothing to stop her from taking a part-time job, and that they would support her in that search. Others said that if she could produce valid reasons for not being able to work full-time then they would have discretion to reduce the hours required.

F: ‘She could only claim IB if she had the certificate from the doctor to say she wasn’t well enough, so she would have to come in and claim JSA – and unless she’s got a health issue precluding her from being able to work full-time, she would have to be told she would have to be prepared to work full-time. But obviously there’s nothing stopping her getting a part-time job, we’re not saying you can’t apply for part-time work, and if we know that that’s what she’s looking for then we would probably look more intensely at the part-time work. As long as it’s over 16 hours and it takes her off the register, we wouldn’t care!’

(ES staff, South coast)
M: ‘Nowhere in that statement has it been said that she’s not fit for work, so we presume she’s fit for work. Now unless she’s caring for somebody else or she’s got a health problem or disability she needs to be available for 40 hours a week. That would be explained to her at the interview.’

I: ‘Supposing she said she was suffering from stress that would make it difficult for her to get a job?’

M: ‘I would possibly make an appointment to see the Disability Adviser to talk to her about that. But I would ask her how the stress impacted upon her chances of getting work. You’ve got to get the information from the client.’

F: ‘And the reason why she’s not caring now might be bereavement or something.’

M: ‘You need to investigate that a bit more, why she feels that she couldn’t cope with 40 hours. And if she can justify it in your opinion then you would reduce the hours that she has to be available for work.’

(ES staff, Rural)

No specific barriers to work were suggested, other than lack of recent experience.

---

**Scenario 5**

A younger person with substance abuse problems insists on claiming/staying on JSA. The ES adviser finds it very difficult to find suitable job opportunities. **How would staff respond? What would they advise?**

This scenario poses a familiar dilemma for ES advisers. They would probably not want to send someone with alcohol or drug problems to prospective employers, and would often welcome a sickness claim that would remove the problem. Indeed some would strongly urge the person to claim sick – sometimes even asking for permission to contact the claimant’s doctor with a view to getting a sickness certificate issued.

M: ‘And that does happen, we’ve got several clients. You would try and advise them to go and see the doctor, because at the end of the day if you send somebody like that to an employer and they found out they were abusing substances, and you knew about it as well, that employer is never going to touch you with a bargepole again. On that one you would test a client’s availability and actively seeking. It’s a very difficult situation, because at the end of the day we’re not trained counsellors to counsel people with health problems and disabilities. I think that’s a very difficult one. What possibly has happened before, and some advisers have gone down this route, is asked permission from the client for us to contact the doctor – and some clients have done that, I’ve certainly done that with clients before. Then if we’ve got to speak to the doctor, put over what the circumstances are and see what the doctor’s said.’

(ES staff, Rural)
F: ‘We had a client who had alcohol abuse and he came to my desk, he was coming through his Restart interviews, and I spent about three-quarters of an hour with him trying to persuade him to claim Incapacity Benefit — basically making him try and see that what we do is not compatible with what he can do, and try and lay out the consequences that we’ve got to help you find work, we’ve got to find you a job, if we can’t find you a job you’re going to lose your benefit, you do not have those pressures whilst claiming Incapacity Benefit, and it will be in your own interests not to have the pressures we are going to place on you. And perhaps over-emphasising the pressures we would place upon them in order to persuade them to go to the right benefit.’

(ES staff, South coast)

### Scenario 6

A person with a fluctuating health problem (eg asthma) lost their previous job because their employer said they had too much time off sick, and is now thinking of claiming IB. They would nevertheless like to work.

**How would staff advise?**

No clear advice emerged about this, although several advisers suggested it would be a suitable problem for DEA referral. Finding suitable kinds of work might be the answer.

M: ‘That’s definitely a case for the Disability Employment Adviser, for them to do an assessment of what they should be doing, and what they can do and what they can’t.’

F: ‘But you wouldn’t dissuade them from claiming JSA, because they could do other types of work.’

M: ‘The Disability Employment Adviser can organise assessments, other college courses, retraining, all sorts of things.’

(ES staff, Rural)

### Scenario 7

A long term IB/ISS claimant is disallowed. The claimant has no recent work experience and no formal qualifications, and seems to lack self-confidence in their attractiveness to employers. **What advice would they be given? What kind of help do they need?**

Not a lot of advice emerged about this case. Lack of experience, qualifications and confidence are often seen as general problems, not peculiar to disability. Some suggested retraining, or confidence-building courses. Some would suggest appealing against the disallowance.
**Scenario 8**

Someone in their 50s, long-term JSA, suddenly says they want to move to IS. *What would happen then?*

The general feeling is that they would just be advised to see a doctor to get a certificate. If they could get one they would be entitled to claim. Only a few officers said they would enquire further into the reasons, and might then try to influence the outcome.

**Scenario 9**

It is noticed that someone has moved from JSA to IB, back again to JSA and then on again to IB. *What would ES/BA do? What advice would be given?*

The general view here was that staff do see cases like this, but that there are no powers or procedures for dealing with this kind of problem (see Section 4.3.2). The latest claim would just have to be accepted and assessed. One BA Decision Maker suggested that a recommendation should be made to bring forward PCA action in such cases – but our impression is that this does not often happen.

_F: ‘We might notice on and off, but no set procedure’s laid down at all.’_

_F: ‘I would’ve thought perhaps you as advisers would notice, especially if they’d done it to try and get out of going on a programme, because you’d have their records of when they’re supposed to come in.’_

_F: ‘Yeah, you look at the link – but don’t know if we can take any action really.’_

(BA/ES staff, Urban/rural)

**Scenario 10**

A JSA claimant says he finds it difficult to work because of depression. *What advice would be given?*

The advice was usually to see his doctor, although some suggested that a session with the DEA might be useful. Some advisers said they feel rather out of their depth with mental illness.
M: ‘Have a chat with your doctor and see what he feels. Again the Disability Employment Adviser might have some input. But again, we don’t know enough about these illnesses.’

F: ‘It’s a difficult one. Mental illness, depression, anything like that, it’s very difficult.’

M: ‘If someone comes with a bad back then you can suggest what they should do and what they shouldn’t, but something like that is beyond my realm. I would ask for them to see the doctor, and ask them on their next signing attendance to tell me what he said – and take it from there really. It would have to be medical advice on that one really.’

F: ‘I’d expect Incapacity on that.’

(ES staff, Rural)

The general impression from the scenario responses is that staff are hesitant to advise people directly about their medical condition, beyond advising them to see their doctor if they don’t feel fit or want to claim sick – or if their sickness makes them so doubtful an employment prospect that the adviser doesn’t know what to do with them. It is also interesting how little DEAs tend to feature in the responses of these mainstream advisers. Even where procedures exist for dealing with these situations, they are not necessarily well-known or consistently interpreted.

5.2.2 Help from outside

Claimants of sickness benefits are often in need of help or advice – as noted in Section 2.4, the benefits themselves are complex and initially unfamiliar, and some people are further confused by their medical condition.

However we found generally low awareness of the potential sources of independent advice, and a very low level of recourse to these even among those who had encountered problems or felt aggrieved by the way their case was handled.

When asked whether they could think of anywhere they could go for help or advice some people could not think of any such source. The only source at all frequently mentioned was CAB, but this in itself now often has a reputation of being difficult to access because of caseload pressure.

Advice agencies other than CAB were not often known. Apart from general advice agencies and welfare rights groups there are various disability rights groups which might offer relevant help, but their existence does not seem widely known even among this sample of currently or recently incapacitated people.

Only a few people had been represented or supported by third parties at appeals and the like, although this seems to affect success (see Section 6.6).
Rights groups and advice agencies seem more active (and according to staff sometimes more aggressive) in certain types of area – for example inner-city locations and some areas of high unemployment.

### Possible action points

- Provide better advisory or help facilities:
  - Explicit personal contact points could be provided for ISS claimants.
  - Contact details of local or relevant advice agencies should be issued to claimants, and their use suggested at key stages (e.g., PCA failure).
  - Access to BA/ES literature should be improved.

This section summarises some of the material relating to the roles and nature of ES and BA. This will change in future when the new Jobcentre Plus proposal is implemented, which may resolve some of the problems outlined below.

ES generally seems to have a more active and user-friendly relationship with its claimants than BA, in spite of the checks Jobcentre staff have to make on jobseeking activity, and the pressures they sometimes have to exert in this connection. This is probably mainly because their relationship with their clients is predominantly face-to-face. JSA claimants regularly see and talk to a small number of individual officers. To some extent they get to know them, but at all events there is a human face and scope for dialogue. Because they meet regularly in connection with signing-on there are opportunities for staff to explain things, and for clients to ask questions.\(^{16}\)

By contrast BA operates sickness benefits largely by remote control. Relationships are conducted mainly by post (and sometimes telephone), and although claimants can go to the Social Security office to make face-to-face enquiries they tend not to do so if they can help it. BA has a negative and off-putting image and seems more fearsome and austere, so some have inhibitions about getting too closely involved. This image partly derives from BA’s role as a benefits gatekeeper, and partly from perceptions of their offices as places to be avoided – because they are pictured as stigmatised and humiliating to visit, and because some people have vivid and alarming pictures of the kinds of people they would have to mix with.

\(^{16}\) However it would be a mistake to idealise the relationship, and frictions clearly do sometimes develop within the Jobcentre environment as well.
F: ‘Oh it is a depressing place, there were beer cans and the floor was littered, rubbish and empty bottles – and I suppose in a way it was an eye-opener because I thought, ‘My God I wouldn’t have thought –’, and it was awful in there, it really was. And I thought, ‘Well, perhaps I’ve been judged as same as some of these that don’t want to work’.’

(Claimant, South coast)

M: ‘The benefit staff just have faces, numbers, numbers, numbers. They have immense pressure from what I’ve seen. And there’s the security guard standing there. It’s not a nice environment to work in. It doesn’t help them. Through failings of the system, not them, they’re not motivated – they’re processing you, they’re not dealing with you as an individual. You’re just a number. But I kicked and screamed and I shouted and I said, ‘No, that’s not right’, ‘Well, why’s that, justify that, prove it to me?’. If you haven’t got those skills you’ll get swamped – you won’t necessarily get what you’re due.’

(Claimant, South coast)

By contrast the image of Jobcentres seems to have moved quite a long way from the associations of the old ‘dole office’.

M: ‘The Jobcentres, I noticed a few years ago when they started to take out all the security devices, the screens that are in front of the faces, that everybody’s attitude in the area changed. They were more welcoming, they had to be a little wary, but not half as wary as when they were behind screens. And nobody coming in came in with an attitude, ‘If I don’t get what I want I’m gonna smash the place up’, which I saw quite a lot of in the city when I came, and weekly there was a violent occurrence in the offices there. Now I find the places more welcoming, the staff generally are, I would say, better informed now.’

(Claimant, Urban/rural)

I: ‘Do you feel differently about Social Security than about the Jobcentre?’
F: ‘Yer, ‘cos I feel like I’m a sponger really.’
I: ‘Did you not feel that when you went to talk to the Jobcentre?’
F: ‘No.’

(Claimant, South coast)

This is one reason why Jobcentre advisers and receptionists often pick up queries about benefits – notably in the present context about sickness benefits. Because of the active face-to-face relationship they can seem friendlier and more accessible. They also often seem to volunteer benefits advice to their clients where they think people should claim something else. The Jobcentre is also often a channel either for issuing benefits forms, or advising people what forms they need and where to ask for them.
F: ‘That’s why they come in here. Incapacity Benefit customers, they’re not seen enough on a regular basis, and unless you’ve got any queries on your claim you wouldn’t probably hear from BA for a year.’

(ES staff, Rural)

When people go sick they need more support rather than less in many ways – their condition itself can be disturbing and confusing, and they have to grapple with complex new benefits. Yet paradoxically this is the time when they move to a more hands-off relationship with the benefit system.

M: ‘The initial hiccup was trying to prove that I’d had the accident to an unknown face as opposed to the person who was sitting in front of me, who could see I was still bleeding all over his desk.’

(Claimant, Urban/rural)

On the other hand some people see advantages in remote operation – particularly if you have mobility problems or inhibitions about discussing your condition. The balance is not easy to get right – but the current position can leave many people short of support and information at a difficult time.

The JSA gateway is generally simpler than the IB/ISS gateway. There is one benefit, one form and one office to deal with. Mysteries like income- or contributions-based JSA are tucked away out of sight within the one benefit – this may not make the mysteries more comprehensible, but at least they don’t get in the way. The basic nature and purpose of JSA seem relatively clear – it is what you claim if you are out of work but looking for a job. Conversely IB/ISS seem much more complicated – there are two possible benefits whose identities and roles seem somewhat blurred and confused, and one of which (IS) is more associated with other client-groups than with sickness (see Section 2.4).

Not surprisingly, BA and ES staff tended to have different perspectives on the moving issue. There was some overlap, but their main preoccupations and concerns tended to differ:

• BA generally seem mainly concerned with eligibility for benefit – in this context particularly whether people should be regarded as incapacitated, and hence eligible for IB or ISS. Their key question is whether IB/ISS claimants are or are not fit for work.

• Conversely ES are mainly concerned with ‘employability’ rather than fitness per se. Their main job is to place people in work, and their key question is whether people are ‘job ready’. This is in many ways a stiffer test. Someone might be technically fit, but still difficult to employ for various reasons. These reasons might sometimes be directly related to their state of health, but in other cases they might also be only indirectly related, or even completely unrelated (see Section 7.2.2).
ES staff have two types of dilemma when it comes to dealing with people who do not seem good employment prospects:

**a) Likelihood of success:** ES advisers have targets related to the number of placements into work they make. It is easier to meet these if advisers concentrate their time and energies mainly on people who have a reasonable prospect of getting a job.

_F: ‘It is restricting, because obviously you are thinking ‘job entries job entries’, there could have been other areas you could be concentrating more on, but at the end of the day that’s what we’re here for, to get people into work – at least that’s what they keep telling us.’_

(DEA staff, South coast)

Some ex-IB/ISS claimants do not seem good prospects for target fulfilment because even if they are fit for work advisers may feel they are a long way from ‘job-ready’ (see Sections 6.5.3 and 7.2.2). They will try to place them, but if it seems apparent (either from the outset or after some attempts) that they aren’t likely to get a job there is a natural tendency to concentrate effort on other more hopeful cases. Arguably this is the most efficient way of using system resources in terms of getting the maximum number of people into work, but that is not much help to people moving off sickness benefits who either want to get a job or have been told they should do so.

**b) Perceived employer acceptability:** Some clients just do not strike advisers as suitable to offer to employers. There is often felt to be a live risk of damaging the credibility of ES with employers as a supplier of quality labour if applicants are submitted who have obvious or problematic physical or mental disabilities. This could harm their service’s reputation and hence limit the future supply of vacancies notified to the Jobcentre. Some staff would be reluctant even to send such clients for interview.

_F: ‘It’s very difficult. We can guide people towards training, build their stamina and so on. It’s very hard for us to send someone like that for a job, because you’ve got to be confident at the end of the day that they can do the job that you’re sending them to. We build a rapport with the employer and if they can’t do the job and we know they can’t do the job our reputation is going to go down the pan, and we work hard to build up with certain employers. And obviously for the client’s sake, if they can’t do the job then you’re sending them up the spout.’_

(DEA staff, South coast)

ES advisers are understandably reluctant to write anyone off as ‘unemployable’ – some point out that even apparently hopeless cases do sometimes find work, and everyone is entitled to a fair chance of employment. Moreover the benefit system does not officially recognise the concept that someone might be ‘unemployable’, nor does it make allowances for this eventuality. There may be good reasons for this, and
it would clearly be unwise and unfair to consign some people to a kind of employment scrapheap. However in practice:

- advisers live with this reality from day-to-day, and sometimes find it hard to handle;
- ‘problem’ cases that don’t seem to stand much chance of getting taken on do sometimes seem to end up ‘parked’ on JSA – in principle they are actively seeking work, but neither they nor their advisers see a lot of point in doing much more than go through the motions.

_F: ‘They haven’t got a big IQ and the personal hygiene isn’t the best. And what you’re battling against is, you’ve still got to see them. There’s no way anybody is going to employ them. I know I shouldn’t say that, but they aren’t, unless somebody sits in the room and tells them straight, and then you’re not going to get it done. So they come with all this, ‘I’ve got backache, I’ve got asthma, I’ve got something wrong with me eye’. You say, ‘Go and see your doctor, go on, because I don’t want to be bothered with you’.’_

_M: ‘Unfortunately nobody ever seems to realise this higher up, but there is an element of people that you would never ever send to an employer that sign on at Jobcentres. You would lose your credibility with an employer. The employer would stop using your services if you sent some of the people that we see.’_

(ES staff, Rural)

_M: ‘People with maybe a severe learning difficulty or getting over perhaps a serious mental health problem, where I would say certainly they would border on unemployable – or certainly without some sort of supported employment.’_

(DEA staff, Urban/rural)

There are of course many reasons why someone might be hard to employ other than their state of health, and the problem is by no means confined to former or future IB/ISS claimants. However the latter do often face various extra difficulties, as noted in Section 7.2.2.

ES staff usually do their best for such people, but tend to see them as problematic. Many would understandably like to get rid of them from their caseload, and tend to express relief if they decide to claim sick. Indeed, in this sense there is a staff incentive to get them on to IB/ISS, and if their problem seems health-related officers may sometimes suggest this course – either because this seems in the client’s interest, or simply to get the problem on to someone else’s desk.
F: ‘That would have been an example of very severe depression and I thought he’d signed off sick, and I saw him in the office last week and I was thinking, ‘Oh no, don’t tell me he’s back!’ – and he just sits here like this and hasn’t worked for 15 years, and couldn’t cope with the day-to-day pressures of working. I thought we’d persuaded him to go back onto Incapacity Benefit, but perhaps not.’

(ES staff, South coast)

One important class of problems for ES staff is where people fail the PCA, and turn up reluctantly to the Jobcentre while maintaining that they are too ill to work – and perhaps clutching a new sicknote (see Section 6.5.3). Staff sometimes seem to encourage such people to appeal, for the same mixture of reasons as above.

5.4 Effects on perceptions of system

Some people were satisfied with their dealings with the benefit system, and it left them with a reasonably favourable impression.

F: ‘I think they’ve been very good meself.’

M: ‘Oh can’t really see how they can make it that much better, it’s a helluva job, I wouldn’t like to do it.’

(Claimant, South coast)

M: ‘I’ve got no complaints whatsoever. No.’

(Claimant, Urban/rural)

M: ‘I understand there’s a tremendous workload there for the people and so it’s not perfect, and therefore mistakes happen – but on the whole I’m very happy with it all.’

(Claimant, Urban/rural)

In some other cases, however people were dissatisfied – sometimes very strongly so. This often revolved around PCA outcomes and their aftermath (see Section 6.5.2), but also reflected delays and errors, difficulties in getting information, and so on.

I: ‘What did you feel generally about the experiences you’ve had?’

F: ‘Absolutely appalling. I was ill and they just made things worse, they just absolutely – you feel less than a number … Absolutely awful – and the thought of having to ring any department up there is terrifying. I’m sure somewhere in there there’s a very good system, but unfortunately when I needed them most it wasn’t there.’

(Claimant, South coast)

M: ‘It’s all been handled abysmally.’

(Claimant, Urban/rural)
M: ‘Definitely not (satisfied). No, not at all. I’m satisfied with the outcome but the only reason I’m satisfied with the outcome is because of the effort I put in to fight it.’

(Claimant, South coast)

Their experiences of the system left some feeling disillusioned.

I: ‘Did the system turn out to be better or worse than you actually expected it to be?’

M: ‘Worse. And my perception of it wasn’t great to begin with. It was worse than I thought it would be and it’s not the people because the people—most of the people I dealt with you can’t fault them. It’s the system and I don’t know how some of them go into work every day.’

(Claimant, South coast)

Sometimes particular members of staff were criticised—but problems were often blamed on the system rather than the staff.

F: ‘I think it’s more of the system, the faceless system, because when you’re talking to people they’re quite compassionate—well they were with me, ‘Oh my God how awful!’ And I still get a bit upset about it. So it’s not the people. It’s just, ‘I’m really sorry but I’ve got to ask you this’. Well why do you have to put somebody through that?’

(Claimant, London)

In a few cases there seemed to have been a large number of problems, as in the following account.

F: ‘I went before a panel and they were very nice, and the doctor asked me various questions, very easy to answer questions. And they did warn me that the tribunal will possibly have to write to me with the result and he said to me, ‘Would you just like to wait outside a moment’. And I waited and he came in and he said, ‘There is no way you’re fit enough to work. Don’t do anything, you haven’t got to do anything’, he said, ‘We inform them, we send you a copy’. Well I heard nothing from the Benefits Agency and I was still on £41. So my cousin wrote to them again and they said they were sorry, there’d been an error. As soon as the tribunal had been heard I should have had my money sorted out. In the meantime the mortgage17 they hadn’t paid at all, and so I’d heard from my mortgage company and they said they were charging me £10 a month for the arrears, and I said, ‘Well I’m only on £41 a week’, and they said, well they’re very sorry but that’s the way it is. Well after a long wait we went to (Social Security) and you see a girl on the desk, and she just sort of dismissed things, and I just said, ‘Oh I can’t cope with any more of this!’. Well my cousin went up there and she said, ‘I’m not leaving until I speak to one of the managers’, and through that they sorted my money out. And they said that they’d sort

17 Presumably she meant mortgage interest—but customers are often muddled about this, and this particular woman was in a very confused state.
out the mortgage problem as the tribunal had gone in my favour. ‘Well, there’s all this arrears, the extra £10 because of you just withholding’. ‘Well, that will be sorted’. Well, to this day it hasn’t, I have to pay more myself now to try and pay it off. And because I’d won the tribunal, they would backdate this amount — well they hadn’t back-dated it, and we had to get in touch with them yet again. And they were very sorry, there was a letter of apology, she was sorry there’d been another hiccup — but this, when you’re waiting to pay off bills, doesn’t help you really. And that they would be looking into the mortgage although it would take some time — well I never heard.’

(Claimant, South coast)
Key points

• The basis of the Personal Capability Assessment (PCA) is not well understood by claimants or many staff. It actually tests someone’s ability to carry out a range of everyday physical and mental tasks, but is generally expected to relate more obviously to the kinds of task someone might have to undertake in the sort of job they might be able to get, and to the particular illness or disability they have. This often leads to puzzlement, and a certain mismatch of expectations.

• Claimants also rarely understand the routine structure into which the PCA fits, and sometimes interpret it as a sign that they are personally suspected. Many are puzzled by the turn of events, particularly the way their own doctor’s opinion appears to be suddenly discounted.

• The role of the PCA is poorly understood by claimants and staff, who generally tend to have a poor image of it. This can only in part be put down to the inevitable discontents of those who have lost out, or whose work is made more difficult by the outcome. It also arises from:
  - the mismatch of expectations described above, notably the lack of obvious connection between failing to meet the PCA criteria and being fit to get a job;
  - the belief that it fails many people who are not really fit – heard not only from some of those who fail it, but also from many staff – particularly ES advisers, who have to deal with the outfall;
  - perceptions that the actual medical examination is perfunctory in nature;
  - concerns about the way in which the PCA is thought to deal with certain types of ailment – those that vary from day-to-day for example, or mental illness;
  - some allegations that the medical report misrepresented what happened at the medical, or that medical officers were insensitive;
  - widespread cynicism about supposed political manipulation of outcomes.
• Having to sign on when they don’t feel fit to work seems anomalous to many claimants – and also to many staff, particularly since appeals often succeed.

• The PCA is not intended to assess employability, but both staff and claimants often feel that there is not much point in failing people whose health gives them little chance of finding or keeping work, even if in theory they would be fit to do it. ES advisers say they would not even be prepared to send some PCA failures to see prospective employers.

• Post-PCA options are not well-explained or understood, and many find it unsatisfactory to give appellants a choice between claiming reduced benefit and making what many would see as a false declaration that they are available for work.

The way in which incapacity is assessed is a significant feature for both movers and staff. It is important to understand the way it is perceived, which in many respects does not reflect the actual principles and procedures as laid down in the regulations.

6.1 How incapacity is assessed

The full IB claim procedure is described in Section 2.1. When a new claim is made for a sickness benefit (IB or ISS) medical evidence is required to support the claim. There are two distinct sets of requirements, which apply at successive stages, as follows:

1. Own occupation test: During the first 28 weeks of incapacity most people who have a regular occupation will be assessed against their ability to do their own job. This is known as the Own Occupation Test. Medical evidence is required throughout this period, usually by the certificate issued by the claimant’s own doctor.18

2. Personal Capability Assessment (PCA): After a varying period of some weeks or months (depending on the type of health problem) claimants normally have their medical status checked through the ‘Personal Capability Assessment’. First they have to fill in a questionnaire about their medical condition or disability, and the effects this may have on their day-to-day functional ability. Claimants may then be asked to attend a medical examination conducted by a Medical Services doctor. Evidence from the claimant’s questionnaire, the medical officer’s report and any other relevant source (such as the claimant’s own doctor) is weighed up by a lay BA Decision Maker, who decides the outcome of the PCA according to the regulations.

18 The Benefits Agency may in certain cases assess whether this medical evidence is reasonable by carrying out a formal Own Occupation Test, advised by their medical officer.
The PCA assesses whether someone’s state of health or disability makes it unreasonable to expect them to work for more than 16 hours a week, in which case they are entitled to receive a state benefit on grounds of incapacity, which exempts them from the obligation to seek work. The assessment is not related to specific types of job, and is designed to consider whether claimants can carry out a range of everyday physical and mental activities, without pain, fatigue or severe discomfort. The type of work is not specified. The PCA is intended to assess both ‘functional limitations’ and ‘restrictions’ arising from the medical condition or disability. Functional limitations are activities the person cannot do, and restrictions are activities the person should not do (say on medical advice).

People who do not satisfy the PCA criteria are no longer eligible for IB/ISS on grounds of medical incapacity, and hence can sign on for JSA and seek work.

This study is in no sense intended as an evaluation of the PCA, nor do we have any objective evidence about what happens, or how effectively or fairly it is administered. We can draw only on the perceptions and reports of movers and staff, which are typically neither disinterested nor fully informed.

In line with the objectives of this research, the views and experiences explored below represent those of clients who have moved between JSA and IB and the staff who work with them. They are not necessarily representative of the perceptions of the wider population of clients who undergo a PCA, and further research would be required to explore these. Staff were asked specifically about their experiences of dealing with movers.

However these perceptions give rise to some concerns – certainly about the public image of the PCA, but also to some extent about how far the basic procedural concept which underlies it matches the values and expectations of staff and public.

- As shown below, there is certainly widespread ignorance and misunderstanding of the principles and procedures laid down, and this applies to some extent to members of staff as well as claimants.
- However there are also some question marks about how well these principles and procedures themselves accord with participants’ perceptions of ‘fairness’ in relation to the needs of the very wide range of cases it has to deal with.

These points are explored further through the rest of this chapter.
In April 2000 the title of the test changed. It had previously been called the ‘All Work Test’ (AWT), but the name then changed to ‘Personal Capability Assessment’ (PCA). However the staff we spoke to usually still talked about the ‘All Work Test’. This applies to both BA and ES staff, but particularly to the latter. There is some awareness of the new title, but this is by no means universal, and few yet seem to use it actively. Staff are apt to see it as a change of name, not one of substance. The new name reflects a change in philosophy, but this has not generally filtered through to staff as yet – perhaps not surprising, since the name changed only about a year previously.19

Claimants often don’t refer to the PCA by any particular title – even those who have undergone one or more assessments frequently don’t know what it’s called. When they refer to it they tend to do so descriptively – eg ‘I had to have a medical’, or ‘I was told to go and see the Social Security doctor’. Neither ‘All Work Test’ nor ‘Personal Capability Assessment’ seemed widely familiar as names.

We use the current title, ‘Personal Capability Assessment’, in this report, but it should be borne in mind that this was not normal usage on the ground at the time. Where we quote participants verbatim the most common term is still ‘All Work Test’.

Claimants do not usually have much understanding of the way medical incapacity is tested for IB/ISS claims:

- They do not generally know about the two-stage nature of the procedure as explained in Section 6.1 above – including the transition from an ‘own occupation’ to an ‘all work basis’, and hence the changing role of GP certification.
- Nor do many participants understand the PCA process itself, and its role in their incapacity claims. Claimants were told by letter at some point that they should fill in questionnaires and/or attend a medical, but they didn’t usually seem to know about this in advance, or to understand how it fits into the structure of the claim.

This means that when recipients are asked to undergo a PCA it tends to some extent to come out of the blue, appearing as a one-off event rather than as a familiar milestone in a planned procedure. It does not always take people by surprise – some assume as a matter of course that at some stage they will have to ‘have a medical’ to prove that they really are too sick to work, and some were even mildly surprised that this did not happen earlier in the proceedings. But the PCA is not clearly positioned as part of a normal chain of routine events that everyone is liable to be

19 Staff were also largely unaware of the new Capability Report – again not surprising, since this at the time was not operational in areas covered by the study.
asked to undergo, so some people interpret the test as a sign that they are personally suspected of lead-swinging.

This lack of understanding is probably partly due to the fact that the assessment process is complex and not intuitively obvious – indeed fairly incomprehensible without clear explanation. Participants tended to say that the sequence of events had not been explained to them when they claimed. It is difficult to be sure how far this is actually the case:

- They might have been told in some cases, but without the information being assimilated or remembered. This could easily happen, because changing from one benefit to another can be a confusing process, with a lot of new information to take in.
- On the other hand it is also likely that the PCA’s existence, nature and role are not always drawn to people’s attention at an early stage in the claim. Applications are often made by post without face-to-face contact, and even where claimants talk to members of staff this would not necessarily be seen as key information to get across at this point in the proceedings. The assessment of incapacity is not prominently featured in claimant leaflets – and in any case the literature does not usually seem to have registered much in claimants’ minds (see Section 5.2.1).20

It is not usually until the PCA comes into effect that most people are aware of the assessment process at all – up to that point they generally just get sick notes.

There was comparatively little comment about the questionnaire aspect of the PCA, apart from some remarks about finding parts of it difficult to answer (see Section 6.4.2). Some people who had been through a PCA couldn’t even remember having had a questionnaire.

Apart from the outcome of the PCA (see Section 6.5) it is typically the medical examination which makes the main impact on clients’ minds.

Any PCA-type process is likely to be intrinsically stressful – people are often apprehensive about any medical test, and the perceived purpose and context of this particular test make it particularly so. Uncertainty about its purpose and implications can make it seem more worrying. It is often seen as a ‘test’ in more than a purely medical sense, which can put customers on the defensive. As reported in 6.7.3 above, some people assume that the fact that a test is happening at all implies that their bona fides are suspected – it can thus appear more like a trial than a medical

20 IB letters and leaflets have been updated within the past year, but most of the cases in the study would have seen the earlier versions (if any). The new materials were not explored in this research, so we cannot tell how far these might have helped to overcome the problems of understanding.
examination. It was often suggested that it is not really an objective medical test, but a filter designed mainly to reduce the numbers of people able to claim sickness benefits.

Some participants found the experience troubling, whatever the outcome in their own case. This was especially likely where they were suffering from anxious or depressive conditions, in which interactions with other people can be painful at the best of times. This means that the way the PCA is presented, explained and carried out is important to the state-of-mind and well-being of the individuals concerned.

Reports of the actual medical itself were mixed. Some people had no complaint about it, and were well satisfied with the way they were treated.

M: ‘He was firm, but friendly.’
(Claimant, South coast)

F: ‘Marvellous that lady was, yeah. ’Cos I can assure you in the past I have had treatment as if a) you were an imbecile, b) if you haven’t got a job and a life you’re nobody. And that is the God’s honest, that’s how you used to feel years ago – but as I said when I went to see this lady I couldn’t believe that she would be sympathetic and you could talk.’
(Claimant, Urban/rural)

M: ‘The doctor was pleasant about it, he came across as totally neutral.’
(Claimant, Urban/rural)

However there were fairly frequent allegations that the doctor had been brusque, unfeeling or insensitive – even rude in some cases. If the examiner seems cold or unfriendly this can increase the emotional impact of the experience.

F: ‘He just asked me, did I sleep all right, could I get out of bed in the morning.’

I: ‘Were there lots of questions that covered different areas?’

F: ‘Sorry, this is just (crying) – not really. Obviously I’m still affected by having to talk about it. He was just very cold and, ‘Let’s look at the physical things’. And then just getting a letter to say, ‘You’re fine, get back out into the workplace’. It was really hard. And it was shortly after that I was diagnosed as having post-traumatic stress disorder, having flashbacks and stuff – and that wasn’t really taken into account at all.’
(Claimant, London)

Some participants also expressed annoyance at what struck them as a perfunctory and off-hand attitude on the part of the examiner. This was an important event for them, but they got the impression that they were simply being processed as rapidly as possible by someone who was not really interested in their case.
M: ‘They’ve got to do something, but doing one exercise once and saying, ‘OK, you’re signed off, you’re fit for work’. I got the impression I was just being processed, heads or tails.’

(claimant, south coast)

We cannot of course be sure how far the perceptions of coldness and/or indifference derive mainly from the doctor’s behaviour or the customer’s heightened sensitivity to the occasion. However, the frequency of these comments underlines how important it is that Medical Services’ doctors should always be mindful of the impact their attitudes and behaviour are likely to make in the emotionally-loaded circumstances of the test. What may be intended as impartial demeanour could easily seem insensitive or even hostile in such a context.21

Moreover there were some reports that on the face of it do give rise to concern about insensitivity. For example one woman in a state of serious clinical depression which had left her unable to face the world said she was asked by the PCA doctor whether she had contemplated suicide, and if so how she would carry it out. It may be necessary to probe such matters in the assessment of mental illness, but this client said she had been disturbed not only by the question but by the manner and context in which it was posed. She said the medical had made her feel even more depressed.

F: ‘He asked me outright would I commit suicide, and if I did how would I do it? And I said I didn’t know. I knew what I’d do, but he was a complete stranger, and for ten minutes I wasn’t going to talk to him — but my own doctor knew …I don’t know if he treated everyone the same but I thought his manner was, ‘Well I’m here to do the job, answer these questions and then you can go’. There was no empathy, no kindness in his voice — and when you’re going through these things eye contact is very hard, and I just couldn’t — there was no bonding.’

(claimant, south coast)

Customers tend to come to the medical expecting some kind of thorough examination, perhaps involving tests, but what they experience often does not appear to mesh with these expectations. The examination did not strike many people as thorough or penetrating enough to provide a reasonable basis for a decision that is extremely important to the individuals concerned. It was not usually seen as a ‘proper examination’ — it often appeared surprisingly short, and even perfunctory.22

21 DWP say this is already a core part of the training for IB approved doctors.
22 The Department says the average PCA examination takes 45 minutes, probably longer than most patients spend with their GP. However, this is not the way it is often remembered — people usually talked of having spent five, ten, 15 or 20 minutes with the medical officer.
It can appear less thorough than the examinations given to participants by their own doctors – and yet it seems to override those opinions where they differ (see Section 6.7 for a discussion of perceptions of the PCA process)\(^23\).

It does not appear to add new or convincing evidence about their state of health, and yet it sometimes seems to reverse previous decisions about entitlement.

The reasons for these apparent reversals are not usually understood (see Section 6.7).

\(M:\) ‘The substance of that medical was what time do you go to bed, and can you touch your toes? (laughs). It was cut and dried, they’re not concerned really whether you are fit for work or not, it’s as if they’re on commission. It said on the form, ‘Attend the medical’, and they’re asking you what time do you go to bed and can you touch your toes? Is that a medical? That’s no medical in any sense. Just ticked the box, that’s all he did, just ticked the box.’

(Claimant, Urban/rural)

Staff often report similar comments from claimants, and they too tend to share the image of a brief and superficial examination.

\(F:\) ‘The clients we see say, ‘Well when I went to see this doctor I was only in for five minutes, they only asked me this, that and the other’ – how can they really get a true picture? I mean I’ve talked to my clients for an hour and I still haven’t got a true picture. They’re determined to cut down the people who’re on the benefit, and they’ll do it no matter what.’

(DEA staff, Rural)

\(F:\) ‘Sometimes when people go for a medical they’ll ring and say, ‘Well the doctor just asked me to stretch my arm, do this and that, how can he know I’m fit to get back to work?’

(BA staff, London)

**6.4.2 General issues**

It was often argued that people with disabilities tend to minimise reports of their symptoms, which may make some people seem fitter than they actually are. The reasons for this are complex, and were not fully explored in this study, but there appears to be a kind of ‘I can manage’ culture, in which you try to make light of your problems (to yourself and to others) – perhaps partly as a way of coping, and partly in order to seem self-reliant rather than self-pitying. Both the questionnaire and medical tests of the PCA seem heavily dependent on self-reporting.\(^24\)

---

\(^23\) Leaflets which explain the PCA process were amended in April 2000 to advise customers that having a medical does not always mean that the doctor will undertake a physical examination and that it is different from the approach the customer’s own GP might take – but (as noted in Section 5.2.1) not many claimants in the study thought they had seen any literature, and the point had not registered in their minds.

\(^24\) The Department has made efforts to help people with this difficult problem. The IB50 form was designed with the help of disability groups, and there is also an official help line (although not well known to these claimants).
M: ‘I don’t like making a fuss about things.’

(Claimant, Urban/rural)

This problem was presented as an issue both with the medical and the questionnaire, but is perhaps particularly acute with the questionnaire element. One former civil servant in his 50s with arthritis and other serious mobility problems (and who passed his own PCA) described how his community nurse wife had suggested he should rewrite his questionnaire responses because he had put down (for example) that he was able to get up and down stairs without saying that he could only do so after waiting for his painkillers to take effect, and had to rest for half an hour afterwards. Without her expert advice his account would have made his problems seem much less incapacitating than they actually are.25 The PCA does not of course rest only on the questionnaire element, but claimants tend to react to experiences as they have them, and do not see the process in the round.

Another problem some participants experienced relates to the variability of some complaints. If asked whether they perform certain tasks the honest and accurate response for some people would be ‘sometimes I can and sometimes I can’t’ – but many feel that this kind of answer is not catered for, even though there are questions about variability, pain and so forth. Again this kind of comment was applied both to the questionnaire and the examination. This point is further considered in Section 6.7 below.

It is very interesting that the PCA was widely described by claimants and almost universally by staff as a pass/fail test, which you fail if you are judged fit for work, and pass if you are not. So if you ‘fail the PCA’ it usually means that you have been told you are no longer regarded as incapable of work, and hence no longer entitled to IB/ISS. ‘Pass’ and ‘fail’ are the terms most often used by both customers and staff.

This is paradoxical in a way, because if it was a normal medical examination people would presumably regard good health as a success and illness as a failure. Why is the common-sense view of health and illness stood on its head in this situation? There are several reasons for this, already touched on in Sections 6.3 and 6.4.1 above:

• Claimants often saw it as a test to decide whether benefit should be withdrawn rather than as the kind of medical examination that throws light on your state of health.
• Because they thought the examination somewhat perfunctory, they did not see it as a potential source of fresh and encouraging evidence about their state of health.

---

25 This point also emerged from earlier research (Hedges, A., Thomas, R. Making a claim for disability benefits NCSR, DWP ASD28, 1994), where it was also made strongly by advice agencies.
Thus very few ‘PCA failures’ interpreted the result as a pleasing sign that they were in better health than they had thought – and where this did occasionally happen it was usually because the claimant had already felt on the mend and nearly ready to find work again. To many participants it meant that although they thought they were just as ill as they had been before the test, their benefit would now be stopped, and they would have to make their own way on the job market, whether or not they felt up to doing so.

Being told that you have ‘failed the PCA’ can come as a surprise and sometimes as a shock – quite traumatic in some cases. This is particularly likely where someone feels sure in their own mind that they are not fit for work, especially if their own doctor seems to take the same view. It can be quite bemusing to get an official notification that you are no longer seen as incapable of work, when your own doctor has just given you another sicknote and said you are still not well enough to work (see Section 6.7).²⁶

6.5.2 Claimant responses to outcome

Some disallowed IB/ISS claimants clearly believed that their result was wrong – hence the feelings of surprise reported above. Their response is not in itself entirely unexpected, nor does it necessarily mean that they really are incapable of earning their living. Some might simply be trying to avoid signing on, and others might be deluding themselves about the severity of their health problems. However their expressions of astonishment (and sometimes anger or bitterness) often seemed genuine, and their view about being incapable of work was sometimes shared by ES staff when they went to see about signing on, and by their own doctors (see Section 6.5.3).

F: ‘Definitely, when they’ve been told they’ve got to look for work.’

F: ‘Yes, I think it makes them have setbacks, and depression sets in – and then they find that they’re not getting the jobs.’

(DEA staff, South coast)

F: ‘Well I wasn’t well, I honestly couldn’t have gone to an interview. My mother, who is 81, took me to the Job Centre, because I couldn’t go out on my own.’

(Claimant, South coast)

²⁶ Technically this is because GPs’ sick notes usually only have force during the initial ‘own occupation’ phase, but this is not normally apparent to claimants (or to some staff), and some would not see it as fair or reasonable.
Many are unhappy about signing on as Jobseekers if they themselves believe that they are not well enough to work. To do so not only seems dishonest, but some fear it might prejudice their position if they sign to say they are ‘actively seeking work’. This concern is also often shared by staff (see Section 6.5.3).

M: ‘Because I was still being signed off by my doctor I could not sign on for Jobseeker’s, because it’s saying, ‘You’re fit for work’. ’
I: ‘A lot of people are in that position and a lot of people do nevertheless sign on.’
M: ‘Well, surely that’s fraudulent!’
(Claimant, South coast)

M: ‘I thought it weren’t fair going on the dole, because I thought if I’m not fit to work, how can I claim money off the dole as well? It was like a bit of a funny situation to be in.’
(Claimant, Urban/rural)

But if they don’t sign on they fear they will get no money. They are not usually aware of the option to claim reduced IS, which is in any case unattractive (see Section 5.1.2).

F: ‘That was the only way I was going to get any money they said – you see I hadn’t had any, I had to go to the Jobcentre to sign on. And when I went to sign on the manager said, ‘I can tell by looking at you you’re not fit to do a job.’
(Claimant, South coast)

The tone of the IB disallowance notice these participants received sometimes seemed very blunt and cold. This can reinforce the shock, particularly where the news comes as a surprise. We understand that these documents have now been revised, but the version in force for these study participants simply said ‘We have decided that you are no longer entitled to…’. The language seems very official, and some of the expressions used (like ‘threshold of incapacity’) are a long way from popular usage.

Receiving this notice can trigger a variety of responses, ranging from anger through resentment and puzzlement to depression.

F: ‘I thought, ‘He didn’t believe me, he didn’t!’ . I thought I’m not even worthy of any monetary help, I’ve always worked hard and now I thought, they really – ’.
I: ‘Did you feel angry or just feel depressed?’
F: ‘No, depressed, I didn’t really feel anger – everything that happens, every problem is your own fault (when you’re depressed).’
(Claimant, South coast)
I: ‘When you do get to see people who failed the All Work Test, how do you find them?’

F: ‘Usually very angry, upset, dissatisfied.’

(DEA staff, Rural)

A lifelong asthma sufferer whose condition has worsened in her 50s related that the PCA doctor said her asthma was ‘terrible’ and commented on the noises (‘music’) in her chest. She was therefore surprised to get a letter a couple of weeks later telling her she was ‘one point short’, and was judged ‘fit for work’. She is adamant that she cannot work at present, although she would like to, and she plans to consult her own doctor before deciding what to do. She felt ‘sick’ and ‘down’ when she got the letter.

Some staff suggested that there should be a ‘disallowance counsellor’ to help people to come to terms with the result and find positive ways forward.27

F: ‘I’ve always thought whether or not (BA) customer services could have a couple of specialist officers down there, because I think they get a bit war-weary down on the counter and a little bit hard on people. Some people are genuinely distressed and worry, ‘What am I going to do now?’, and they’re crying on the phone – that’s the worst, I’d rather have them swear than cry. I think they could be more of a counsellor if you like – what to do now, like a disallowance counsellor. Certainly there’s a lot of people who are genuinely upset, distressed and made worse by a disallowance, made more ill. But a sympathetic ear and a little bit of coaching and counselling is the road that they want to take – because some people don’t want to appeal, they say, ‘Well I’ll try’, but they just want somebody to listen.’

(BA/ES staff, Urban/rural)

M: ‘I suffered a bout of depression for quite a while after that. I’m fine now but during that time I did become a bit disillusioned with things. I think counselling would have helped a lot because I did sink quite low the first time. But luckily I’ve got very good friends and so they helped me through it, and I was fine after that. That would have been helpful, yeah. Just someone to turn to and say, ‘What do I do now?’

(Claimant, Urban/rural)

Some people alleged that events at the PCA were actually misreported or misrepresented in the medical officer’s report. Claimants had only seen the PCA report in a few cases where they had asked for a copy, but some said they had been puzzled or angry to find that what the doctor had said

---

27 The Personal Adviser proposed for Jobcentre Plus might well be helpful here.
about their performance during the test did not line up in material respects with their own recollections of what they said or did.

M: ‘He actually got it wrong saying that I’d managed to travel here by bus, I managed to do things like that. I travelled by car and I sat in their car park for about half an hour before my appointment drinking about two pints of water, recovering, in inverted commas, and then going in – and perhaps if I’d got there two minutes before I was supposed to go in, gone there all sweaty, wound up, it might have been beneficial to me, ‘cos he might have said I’d been unfit.’

(Claimant, South coast)

One such allegation came from a DEA who had attended the PCA of his own disabled wife, and said that the report was not a fair representation of what had happened and what had been said.

M: ‘I know for a fact that things that the doctor is writing in reports simply didn’t happen, they are untruths, what was written in was untrue – but the system doesn’t allow for you to say, ‘Hang on now that didn’t happen’, they would support their doctor. For instance it said on the report that she had no trouble getting up from a chair, well actually my wife said, ‘Well I can’t sit in that chair, can I use the upright chair?’ And she did struggle.’

(DEA staff, Urban/rural)

Some other members of staff reported hearing such complaints, including this BA DM.

F: ‘Sometimes the medical report seems to bear no relation to the person at all, and so often when a person is disallowed the story that they tell us is so different. The medical officer may say something like, ‘Dressed and undressed without difficulty’, and so on, and the person will say, ‘The nurse had to help me, I couldn’t do it myself.’

(BA/ES staff, Urban/rural)

6.5.3 Staff responses to outcome

ES staff tend to feel that they often see disallowance cases who either:

- strike them as ‘unfit to work’ – this is the kind of term often used, and what they mean by it is that the client’s apparent state of health suggests to the adviser that they are not well enough to be trying to find a job; and/or
- look as if they would be difficult to place in suitable jobs.

We will consider both these perceptions in turn.

1. Not well enough to work: ES advisers and receptionists are not medically qualified, nor do they necessarily have a good understanding of the regulations and procedures governing the PCA. Moreover they are not disinterested observers, since they may not be keen to work with claimants whose condition makes them hard to place. Their opinions about whether or not someone is medically capable of finding work have to be read in this light.
Most ES staff we talked to feel they see a lot of people who in their opinion should not have failed – or whose failure at least seems doubtful. This view tended to be heard from DEAs and receptionists as well as mainstream advisers.

Such opinions tend to be based on three main considerations:

- They largely arise from their own subjective judgements of the person’s state of health during interview – some people just do not strike them as well enough to go out to work.
  
  F: ‘There are cases that in no way are they capable for work. This is the problem, this is happening more and more. I had a client yesterday who’s got agoraphobia and claustrophobia, and because of this she couldn’t attend the appeal, and so it came back, ‘No evidence’. The woman was an absolute nervous wreck. She’s come in – and there was absolutely no way that that woman could go to work.’
  
  (DEA staff, Rural)

- The clients concerned also often strongly maintain they are not fit, and complain about the decision. Advisers obviously realise that this is not evidence in itself, and that some people may pretend to have health problems simply in order to avoid signing on. However they sometimes find their client’s protestations convincing.
  
  M: ‘When you see people coming in and they struggle to climb up a flight of stairs, and they tell me, ‘Oh well I failed that test and somebody’s marked me on my performance, a doctor has, who doesn’t even know me, and my GP’s screaming, saying there’s no way I can work’.’
  
  (ES staff, South coast)

- Some clients bring a fresh sick note to prove their point – and can’t understand why these now seem to have no effect (see Section 6.7). ES staff usually know in a general way that these are no longer passports to IB/ISS entitlement, although many do not seem clear about the technical distinction between the GP-certified ‘own occupation’ phase and the ‘all work’ assessment of the PCA, into which GPs merely make an input (see Section 6.1). However they personally often see the fact that the GP is still willing to certify as further evidence that the client is not just putting it on.
  
  F: ‘We have a lot of people who were claiming Incapacity Benefit but who have failed the All Works Test, and they come in to us, still convinced that they are unable to work – and quite often we think they’re not well enough to work as well.’

  M: ‘They’ve even got documentation from the doctor that they’re just unfit to work.’
  
  (ES staff, South coast)
F: ‘I don’t know really whether the All Work Test is very fair. The majority of clients that come in – I appreciate that they are all going to moan about it, because if you’ve been kicked off it’s not a very good system. However, when I listen to them, I think, ‘No that isn’t fair’. You get genuine people who’ve filled forms in, it said, ‘Can you walk 300 yards?’, and on the day, ‘Well, yeah, I can’. The more honest they are the worse this is for them.’

(DEA staff, Rural)

Whether or not staff are convinced by a client’s protestations that they are too ill to work, the very fact that they are maintaining this presents a problem. A condition of JSA eligibility is that the claimants must be ‘actively seeking work’, and they have to sign a Jobseeker’s Agreement which commits them to this. But both advisers and their clients are often very uncomfortable about the idea of someone who continues to declare themselves incapable of work also at the same time declaring that they are actively seeking it. This poses a dilemma:

- Some feel it undermines the basis of JSA if they allow people to sign on while maintaining they aren’t fit, which makes them professionally uneasy.
- On the other hand it can seem harsh simply to say, ‘Sorry, but you don’t get any money unless you do sign’ – particularly if the adviser suspects the client really isn’t fit enough.

F: ‘They’ve been told, ‘You’ve got to be available for work because you’re fit for work’. So we have them come to us and the person’s saying to us, ‘Listen, I’m not fit for work’. At the same time we can’t – sending them back to DSS means no benefit for them, and then telling us that they’re not fit for work means no benefit from us either, so we’re caught between a situation where – what do we do with the client? ‘Cos we can’t turn them away, so we say, ‘Well listen, you’ll just have to make yourself available for work’. So the client basically has to lie to say, ‘I’m fit for work, I’m looking for work’, when clearly they’re not.’

(ES staff, London)

Staff see this situation as difficult and anomalous. They tend to get round it by fudging either:

- by writing the Jobseeker’s Agreement as permissively as they can – what someone described as a ‘makeshift JSAg’. There seem to be different views about how much scope they have in this direction, but we did not have time to explore this fully; or
- simply by making allowances and looking the other way if the person does not do much to pursue their jobsearch.
I: ‘So what do you do if someone like this (failed AWT) comes in?’

M: ‘Well we have to do a restricted agreement between themselves about the types of work they can possibly do, and restriction on hours – because part of the criteria is that they must be available for full-time work, but I’d say 80 per cent of them aren’t capable of full-time work.’

F: ‘Some people you tend to go through the motions with, there’s nothing you can do with them. You know they can’t go back to Incapacity Benefit, which is where you feel they should be, and in those cases, whether we should or shouldn’t, we tend to go through the motions of the interview processes – and don’t tend to get very far.’

(ES staff, South coast)

M: ‘They (Jobcentre staff) couldn’t understand at the time why people were being sent up to them available for work when in actual fact they were quite plainly sick, they seemed to accept that the DHSS were pushing the boat out a bit, so they went along with you on that.’

(Claimant, Urban/rural)

Advisers vary, however, and some seem more sympathetic or more flexible than others. If they adopt a firm ‘business as usual’ approach this can put pressure on the claimant.

F: ‘By signing the JSAg, they’re saying that they’re fit for work, but within the agreed restrictions. If they wouldn’t sign the JSAg because they’re saying they’re not fit for work, then unfortunately there’s no JSA paid, ’cos they have to sign that in order to get it.’

(ES staff, South coast)

M: ‘He said, ‘Well, I’ve got a job here, it’s a security job’. I goes, ‘But I’m not fit to work’, he goes, ‘Well, you can’t claim Jobseeker’s’, I goes, ‘Well that’s not my fault, they took me off the sick, I’ve got to have an income, I’ve got to live’. So he was more-or-less forcing me to go and take this security job.’

(Claimant, London)

Whatever their approach, however, there is a general feeling that the situation is indeed anomalous, and not satisfactorily recognised or covered by regulations or procedures – hence the perceived need to improvise and fudge, which is often found unsatisfactory. Sometimes they feel they are actually telling their clients to be dishonest.
F: ‘Of course it’s a condition of signing as unemployed that they must be able to say ‘I’m available for work’, but we’re telling them it’s all right – we have to basically tell them to go along and tell lies, keep quiet about the fact that they personally don’t think they’re fit for work.’

(BA/ES staff, Urban/rural)

M: ‘We were looking to put this chap on some work preparation programme, but to be satisfied that it would be a safe thing for him because of his health condition, and he had heart problems, we sent him for one of our occupational health assessments with our doctor, and the doctor says there’s no way that he should be looking for work28, and he’s quite prepared to put that in any letter to any tribunal. And what would happen if myself as a Disability Adviser sent this gentleman on a work preparation and work placement and something happened, who’s to blame then?’

(DEA staff, Urban/rural)

This tends to provoke two kinds of reaction among ES staff:

- Sympathy from many advisers for the claimant’s situation, if they appear to have genuine health problems.
- At least a mild sense of irritation or frustration at:
  - having to grapple with their anomalous status over signing on for work;
  - being landed with someone who may prove hard to place (see below);
  - having to deal with someone who is angry, distressed or confused – and sometimes tearful – about their disallowance by another agency.

M: ‘These people are sitting in front of you, they’re not having a good day, they’re really having a bad day – they don’t want to be in there, they don’t feel they’re capable of looking for work, they feel they’re being forced to look for work. So they come in with that attitude, with that hurt, that anger and bitterness, that, ‘I’m being called a liar, I’m sick, I’m in pain, and the (doctor) just asked me to raise up my arms and touch my toes, and I was signed off’. And so when they come in we’re faced with their anger, because they’re talking to you and they’re releasing all that in your face.’

(ES staff, London)

Some advisers tend to encourage clients in this situation to appeal, if they seem undecided about this. This does not seem to be an approved procedure, but it was fairly common among our ES participants – and is understandable, given their view of the situation. Sometimes they suggest going to a welfare rights agency.

---

28 It is outside the remit of occupational health doctors to pronounce on a client’s eligibility for IB/ISS.
F: ‘If they’re adamant that they’re not fit to work we’ve got a local client’s representation centre called ——— and we will put them in touch with them, and advise them if they want to appeal against it then they can do so … They take the appeal up and quite often they’re successful when they come through ———.’

(ES staff, South coast)

F: ‘Sometimes you think, ‘Yeah, no wonder they failed it’, and there are other times when you think, ‘Goodness me, what’s happening?’

I: ‘And what would you do in that case?’

F: ‘I would advise them to appeal.’

F: ‘They need pointing in the right direction, and quite honestly it’s the welfare rights.’

(DEA staff, Rural)

2. **Hard to place:** The foregoing discussion covers issues relating to people’s perceived or claimed fitness to go to work. The other matter which often exercises staff in relation to disallowance cases is their employability. As noted in Section 6.1, the PCA is not intended to assess whether someone is likely to be able to get work, or to carry out particular jobs, but both claimants and staff still often see this as a key problem.

From the perspective of ES advisers there is active interaction between health and employability. They are not directly involved in decisions about eligibility, but they are responsible for picking up PCA failures who sign on for JSA, and trying to help them into work. Sometimes there is no problem in finding work for people coming off IB/ISS – particularly if they move voluntarily, but sometimes even after they have been disallowed. However in a number of other cases staff feel that it will be very hard for the client to get a job – and that sometimes they may be unable to do so. The expected difficulty is often (although not always) related directly or indirectly to the effects of their health condition.

There are various reasons why a number of these cases are considered hard to place. These are listed briefly below, and discussed in more detail in Sections 7.2.2 and 7.3:

1. There may be no suitable jobs available in the local labour market within the limitations imposed by the individual’s health, skills, experience and abilities.

2. Even if there are jobs they could do in principle there may be considerable difficulty in persuading an employer that they should take someone with a disability.
3. Advisers are very hesitant about sending some former IB/ISS cases for interview if they seem likely to make a bad impression on employers, and tend in any case to focus their attention mainly on the more marketable cases.

4. Some people moving off sickness benefits may in any case not be anywhere near ‘job ready’, particularly if they have had a long layoff, or if their confidence and motivation are undermined by their disability and/or their experiences. In this situation they need training or support to get them ready for the marketplace.

ES staff say they continually come up against the above problems when working with new JSA clients who have recently failed a PCA, and criticise those who operate the PCA for being ‘unrealistic’ or ‘naïve’. The comment is usually that the PCA has judged the person is ‘fit for work’ without considering what work they might be able to do. Again, this is not the business of the PCA under current regulations, but in ES advisers’ eyes the resulting situation does not seem to make sense. They tend to feel instinctively that decisions about whether someone is to be judged capable of going out to work ought in some way to reflect employability and the availability of suitable work.

F: ‘They’re being told by the medical doctors, ‘Well you can do something’, but they won’t elaborate on what that something is.’

I: ‘And does it sometimes seem to you unrealistic to say that they can do something?’

F: ‘Yes, for instance people have been told that you can be a car park attendant – well with this day and age of pay and display those jobs don’t exist. Or you can be a weighbridge operator, and we don’t have any weighbridges in this day and age. It’s the doctors not being realistic as to what’s available in the area. They’re looking at a list of vacancies a person could do, but not establishing if those vacancies are actually available in the area.’

(ES staff, South coast)

F: ‘IVB was better from that point of view – as an adjudication officer on IVB if somebody was found fit for some sort of work you had to be able to identify two or three jobs that they might be able to do.’

(BA/ES staff, Urban/rural)

ES staff say that current practice tends to create difficult and anomalous situations for them and for some of their clients, but under the current regulations and procedures they have no input to PCA decisions.

F: ‘I think liaison between the doctor and the Employment Service wouldn’t go amiss, to say, ‘I would suggest the person could do this type of work, is this type of work available in the area?’

(ES staff, South coast)
Some BA staff tend to sympathise with this viewpoint, although they do not themselves have to deal with the problems of trying to place people in work.

The viewpoint of claimants also seems closer to the ES perspective than to the remit of the PCA as it exists. They cannot see the point in saying they should be getting a job if there is no work that they can realistically find or do. This apparently ‘commonsense’ view often makes people feel there is something wrong and ‘unfair’ about the way the system works.

\[ F: \text{I felt really pressured, really pressured. And it's like, what work am I going to get doing this, and not being able to tie my own shoes?} \]

(Claimant, London)

It might have been expected because of the problems listed above that people failing the PCA would get referred to DEAs rather than seeing mainstream advisers, since DEAs would have relevant expertise and facilities. However, judging by what both staff and claimants said this seems to be the exception rather than the rule. Referrals are sometimes made, but some advisers would only do this if there are exceptional reasons for it. The PCA failures we talked to usually seemed to have as little knowledge and experience of DEAs as everyone else (see Section 7.5.2).

\[ M: \text{The general rule is they don’t get referred to the Disability Adviser whilst they are appealing, mainly because they’re saying they’re not fit, and the appeal is pending, and we would not be inviting people on to expensive work preparation provision when in the end the work that we’ve done with them —} \]

(DEA staff, Urban/rural)

This is partly because it would seem a waste of specialist time referring someone who may well shortly disappear back to IB/ISS (see ‘Appeals’, in Section 6.6 below).

The foregoing analysis largely relates to ES staff, because they are normally the people who have to pick up clients moving off IB/ISS. However similar comments were also quite often heard from BA staff.

Sometimes even BA Decision Makers take the view that the system fails people who are not really capable of work. At first sight this seems odd, because they are the people responsible for determining disallowance. However they sometimes appear to feel constrained by the regulations to take decisions they would not have taken as free agents. The following comments were all made by BA DMs.
F: ‘There’s a lot of people with genuine incapacity that are unable to work, but that don’t fit into the criteria of the PCA. You can have someone with angina\(^\text{29}\) who can sit and stand, and who fail the test – but are unable to work. They fail because of the points system.’

F: ‘There were times when we were working on appeals and we racked our brains because we were quite happy that this person was unfit for work and should not be having to go and sign on – but because of this test they dropped through the net.’

(BA staff, Northern city)

F: ‘You know they’re going to be back because there’s no way they’re going to be able to work.’

(BA staff, Northern city)

BA staff (particularly receptionists and those in IB and IS sections) also sometimes have to take flak from disallowed claimants about the PCA outcome. IS staff in particular sometimes complained that they get emotional customers who are upset about the PCA or its aftermath – which they feel should really be more the concern of IB than IS sections.

There seems to be an image among both BA and ES staff that the level of failure is somehow manipulated in response to ‘political pressures’.

M: ‘It’s to chuck people off Incapacity Benefit. That’s how we see it.’

(ES staff, Rural)

Some suspect that there are quotas which fluctuate according to the political need to adjust the number of people claiming particular benefits.

F: ‘All the time you just get this sense of this behind the scenes quota operating. I’m sorry, but I just do think that there’s this hidden agenda the whole time, so in a sense if there’s an R in a month you fail the test, if there isn’t you pass it.’

F: ‘They seem to be in peaks and troughs. You have like an influx of people who have been found fit for work and then you go a couple of months and then you won’t seem to see many coming through. I think they do them en masse – I don’t know how they work it but that’s the way it seems.’

\(^{29}\) Whether someone with angina should be deemed capable of going to work would presumably depend on the seriousness of the case. The point this DM is making is that she often encounters cases where her judgment about whether someone is able to work conflicts with their points.
F: ‘I’m glad you’ve said that, because I don’t know whether my view is peculiarly cynical or what, but certainly on the decision-making side there’s a strong feeling that there’s a lot of politics right at the top of this and the figures are being manipulated. Certainly the flow of work through the section which deals with the referrals to the PCA, you get spells where an awful lot of people pass the test on scrutiny without being examined and then you get a lot that suddenly are examined – and generally speaking those cases are for disallowance.’

(BA/ES staff, Urban/rural)

F: ‘We get two or three in a week and then hardly any for a few months and then we get a spate of a few more, it seems to come in blocks.’

F: ‘We always used to mutter that we felt there was quotas. Yes, we’ve got to get X amount failed so – !’

(ES staff, South coast)

Officers seem to base these assumptions:

- partly on anecdotes and folklore about alleged instances;
- partly on observation of seemingly unaccountable surges and patterns in the numbers of failures coming through, which they interpret as signs of high-level manipulation.

Such suspicions encourage staff to question whether PCA outcomes are necessarily fair reflections of the individual’s state of health.

However, DWP say that there are no such quotas, and point out that PCA doctors are not even told the eventual outcome, so that their opinions are as objective as possible. It is suggested that patterns in the numbers failing might (for example) simply reflect natural procedural rhythms in the way local BA offices allocate work to sections.

6.6 Appeals

People who fail the PCA are usually clear they have the right of appeal – although some are reluctant to exercise it for a variety of reasons.

Some claimants do not appeal even though they believe that their PCA failure was unfair and that they are not ‘fit for work’. Some of our participants just didn’t think they would win, others were apprehensive about an official-sounding process. One young man decided not to because a friend had once appealed and failed. Those who are anxious or depressed can find appealing a special ordeal.

F: ‘It was just too much of a stress (appealing). If somebody turns round and says, ‘You’re fine’, to kick up a stink and say, ‘I really don’t think I am’, that’s just more stuff that you’ve got to deal with. And having somebody saying, ‘Well go on then, show us what the problem is’, I’d rather just not say anything and not have to go through it.’

(Claimant, London)
The fact that they are entitled to a case review short of a full appeal is not usually known. The notion of case review is not a clear concept in many people’s minds, but when it was explained some thought it a useful approach. They are attracted by the idea of being able to express dissent and get your case dispassionately reviewed without having to go to something as fearsome as an appeal tribunal.

In some cases an appeal seemed to have been instigated or encouraged by ES staff or by the claimant’s own doctor – apparently because they disagreed strongly with the verdict.

In one case the GP was said to be so angry about the result that he offered to speak at the appeal hearing. In the event this did not happen, because no definite appointment could be made for the hearing, and the doctor did not feel able to turn up and hang around. The claimant therefore decided to make a written submission – and lost his case.

The instance quoted above raises another issue. Appeals Service GAPS data for Quarter 4 of 2000 show that the chance of winning an appeal was highest where both appellant and representative attended an oral hearing, and lowest where neither attended. Those who take professional representatives are more likely to win their case, and those who appeal only in writing are very unlikely to win it. One obvious interpretation is that the level and nature of advocacy counts. However some of our appeals cases did not get representation for a variety of reasons. Awareness of relevant advice agencies often seems limited (see Section 5.2.2), and claimants do not always realise that they can be represented – or understand that it is important. As the example above makes clear, representation by their own doctor can be difficult for timing reasons.

Where JSA is claimed while a PCA appeal is lodged many mainstream ES advisers tend to put the case on ice – not officially, but by being more lenient and not expecting much activity. Some staff admit that they ‘don’t pressure’ clients to be active in seeking work during this phase (see Section 6.5.3). Sympathy apart they do not feel there is much point in investing a lot of time in someone who may soon disappear back to the sick.

F: ‘During the appeal period we tend to try and be more – turn a blind eye really.’

F: ‘Flexible and relaxed, aren’t we?’

(ES staff, South coast)

---

30 This is not of course the only possible interpretation. Some people with weak cases might only be going through the motions of appealing, and might fail even if represented. Both these effects may well apply.
The extent to which this happens varies between individual officers, but there is often some feeling that in order to be humane and realistic they sometimes have to work against the grain of the system.

Appellants are also not usually referred to a DEA until their appeal is resolved – again largely to avoid wasting scarce DEA time (see Section 7.5.2). This means that DEAs are not usually in a position to act as disallowance counsellors, and mainstream advisers may not have either the time nor the skill for this role.

The fact that their cases tend to get parked in this way can leave appellants in limbo. They are told they should get a job, but quite apart from their own reservations it sometimes seems that the Jobcentres don’t really want to know about them.

As discussed in Sections 5.1.2 and 6.5.3, people are also often very unclear about their options while appealing, and unhappy with these when they are explained.

Since appeals can take six months or more the above problems of options and ‘parking’ can be quite prolonged.

6.7 Perceptions of the process

The earlier parts of this chapter recount participants’ understanding of the way incapacity is assessed, their experiences with the process, and their reactions to these. We conclude by looking at their perceptions and images of the process.

The PCA seems to have a considerable image problem among movers and the staff who work with them. It was widely criticised by study participants – by staff as well as claimants, and frequently by BA as well as ES staff. There was a good deal of cynicism and mistrust expressed about the process, and about the fairness of its judgements in individual cases.

It is not to be expected that any regulatory procedure would be loved, and a certain amount of adverse comment is only to be expected. Moreover some of the criticism comes from people who have a stake in its operation and outcome – claimants whose entitlement to IB/ISS has been withdrawn, and ES staff who have to grapple with some difficult cases as a result. All this has to be allowed for.

However we feel that the concerns expressed should not just be dismissed as reactions to failure by people with grievances or axes to grind:

- Some of them were shared by claimants whose eligibility had been confirmed by the PCA, and by staff with no obvious personal stake in the outcome (including some BA Decision Makers), and some of the accounts given carried a degree of conviction.
- Images are important, whether or not they are accurate or fairly-based, because they can affect the ways people react and behave.
Criticisms often arise from a mismatch of expectations. This is explored further below, but it has two principal kinds of root:

- In part it is due to limited knowledge and poor understanding of the actual regulations and procedures (see Section 6.3). These are quite difficult to follow and do not always operate in the ways lay observers would expect.
- In part it also sometimes arises because aspects of the regulatory basis of the assessment process do not seem to accord well with participants’ own intuitive sense of what is reasonable or fair.

Thus if people knew more about the regulatory background they would understand why some things happen as they do. If they did understand this our evidence suggests that they would sometimes be more satisfied as a result, but in other cases there might be a clash of values, and they would simply feel there was something wrong with a system that was meant to work in that way.

A good example of this is the way that the process seems to change character when the PCA comes into operation. As we have already observed, it often seems puzzling to claimants that GP sick notes suddenly seem to be devalued, for reasons that are not apparent to them. From the claimant’s perspective the system does seem to change character at the point of the PCA – quite suddenly, and in ways they neither clearly understand, nor have any basis for anticipating. From the point of claim up to the PCA the system appears to be basically trusting, and entirely reliant on the advice of their own doctor. A claimant is entitled to a sickness benefit as long as their own doctor provides a sicknote, and this entitlement is not normally questioned or tested.31 However, when the PCA kicks in the system suddenly seems to flip into a different mode:

- People often feel suspected – sometimes just by the fact of having to go for a medical, but often because of what happens at the PCA itself (see Section 6.4.1).
- Clients are sometimes surprised to find that their own doctor’s opinion suddenly appears to become irrelevant.32 It is not uncommon to find that the GP continues to maintain that a patient who has failed their PCA is unfit for work, and continues to sign sick notes – but whereas these notes have hitherto been unchallenged passports to benefit they have now become ineffective overnight, and often seem disregarded by the benefit authorities.

31 Even where facets of the claimant’s sickness or claim strike staff as doubtful, see Section 4.3.2.

32 The GP’s evidence is not ignored, but is presented to the Medical Services as part of the scrutiny evidence, and considered by the Decision Maker – but this is not widely apparent to claimants, nor would it often be seen as consoling where the PCA verdict does not accord with the GP’s view.
M: ‘He did give me a paper, then DHSS turned round and said, ‘Well, we have our own doctors’, and I said, ‘Well what are you doing then going against my GP? You’re finding against my GP’.’

(Claimant, Urban/rural)

F: ‘Well she (GP) said just appeal against it and see what happens. She didn’t find me fit enough for work, but obviously these people were higher than her.’

(Claimant, Urban/rural)

In fact, under the regulations the GP’s certificate is only a passport to IB/ISS under the initial ‘own occupation’ criteria, which no longer have force at the point where the PCA comes into operation. The GP normally has no decisive standing in the decision from then on. Moreover, their opinion is not ignored, but is part of the evidence considered by the BA Decision Maker.

However, these aspects of the procedures are not generally understood—and they are not matters which people could be expected to realise intuitively. It therefore often seems to participants that the system has made a complete and inexplicable volte face, which can be puzzling and disturbing for claimants.

If they understood the process better the reason for the change would at least become apparent. But from the perspective of the ‘commonsense’ lay observer it would still strike many people as odd and perhaps unfair that the views of the expert with apparently the best knowledge of the patient (GP or consultant) do not prevail when their conclusion is opposite to the PCA verdict, which many feel is based on a more perfunctory exploration of the case.

M: ‘At one time if your doctor give you a sick note that was law. Nobody argued. But now they’re even arguing against your doctor. My doctor gave me a sick note for six months and they just totally ignored it and said, ‘No, we’re not interested, we think you’re fit for work’, which I think is wrong. If your doctor thinks you’re unfit for work, I mean surely the system should say right, the doctor must know what he’s talking about. But because I went in front of a tribunal and the guy says if you can walk unaided to a certain distance etc, you’re fit for work.’

(Claimant, Northern city)

Another mismatch of expectations arises from what the PCA sets out to measure. The test is constructed to deal with a series of everyday physical and mental activities, like walking, sitting, lifting, speaking, seeing, standing, bending etc. It was often argued by participants that this does not really reflect capacity for work—that someone whose state of health should classify them as incapable of working might still be more-or-less able to do all these things. Their inference is often that ‘if you can walk,
talk, stand up and sit down you are deemed ‘fit for work’, which is not a proposition many people would agree with.

In fact the PCA procedure is not meant to relate to particular kinds of job, or to check whether people could perform the specific tasks which these might involve. This is because it aims to assess whether someone is capable or incapable of work in general, not whether they can do a particular kind of job. Nor is the test meant to be specific to particular kinds of illness or disability. But claimants understandably tend to think of their own fitness for work in terms of what they might have to do if they were in a job, and the particular problems their own ailment or disability might cause. From this perspective it can seem puzzling and unfair that the PCA seems to make no attempt to assess these specifics.

F: ‘It was like, ‘Can you stand up, can you walk across the room, can you lift your arms above your head, can you untie your own shoes’. And that was pretty much it. You know, push against my arm and stuff. That kind of thing. It is quite strange. I don’t think it was specifically related to my injuries.’

(Claimant, London)

Claimants are also understandably likely to think in terms of the particular jobs they think might be open to them. For example a manual labourer might expect to be assessed by his ability to shovel concrete rather than simply walking and bending. However the test is not meant to be specifically occupational in this way – again it is conceived as an assessment of broad core functions. That is why it was originally called the ‘All Work Test’, as distinct from the ‘Own Occupation Test’, which for people previously in work is the key criterion up to the point of PCA. This distinction often made some sense to claimants if we explained it to them, but was not something they had hitherto known about or understood. In default of this understanding people tend to assume something closer to an ‘own occupation’ context, because that seems most relevant.

M: ‘They should take into consideration what you do for a living. If I was sitting at a desk, yes I could understand. But I climb ladders etc. My doctor was quite concerned. That’s where the system lets people down I think. People make a judgement on you without really judging what you do for a living.’

(Claimant, Northern city)

There are different procedures for mental and physical problems, but the tests are concerned with the functions people can perform, not with diagnosing particular ailments. Patients do not understand this. They would expect a GP or consultant to apply different diagnostic procedures and tests to suspected heart disease than to bronchitis or epilepsy, and they are surprised if their PCA examination seems to be based on relatively standard procedures which do not seem to them to relate directly to their particular type of health problem.
The implication of the ‘all work’ context is that if someone judged capable of working has a health problem that bars them from their original line of work they could find some other type of job which would they would be able to do. The tacit assumption is that work suitable to their particular pattern of illness or disability would in principle be available and accessible to them. However in practice opportunities for people coming off IB/ISS to change their type of work often seem limited by one or more of a range of factors, as described in Section 7.2.2 below. This is where health-based incapacity intersects with the otherwise distinct realms of job availability and employability. It strikes many people as unreasonable to say someone is well enough to work at a job they have no reasonable chance of getting.

The PCA is generally perceived by staff as well as claimants as a test of whether someone is ‘fit for work’ or ‘unfit for work’ – these actual phrases are commonly used, and the results of the PCA are very often described in these terms. It is often argued that work tends to involve more severe or more sustained physical or mental pressures than those tested. For example, someone might be able to perform an action once or twice but be unable to repeat it many times or do it carrying weights, as they might need to do in the workplace. The PCA is designed to take account of this kind of factor through the IB50 questionnaire and doctor’s evidence, but this is not the way it is generally perceived.

M: ‘Can I get up, can I do this, can I do that, can I sit back down again? Do it once and if I was all right, ‘You’re fit for work’. But at that stage going to a job and doing that 30 or 40 times a day – no way … I don’t think he grasped the fact that, yes I can do these things in isolation, yes I can possibly do them for two days or three days a week, but the fourth and fifth day of the week, I’m not doing it – I’m at home and I’m having a sleep’. It’s, ‘Can he do it once, perform it without any aggravation in front of me? Yeah, you’re fit’.

(Claimant, South coast)

M: ‘What the All Work Test never did was say, ‘Yes they could do something, but could that person do it day in, day out, week in, week out’?. And if not, who’s going to employ them? That’s the acid test isn’t it? OK, we can help them find a job, we’ll maybe secure them a job, but how long is it going to last if their attendance is going to be erratic and so on?’

(DEA staff, Urban/rural)

It is also often felt by both staff and claimants that those who suffer from variable types of complaint can be disadvantaged by the fact that the PCA appears to assess incapacity at a single point in time. Many people believe that the performance of an individual on a given day may not be a fair reflection of their general state of health (see Section 3.2). In this view ‘Fitness’ is a continuum not a dichotomy, and some people oscillate along it. This would often apply (for example) in cases of asthma, arthritis, epilepsy, multiple sclerosis, and many other problems.
F: ‘I can climb the stairs, then sometimes if my legs are really painful, they’re like jelly, I have to hold on, it’s awful – but then I have good days. In a way I would’ve been lying (if she said she couldn’t do it), because sometimes it’s better than on other days.’

(Claimant, South coast)

F: ‘If you’ve got bad asthma, what if you’d recently taken your inhalers, surely you’d be able to walk further? And what if you’d had them half an hour before your All Work Test? They’d probably say, ‘Well what’s up with you?’ To me it’s just a complete waste of space that test is. No value.’

(ES staff, Rural)

In fact the PCA is designed to take account of fluctuating conditions through the IB50 questionnaire and evidence from the GP as well as the actual examination itself, but claimants and some staff were unaware of this – and again participants did not generally tend to see it in this light.

Another related perception is that ailments that are intangible or difficult to measure or demonstrate would score less well at PCA than those that are obvious or easily visible. Mental illness in particular is widely thought to fare badly in the tests. One senior BA Decision Maker thought that ‘you would have to be practically doolally’ before the PCA would judge you incapacitated on mental health grounds. There are actually different procedures for assessing mental illness but these are not generally known – and if known they might or might not allay people’s concerns.

F: ‘There are these people who will fail the PCA, but by any other yardstick are unemployable. For example a person who has chronic heart disease – it’s just the way the PCA has been designed. I remember one of the first All Work Test cases I looked at, a man had had something like two or three heart attacks under the age of 40 and he had to be very careful about everything, but he failed the All Work Test as it then was. And this is the trouble, people with that type of condition – and also people with certain kinds of personality disorders – and we get lots of that don’t we? They’ll score nothing or next to nothing.’

(BA/ES staff, Urban/rural)

One final but important feature is that the PCA often has an ‘unfair’ image among the target population for this research – it is assumed to fail some people who in participants’ eyes ‘ought’ to pass, because they are not really thought well enough to go to work.34 If anything this view is more common among staff, because they have a continuous involvement rather than just passing through as many claimants do.

---

34 Some staff suggested that the reverse also might sometimes happen, with people being passed who are really fit to work – but such cases would inevitably be less visible.
This image derives partly from the general perceptions reported earlier in this section about relevance to work and to different types of health problem, and partly from observation of what seems to happen in particular cases (as reported in Sections 6.5.2 and 6.5.3). But for staff it also derives from the fact that they often see decisions being reversed on appeal – some officers have the impression that this is more common than it actually is, but the reality is that something like one in eight disallowances are successfully appealed. Generic Appeals Processing System data shows that appeals were lodged for about 28 per cent of PCA failures in calendar year 2000, and that claimants won their appeal in 41 per cent of these cases. The fact that an appeal is upheld is of course not necessarily evidence that the original decision was ‘wrong’ in an absolute sense, but that interpretation is often put on it. If a lot of appeals succeed it suggests to observers that there is often at least room for debate about the outcome.

Possible action points

- Explain the medical assessment process more clearly when IB/ISS is first claimed, and again when people are asked to attend.
- Explain the nature and scope of the PCA better.
- Review the regulations governing the conceptual and procedural basis of the PCA and the way it operates.
- Ensure that Medical Officers realise the importance of a friendly and reassuring demeanour.
- Consider a ‘disallowance counsellor’ to help handle stress, and encourage positive ways of thinking.
- Provide disallowance cases with advice agency contacts.
- Consider other ways of handling those failing the PCA to give them:
  - better support during a difficult transition;
  - a chance to have their case and needs looked at in more depth;
  - a more positive attitude to and confidence in the possibility of working;
  - better preparation for work;
  - access to a better range of disability-friendly work opportunities.
- Clarify (including to ES staff) the option of case review short of appeal.
- Options following PCA failure should be clarified and reviewed.
- Reconsider the relationship between incapacity and employability.
Key points

- Many movers would like a job if they believed they could get one, and could handle the work. Working is seen to have many advantages – the right kind of work can stop you getting bored and depressed, and can make you feel better about yourself.

- But those moving from sickness benefit to JSA often face a range of barriers – some imposed by their health condition, others by their own or their prospective employers’ perception of their capabilities and/or their prospects in the job market.

- Some people therefore lack confidence and motivation when it comes to re-engaging with the world of work. This does not mean they are ‘workshy’, but it can make them nervous and negative about leaving the security of sickness benefits and venturing on to an uncertain path towards work.

- The kind of work also often needs to be carefully chosen if it is not to aggravate their health problem and/or end in failure.

- The supply of suitable jobs with disability-friendly employers is limited.

- Re-training can be important in some cases, although there needs to be realism about how far some people with limited skill can effectively change course.

- The implication of the above is that people in this target group sometimes need a good deal of support to help them back to work. This support needs to recognise issues of confidence and emotional turbulence as well as skills and experience.

- In principle this kind of support should be available from DEAs within the Jobcentre, but in practice most of our movers never get to see a DEA. Awareness of the role is poor, and pressures on their time considerable. Some people don’t feel they get much help in dealing with the barriers they face.

- There seems a need to extend contacts between movers and DEAs, particularly at the point when they move back to JSA (and even more so after PCA failure). And we will argue that the role could be further developed to provide a more effective bridge between sickness and work (see Section 8.2.3).
7.1 Desire to work

Many of our claimant participants who are still getting IB/ISS say they would like to work. There are various reasons for this:

**a)** As some IB/ISS recipients themselves say, it is not good simply to be sat on benefits for longer than necessary, because this gives people a sense of dependency, and can lead to vegetative decline and increase depression.

*F: ‘I wanted to get off the Social 'cos I’ve had enough, 'cos it’s just sitting up there all the time waiting, and then wait for your giro to come through.’*  
(Claimant, London)

*M: ‘I’ve been grateful for him for doing that because he (friend who gave him a job) actually forced me off me arse as it were. He said, ‘Oh come on give it a go’, because actually he’d been through it, he’d been there. You do feel completely that no-one else has been through this and you’re on your own. You’ve got to go out there and socialise and work. It was sitting around thinking, trying to work meself out of it that made it worse, that plunged worse into it. But it was a job I could handle, it was labouring. I didn’t have to concentrate, I couldn’t make a mistake. That’s the way I felt, and still feel to this day – that if he hadn’t pushed me into it then I probably would have still been sitting in me chair in there.’*  
(Claimant, South coast)

*F: ‘I don’t like to be not going to work, ‘cos I would love to be able to do something, get my mind working again.’*  
(Claimant, South coast)

**b)** Having a suitable job can make people feel better – physically, mentally, socially and/or economically. It can encourage those who have been through depressing or stressful experiences with their health to feel better about themselves, and restore self-respect and confidence. It can build up people’s sense of personal worth and independence.

*M: ‘It’s a tremendous boost to get back into employment and start again. I’m gonna write to Tony Blair … I think the New Deal’s out of this world (ND 50+), can’t believe it, I think it’s terrific!’*  
(Claimant, Rural)

**c)** It can also lessen any sense of being cut off from the world by disability. People who are incapacitated can easily feel useless if they are unable to do things or make a normal contribution.

*F: ‘It’s still too easy to not bother and you suddenly say, ‘All right, I’ll sit at home and I won’t do anything’. You do think then of yourself as sick and disabled.’*  
(Claimant, Urban/rural)

**d)** Working gives people something to do, a ‘reason for getting up in the morning’, and a means of keeping active. One of the problems of being incapacitated is that it can be more difficult to do things, and it is easy to lose the motivation to keep moving.
F: ‘It was my GP initially, and he actually said, ‘I think it’d be really good for you if you got a part-time job, basically, to get your mind active again and get you active again’. He was like, ‘This is obviously a young woman who’s got a very active mind, and if she’s sitting at home she’s just going to dwell on it and get more depressed’.

(Claimant, London)

M: ‘That would’ve been helpful because of me confidence going and everything like this, I suppose they should’ve said, ‘Can we slot you in somewhere just to keep you at it?’ Now that would have been handy because I found out that just being active is a complete turnaround on everything.’

(Claimant, South coast)

F: ‘I love my work, I enjoyed going to work – well when you’ve worked all your life you get so bored at home.’

(Claimant, Rural)

e) Going out to work can help ward off depression, which may be brought on by ‘just looking at four walls’, and by feelings of helplessness or worthlessness. Apart from bolstering morale it gives people something to think about other than their disability.

F: ‘I would’ve liked to have been able to have gone out to work ‘cos obviously I have to be here and my son used to get depressed and he used to self-inflict, so if anything happened I have to be here for him. But being at home all the time you do get depressed because – there’s nothing you can do.’

(Claimant, South coast)

f) There are often economic advantages from working, and many of those who have had to depend on benefits find themselves in straitened circumstances.

Most participants said they would like to work if their health permitted and a suitable job could be found, but some were not optimistic about the prospects of this (see Section 7.2).

Some Jobcentre staff said that people on sickness benefits sometimes come in and try to sign on when they do not seem ready for this – and sometimes they try to dissuade them from doing so.

However, in some other cases people have low motivation to seek work, or even resistances to doing so. With the present target group these negative feelings do not necessarily imply a ‘workshy’ attitude. Although there are doubtless some cases where people simply ‘don’t want to work’, those with sickness or disability are often inhibited from seeking work by a range of other factors as described in Section 7.2.2.
The study has identified two different sets of barriers to work for those moving from IB/ISS to JSA:

a) **Issues of capability**, related to their health and fitness. These arise more-or-less directly from their sickness or disability, and relate to limitations their health places on the kinds of activity they can carry out, and their ability to sustain these in the context of a job.

b) **Issues of employability**. These concern their chances of getting a job. These may in part arise from (or be affected by) health-determined capability factors, but also stem from general life history, abilities, mental states and circumstances.

These two sets of factors are conceptually distinct, but they often inter-relate in both directions. People whose capability is compromised by their state of health are likely to be less employable; and conversely health problems sometimes arise from (or are exacerbated by) continued inability to get work.

Capability factors are intrinsically rooted in states of health, but some of the employability factors could apply to anyone, not just to those with sickness or disability. Many people have limited skills or experience, for example. However in many cases the movers in our sample have an extra layer of employability problems arising from or compounded by their ailments. These not only include the current effects of their health problems, but in cases of longer-term sickness also their cumulative effects on work experience, education, personality, motivation etc.

In both cases the barriers may be either real or perceived – or sometimes both:

- **Real barriers** are largely matters of objective fact. As an obvious example, a man with a painful arthritic shoulder was unable to do a job which involved heavy manual lifting. But they may also be less tangible in effect – for example a woman with bad asthma who could not work as a machinist if this brought her into contact with wool dust, and someone with an anxiety problem who was unable to handle work involving decisions and social interactions.

Real barriers are not necessarily immutable – people may get better or worse, and the right kind of work can even be remedial (see Section 7.6.1). But they cannot simply be disregarded – attempts to ignore significant real barriers are likely to lead to job failure and possibly further damage.

*M: ‘I went back to the dole (after failing AWT) and I found a job, and it was a lot of bending and all that – and to be honest with you I lost interest like.’*

(Claimant, Urban/rural)
However they might in some cases be got round by:
- special provision in the workplace;
- steps to improve the health condition itself;
- a different kind of work which does not make the same demands, or does not pose the same health and safety risks.

- **Perceived barriers** arise from beliefs, images and attitudes. They involve perceived opportunities, confidence, and/or motivation. They often exist in the minds of claimants, but no less importantly in the minds of many employers — and sometimes of advisers.

The distinguishing feature of perceived barriers is that they can sometimes be changed by working on beliefs or attitudes. Training or supportive advice may sometimes help to overcome them. However they may sometimes be deep-rooted, and can be as potent in their effects as the ‘real’ barriers.\(^3\)

As the following diagram shows, someone may face either real or perceived barriers, or both at once. The left hand segment relates to people whose disability would pose real problems in the workplace, but who do not have mental barriers to finding a job. At the opposite end are people who would be capable of working, but are handicapped in getting a job by their own or other people’s attitudes or beliefs. In the middle are the most problematic group, who are inhibited at both levels.

![Figure 7.1 Real or perceived barriers to work](image)

### 7.2.2 Some important barriers

**Employer-based barriers:** It seems widely believed among claimants that many employers have problems with sickness and disability — that they are intolerant of disabilities, ignorant about the real nature and implications of these, or prejudiced about the people who have them. This view is sometimes also held by ES staff. Indeed from the employer’s perspective it is understandable that they would want employees who are best able to do the job, and it would not be surprising if some saw any kind of impairment as a limitation or obstacle in this.

---

\(^3\) There is a point at which ‘real’ and ‘perceived’ barriers intersect, in mental illness. If someone is depressed about their prospect of finding a job to the point where this demotivated their search we would call this a ‘perceived’ barrier — but they might be perfectly capable of working if this was overcome. If they were clinically depressed to the point where they simply could not function in a work context that would be a real barrier.
M: ‘Not many employers are willing to take on people with disabilities. So, for example, ES has a positive policy of employing people with disabilities, but then if you have an employer who’s profit-driven, who wants to maximise the moments, hours and the minutes, to make sure that things are done, now he probably won’t be very positive when it comes to employing people with disabilities.’

(ES staff, London)

However, perceived employer prejudices are often seen to magnify the barriers to work. It is widely believed that:

- having a disability often handicaps job applicants and makes it hard for them to get taken on; and
- once in work they are more likely to get laid off again because of real or fancied limitations in their ability to cope with the work, time off, and so on.

M: ‘Epilepsy in particular is one of the cases where there is a lot of employer prejudice – mainly I think through ignorance, employers don’t understand, they see epilepsy on a form, or hear epilepsy, and it’s up run a mile, and of course many people are well controlled by medication or never have an episode.’

(DEA staff, Urban/rural)

F: ‘Any job that would come up, I’d be there a little while, and as soon as the disability came up, come into focus, it’d be a case of, ‘Oh well, you –.’

(Claimant, South coast)

F: ‘Once they were aware that that individual had had a sensory impairment I could sense an obstacle had been implanted. And that was just down to that employer’s lack of knowledge.’

(DEA staff, London)

For example, one woman with well-controlled epilepsy would very much like to work and feels she is capable of doing so, but has finally despaired of being able to get and keep a job. She says she has tried telling prospective employers about her epilepsy, but finds they won’t then offer her a job; and has tried concealing it, but then gets fired as soon as they find out.

Sometimes employers are said to be insensitive in failing to take account of disabilities when allocating people to tasks. One man with severe arthritis pain reported that there were many jobs he could have done comfortably within his last workplace, but when he was assigned to warehouse work which needed a lot of bending and lifting, he had to take time off, and lost his job. He felt his employer had not been sympathetic or prepared to listen.

M: ‘I did ask to be moved goodness knows how many times to a different area, and there were vacancies there … I think if they’d moved me I’d still be there.’

(Claimant, Urban/rural)
Overcoming these employer-related barriers would mean working to increase the number of disability-tolerant employers, and the level of understanding of the true implications of different types of illness or disability.

F: ‘Mine’s a very minor epilepsy, and a lot of people wouldn’t even notice that it had happened … It’s not me that finds the disability a problem, it’s other people. People worry about it, they know the word ‘epilepsy’ and they imagine the worst.’

(Claimant, South coast)

The employment provisions of the Disability Discrimination Act may help to reduce discrimination, and in the longer-term this may play an important part in helping disabled people into work. However it does not remove the immediate problem for cases going through at present.

Some of the problems might also be tackled by having more disability-equipped workplaces, which might minimise the impact of particular impairments.

Disability Employment Advisers (see Section 7.5.2) are working to reduce such barriers in all these ways, but the impression from talking to a few of them in this study is that considerably more time and resources would be needed to make a big impact on an intrinsically difficult situation.

F: ‘I think we need to raise disability awareness among employers, to encourage clients to be confident to look for employment.’

(DEA staff, London)

**Health-based limitations:** Apart from alleged unwillingness on the employer’s part, in some cases there are limitations imposed by the disability itself. These may include:

a) Physical or mental impairments which restrict the activities people can carry out, the environments they can work in, or the hours they can work for. For example some participants with bad backs or joint pain said they couldn’t do work which entails a lot of bending or lifting, others with severe asthma said they couldn’t cope with a lot of stairs or dusty atmospheres, a woman with epilepsy can’t work with computer screens which trigger attacks, and someone with heart problems cannot handle much workplace stress. Sometimes these impairments are obvious in nature and effect, but sometimes their nature or effects are more complex or less tangible. Sometimes these impairments would be totally incapacitating, but sometimes they only restrict the kinds of work people can do. These are the kinds of problem that we referred to above as ‘real barriers’.

Given the will and the means these impairments may sometimes be got round by adaptations on the part of the individual and/or the employer, as the following comment suggests. However such adaptations are often not available, and may not be practicable.
F: ‘I read an article in a newspaper yesterday about a long distance driver who’s paralysed from the chest down from an accident and because he’s got mobility in his arms and above and he winches himself into the cab and out into his wheelchair, and I thought, ‘If he can do it!’ – but that’s down to mental attitude again, and someone else in the same situation with a different mental attitude wouldn’t be able to do it.’

(ES staff, South coast)

b) Reliability problems – having to take time off, or periods of low or erratic performance, when the health problem flares up. This is a particular issue with variable or recurrent ailments. If this is serious or frequent enough we might refer to it as a real barrier, but it may be surmountable if the claimant is confident, the employer is tolerant, and the workload is sufficiently flexible.

F: ‘A lot of people, they don’t like you taking time off. I mean if I’ve got three appointments in one week – ‘cos I’ve got no car and I have to go to the hospital, it takes two hours, so basically you’d be having the whole day off – and who’s going to want to take a person who’s got to go to the hospital up to three times a week?’

(Claimant, South coast)

Work activities or pressures can sometimes aggravate the health condition or its symptoms.

M: ‘I went back to work for roughly about six months. Because I’m quite a bit older, our generation, you’re used to working. I’ve worked 12 hour shifts, seven days a week all my life, and I wanted to get back to work and try it. And I went back for six months, but I couldn’t cope – so I had to go into hospital.’

(Claimant, Northern city)

**Restricted range of suitable jobs:** The range of suitable jobs in the locality may be limited, or their impairment may require the job to have uncommon features.

In particular Jobcentres often report a decline in low-skill non-manual opportunities, which might be useful (for example) to former labourers whose ailments now preclude heavy physical work, but have no other skills and little education to call on. ES advisers say there is a shortage of jobs which are physically light yet do not require skills or experience.

F: ‘A lot of times they tell us they can do light work, but what is light work? It covers a whole section of things but where are the light work jobs?’

(DEA staff, South coast)

Staff argue that jobs which used to fit this need (like car-park attendant) have now virtually dried up, and even routine clerical jobs tend to demand (eg) computer skills. From a physical point of view a former labourer might be able to operate a computer, and in principle the answer might be retraining – but in practice someone in this position might not have the aptitudes or cultural background needed for the transition.
F: ‘Very often when I get someone who’s failed the All Work Test coming in to see me, I think, ‘God, I wish that person who’d failed them had now got to try and find them some kind of work’. Sometimes they come back ‘Can do light work’, I’d like them to explain to me what light work is. Years ago, yes, there was light work, somebody would just stand and pack things, now that person has to go and get whatever products they’re going to pack, pack them, and then load them onto something. There’s no such thing as light work any more.’

(DEA staff, Rural)

M: ‘I’d worked as a courier for eight years, the only job they was offering me at the Jobcentre was driving jobs, and all the driving jobs they were sending me for was for HGV drivers with heavy lifting involved, and I was explaining to them over and over I can’t do heavy lifting, I’ve got a bad back.’

(Claimant, London)

Lack of confidence or motivation: Apart from any incapacity caused directly by their medical condition many people in this situation feel insecure about getting work. They often lack confidence about being able to:

• get a job at all, because employers are often assumed to be intolerant of disability;
• find a suitable job which fits in with their physical or mental needs or limitations;
• do the job, without aggravating their health problem;
• keep the job, again because they assume employers would be intolerant of their impairments.

Some people’s motivations are further inhibited by depression or anxiety. In some cases where the incapacity itself is mental-health-based these conditions are endemic, but even where this is not the primary root cause of the incapacity people with disabilities can easily become depressed or anxious as a secondary effect. This was apparent in a number of our participants. Such secondary mental states can arise on account of:

• the disability itself – people whose medical condition is poor, painful or uncertain can easily get upset about that, even if the primary problem is purely physical;
• the effects of the disability – in many cases persistent inability to get or hold down jobs is in itself demoralising, and this can also have unsettling and depressing economic consequences.

Lack of marketable skills: Some movers lack skills, qualifications or experience which restricts the jobs open to them. This is of course not peculiar to IB/ISS claimants, but prolonged sickness can exacerbate these difficulties, and their effects may be worse for people who also face the other barriers listed above.
Limited track record: ES staff report that an important problem in getting a job tends to be lack of (recent) work experience, particularly for people who have been incapacitated for some while, or for whom periods of incapacity have alternated with periods of unemployment.

F: ‘It’s the lack of recent experience, someone who’s been on Incapacity Benefit for three or four years has got nothing to show an employer what he or she can do.’

M: ‘They can’t sell themselves in any way can they? I try to advise about voluntary work.’

(ES staff, South coast)

Multiple barriers: Sometimes individuals are affected by clusters of the above (or other) barriers, real and/or perceived. Someone may have several different health problems, or health barriers may be combined with clusters of problems related to confidence or skills (see Section 3.3).

Sometimes age can be a further overlay for people above 40 or 50. Many feel that employers are not interested in taking on older people. Age may combine with health and other problems to form a powerful obstacle to finding work.

Economic problems: The effect of many of these barriers is to limit the number and nature of the jobs which a given individual might have access to. What is left are often the most poorly-paid vacancies. If their disability also limits their hours there may be real difficulties in making ends meet. This idea further reduces motivation.

F: ‘You get to a point where you become dependent. If you can’t get a job with enough money – when you take your rent out, your Council Tax and your living expenses, sometimes you cannot earn enough to cover all of it, so you think, ‘Oh for God’s sake’, you go back on benefit. And I’ve done that a few times, because I’m flogging a dead horse.’

(Claimant, Urban/rural)

In-work benefits ought to be at least a partial answer to this problem, yet awareness of these seems very limited. Many movers had never heard of DPTC or WFTC, for example. Since these Tax Credits were still relatively new at the time of fieldwork this may not be surprising in itself, but some people were quite surprised to learn that there might be any kind of support they could get while actually in work. And some ex-IB/ISS cases ought to be eligible for DPTC.

How have the experiences of the work and benefit system, related in previous chapters, impacted on the likelihood of movers getting jobs?

In some cases the experience was very positive, particularly where people were getting over a reasonably short-term ailment from which they expected to recover. At the other extreme some people were left feeling
adrift and bitter, feeling unsupported, but also lacking any meaningful connection with the labour market.

We can summarise a number of principal messages that emerge from the study:

a) It is a good idea that people who are incapacitated should be stimulated into activity, and encouraged to seek work as and when they are capable of doing so, for the reasons outlined in Section 7.1.

b) However, the beneficial effects of being stimulated to seek work are most likely to be realised if people really are fit enough to go back to work and have positive and conducive attitudes. Quite apart from any hardship involved, simply dropping someone who believes they are not well enough to work into the labour market tends to be counterproductive, because it produces negative attitudes in the minds of both the claimant and the advisers they meet at the Jobcentre. The claimant resents being put into what they see as an unfair and untenable position, and the adviser has to cope with the anomalous situation, and with someone who may be hard to place. Both often end up going through the motions with little constructive progress towards work, and dissatisfaction on both sides.

F: ‘It’s their motivation a lot of it, they really don’t feel they can work, and it’s an uphill struggle. If you’ve got a vacancy in front of them that matches their Jobseeker’s Agreement, you tell them about the vacancy – they find reasons why they can’t apply for it. And it does make it more difficult for us with somebody that’s in that frame of mind who thinks, ‘I can’t do that, no way I can do it’.’

(ES staff, South coast)

c) As we have seen, confidence and motivation are crucial, and these are often in short supply among people who feel they face the barriers outlined in Section 7.2.2. In order to move forward they need to believe that:

- they stand a reasonable chance of getting a worthwhile job;
- this will be suited to their disability, and will not demand things of them that they will be unable to handle;
- they will not be victimised or fired by an employer who cannot tolerate their disability.

M: ‘Some of the time I lack confidence, lack confidence in me, sometimes. Like here I’m all right, and then the slightest thing will get to me and I’m thinking, ‘Oh God’, and it does me confidence, and I think, ‘I can’t do that any more’ – I know it sounds silly.’

(Claimant, Rural)

Of course none of these things can be guaranteed for anybody, but at the moment some people on sickness benefit would rate their chances as pretty low on many if not all of these dimensions. This pessimism often makes them very nervous about plunging into the job market. Given that this is the case they also need to believe that there is a way back if the
attempt to get work doesn’t work out. Some of the proposed new linking provisions could help a great deal with this, but at present there is often a sink-or-swim feeling about the system.

Various situations emerged where DEAs should have a special role to play, as detailed below. However, as we shall see in Section 7.5.2, most movers to JSA did not get to see a DEA at all, so the needs set out below were not in practice met.

1. In many cases people moving off sickness benefits need preparation and support in order to establish a positive mindset and to provide confidence and motivation. In some cases a bit of sympathetic advice from someone who understands their problems may suffice. In other cases it may involve more extensive counselling or training. Access to all these types of support needs to be improved.

   F: ‘They’ve given me more confidence basically, coming out of myself. Before I used to be a shy person, but now, since I went on the courses, I’ve just come out of myself.’

   (Claimant, London)

2. Some may need special support in their jobsearch activities, and Jobcentres sometimes need to be more sensitive about the types of work and hours that are compatible with their disability. Some people reported that their advisers did not seem to have taken these needs on board, and expected them to apply for vacancies that seemed unrealistic. This tends to make claimants feel more negative and pessimistic.

   M: ‘I have an HGV licence and I can drive, but what one forgets is there’s a lot of work involved – you’re in and out of these container trucks all day. I have pain in my hip, and it’s unreliable.’

   (Claimant, Urban/rural)

   F: ‘People think a secretary, all she does is sit and type all day, but my last employment, I was on the first floor and the photocopier and other forms that I needed were on the ground floor, so it’s up and down stairs all day long – which at the moment I can’t do.’

   (Claimant, South coast)

DEAs should be able to assess what individuals are really capable of, draw up a suitable JSAg, and help match them to suitable jobs. Mainstream advisers vary, but don’t always have the skills or the focus needed to do this effectively.

3. Some people leaving sickness benefits have limited skills and experience to offer, and some are debarred by their health problems from engaging in low-skill manual work. Training can be important – but there also needs to be more realism about the availability of low-skill non-manual vacancies, and about the extent to which some jobseekers can be expected to develop credible new skills, and the help they would need even where
this seems feasible. DEAs should be able to help assess how far people could usefully be retrained, and to give them access to suitable courses.

F: ‘It really depends on the literacy levels, a lot of people – especially a labourer with a bad back, generally the literacy isn’t good enough to be working with computers, to do things like that.’

(ES staff, South coast)

F: ‘Gentleman who’s been a labourer all his life, illiterate, very bad back and had a heart attack in his middle 50s – but he failed the All Work Test because there was ‘something you could do’! Yes, there was something he could do, but he couldn’t work indoors because he just hasn’t got the patience, he hasn’t got the disposition to work indoors – and nor has he got the skills to be able to do something indoors.’

(ES staff, South coast)

F: ‘We’ve had people come in and they’ve got emphysema – perhaps not bad, but they’re puffing away. They’re not very good at reading and writing, and the doctor’s told them they can get a clerical job, ‘You can sit down and do a desk job’.’

F: ‘The jobs that they tell them they can do, it’s pathetic!’

F: ‘You just think, ‘I can’t send you to anywhere’.’

F: ‘They don’t take into account any qualifications.’

(ES staff, Rural)

4. More realistic job opportunities need to be available for people with a wide range of health problems and needs, and the supply of disability-friendly employers needs to be developed. Once more, it is the DEA’s role to develop these opportunities, but it seems a huge task on which current resources do not make much impact.

The above points have particular force where people have been off work for a long time, suffer from recurrent, long-term or difficult ailments, or lack skills, experience and qualifications.

F: ‘Get out of the working routine (long-term sick). They get out of the habit and forget what it’s like to work.’

(BA staff, Northern city)

7.4 Role of Jobcentre

As we saw in Section 5.3, people tend to like dealing with Jobcentres better than with Social Security offices, and given that Jobcentres do sometimes have to play a coercive as well as a supportive role relationships and claimant attitudes often seem fairly good.

Advisers have to make sure that people are genuinely seeking work, and to apply sanctions if they do not. This often seems to be fairly sensitively managed, but occasionally people become either anxious or irritated by it. Where it seems to both parties that jobsearch is likely to be fruitless it can become a pointless-seeming game.
F: ‘It was awful. Just going into the Jobcentre I find alarming, a horrible experience. You get a little diary to write everything down on. Even if you’ve written down a million things that you’ve done in those two weeks, I don’t care what anyone says, the people in the Jobcentre look down on people without employment. They question everything you’ve done … I used to look at what I’d written and think, ‘Have I done enough?’. You make plans of what you’re going to do to find a job, you’re going to write to, say, three employers a week, looking at the Chronicle, visit the Jobcentre three times a week. I used to do twice as much as what I’d actually agreed to do, and I’d still think, ‘Is it enough? Are they going to shout at us? Am I going to have me benefit stopped because they don’t think it’s enough?’ It’s just a horrible experience signing on. And I was asking them for about four months, ‘Can you just put us onto New Deal, please, just so that I can actually train and work?’’

(Claimant, Northern city)

M: ‘They seem talk to you all right, but sometimes you have to push ‘em to have a look. Or they go, ‘Sign here’, ‘Sign here’, and that’s it – and you think, ‘Hold on a minute, can you just look to see if there’s any jobs going’.’

(Claimant, Rural)

It was interesting that even those people who seemed to get on well with Jobcentre staff often did not rate the Jobcentre highly as a source of actual job opportunities. It often seemed to be assumed that if they wanted to get a job they would probably have to do it through other channels.

This is not necessarily a problem in itself, providing they can access other satisfactory channels. However people facing the kind of barriers outlined in Section 7.2.2 may not be well served by normal job market mechanisms, and are likely to need special help in actually tracking down suitable, accessible and disability-friendly jobs.

While some people feel they get good support from their Jobcentres there is a sense in some other cases that there is an element of mechanical process about it, and that some people do not feel they are getting much help to overcome their barriers.
I: ‘Do you feel that you’re getting the support that you need from the Jobcentre, are they helpful to you?’

F: ‘Well I don’t think so, because I don’t think they care, because when you go there to complain to them, they just treat you – like the young ones as well, they just churn you up, they don’t care, they don’t have time, you have to go and do it. And I told them the kind of job, they say, ‘Nobody’s going to take you, you have so much time away from work’, they try to phone about, ‘These people, they won’t take you’, even if it’s the work I had. And if I get a job – anywhere, anything, I’m prepared to do it. I’m not doing anything, at the moment, I don’t think anybody’s helping – I feel that nobody’s helping me. They just say to me I must go and look for job. I try to – but you can’t tell them these things, because they don’t really want to listen, they don’t care. God knows I’m trying, every day – I buy the papers, I phone them there, I go there, if anything I can do, but maybe it’s my own luck.’

(Claimant, London)

M: ‘It’s depressing when you’re sitting there for three hours for a job you know you don’t want and you’re not going to get, but you’re doing it just so they don’t cut your dole off.’

(Claimant, London)

These feelings can be very demoralising and demotivating – and those who have failed the PCA sometimes seem genuinely puzzled that they have been (as they see it) tipped off sickness benefit in order to find jobs no-one seems to want to give them.

DEAs talked of many different kinds of resource and facility which can be made available to help this client group (see Section 7.5.1) – but few of the claimants we talked to seemed to have access to these – or even to know about them.
Possible action points

- Recognise that some movers need a good deal of support, advice and/or retraining. This will sometimes need to include personal and social as well as occupational support to help build:
  - confidence and/or motivation;
  - personal and interpersonal skills;
  - basic skills like literacy and numeracy;
  - occupational skills.

- Step up efforts to increase the supply of disability-friendly employment opportunities, and to build more widespread employer tolerance.

- Improve awareness of and access to DEA services (see Section 7.5.2).

Disability Employment Advisers (DEAs) are advisers attached to Jobcentres, but working to a separate command. Their role is partly to advise and help to place clients who have sickness or disability problems; and partly to work with local employers in a variety of ways – for example:

- encouraging them to take disabled\(^{36}\) people;
- providing access to grants to improve the disability-friendliness of the workplace; and
- troubleshooting problems which arise for disabled employees.

\(F:\) ‘We go out to employers, take the CVs out, our literature. We also go out to employers that are having problems with people who have disabilities, people who are having problems doing their jobs – rather than them lose their jobs we’ve got things we can offer.’

(DEA staff, South coast)

DEAs should be important players where people move between JSA and IB/ISS:

- They have access to specialised disability-related courses, budgets, grants and facilities. These include supported employment (where part of the wage or other costs are paid to the employer), sheltered workshops, grants for special equipment in the workplace, medical assessments, occupational psychologists, etc.

---

\(^{36}\) The words ‘disabled’ and ‘disability’ are used here in a general sense to include all forms of sickness and disability, but as explained later in the chapter, they sometimes carry narrower connotations for claimants.
F: ‘We’ve got the educational psychologist that we can use. We would refer them, it’s one of our services.’

I: ‘When would you refer them to an occupational psychologist?’

F: ‘Generally if we feel that they’ve come up with a job goal which we feel is unrealistic taking into account their disability and their skills, we would then refer the psychologist to guide them in another direction.’

(DEA staff, South coast)

F: ‘If we need an assessment we can get that, but the majority of that will be looking at realistic job goals and an occupational psychologist will make recommendations for the next steps onwards. And once we have got a report back we can work with the client and say, ‘This is what the report is saying, and these are the options’, and we will work with the most realistic of those, and work with them to achieve them. So it is a slow process, but it is the best process for that individual.’

(DEA staff, London)

- They have some expertise in health/employment issues, which is not always available from mainstream advisers. They should be better placed to:
  - understand the kinds of problem that people with different types of disability have, and the employment implications of these (including the kinds of work people with given ailments can and can’t do);
  - get people with disabilities on suitable courses;
  - advise them how to present themselves to employers;
  - provide contacts with disability-friendly employers; and
  - help and advise if disability-related problems with the job subsequently arise.

F: ‘We have things that we can do to help build confidence and so on, and try and aim them to look at realistic job goals, possibly retraining or looking at skills that they had in the past and try and – . We’ve got some employers with sympathy, and help with equipment which people aren’t aware of. Some of those jobs wouldn’t be unrealistic if the equipment was in place and some sort of funding.’

(DEA staff, South coast)

F: ‘With our clients we get to speak to the employer and explain what to do if they have a seizure and so on, and we try to give them as much information as possible. There’s a certain project that’s changed its name now to Workstep, whereby if she couldn’t come in – say she was supposed to work five days and she was having a seizure and she was off one day a week, we wouldn’t expect the employer to keep paying sick pay to her, we would actually try and supplement her wage so that she wasn’t a burden to the company.’

(DEA staff, South coast)
Mainstream advisers as well as DEAs themselves sometimes mentioned these roles.

F: ‘I think the DEA is far more aware of the restrictions that epilepsy would place on a client – someone who’s worked in the Employment Service for a long time would also know that, simply because of what they’ve picked up, whereas if you’re looking at newer members of staff, they wouldn’t know quite so much perhaps about it. And therefore that’s where the DEA comes in, because you would hope that they’ve been taught what an epileptic person can or can’t do.’

F: ‘They have the flexibility with visiting an employer as well, for specific jobs for clients.’

(ES staff, South coast)

F: ‘I’ve got a client on my New Deal caseload I’ve just taken on, and he’s deaf in both ears and is suffering from tinnitus, and tinnitus is getting him down and has given him depression, and so I asked the DEA to come and speak to him – and the questions she was asking were totally different to the questions I was asking, because she has the understanding of how things occur and what the implications of certain things are.’

(ES staff, South coast)

7.5.2 Constraints on DEA contribution

However, at present the contribution of DEAs seems somewhat constrained by a range of factors:

1. Pressures on time: There seems to be a lot of pressure on the limited amount of time DEAs have available. DEAs are often shared between several Jobcentres, and they have to spend time dealing with employers as well as with clients. The potential demand usually seems to outstrip the supply by a considerable margin. For example advisers in one Jobcentre have a DEA in the office for only one day a week, but agreed that there is a potential demand for two-thirds or three-quarters of a full-time post. One DEA guessed that she spent only about half her time in Jobcentres, and the rest out in the field.

F: ‘Our DEA is here once a week, isn’t she? One day a week – a large proportion of which she spends visiting employers, clients on placements etc … We’ve gone below the one million mark in unemployment and we’ve got vacancies which we can’t fill, and I’m sure a lot of people who’re coming towards the end of their time on Incapacity Benefit could do with some transitional help, and we need to look at new ways of getting more people into jobs. But with two DEAs for the whole district I don’t see how that can feasibly work, really.’

(ES staff, South coast)

The severity of the time pressures apparently varies from office to office, but the problem seems fairly general.

Where time is under heavy pressure people have to focus their activities on the most important or productive tasks. Paradoxically some DEAs are said to be loth to take on cases which are not job-ready – although
this policy would seem to inhibit what seems to us one of their most important roles, namely working with people who need a lot of help if they are to make progress towards work (see Sections 7.2 and 7.3). Similarly some offices seem to have a policy of not referring people who are appealing against their PCA disallowance to DEAs unless and until the appeal is turned down. The argument is that this would be a waste of scarce resources. But this means that DEA skills are not being brought to bear on some of the most distressed and problematic cases at a time when they need someone to support and counsel, to advise them what to do next, and to look further into their capability and job prospects. Instead they are largely put on ice.

DEAs (like other advisers) are locked into targets that can best be met by concentrating on job-ready cases. Although they are organisationally distinct their work contributes to Jobcentre targets, and these are placement-based (as they are for mainstream advisers). Someone described them as ‘results-driven’. The effect of this is sometimes to limit the amount of time they can afford to spend with difficult-to-place clients. This is particularly paradoxical in the case of DEAs, whose core target group are often intrinsically difficult to place. The more barriers to work they have the more they need the kind of specialist help DEAs can provide.

M: ‘We’ve mentioned hitting our targets and figures, obviously where you’ve got people who are an easier placing prospect then it might be that these are the people you’re pushing – and particularly when the resource is getting a bit thin on the ground, then the more difficult cases are getting less of your time and attention.’

(DEA staff, Urban/rural)

M: ‘Depressions and panic attacks do provide a bit of a problem really – DEAs are results-driven too, so it can be bit of a problem.’

(BA/ES staff, Urban/rural)

2. Lack of awareness: DEAs are rarely known by those claimants who move between JSA and IB/ISS – people you might expect to need and use their services. Indeed, few of our participants had ever seen one, and most didn’t even know that such a person exists.

DEAs do not seem to be much marketed as a facility. Their clients apparently come mainly from referrals, usually by mainstream advisers, perhaps also occasionally by GPs. In principle clients can refer themselves to DEAs, but self-referral does not seem common, simply because not many people know about DEAs. Very few of the research participants would have been in a position to do this, through lack of awareness – although some thought it might have been useful to talk to a DEA once their role was explained in the interviews.

DEAs themselves are sometimes conscious of the lack of public awareness. One of the main limits on marketing activity is shortage of time. It not only takes time to publicise services effectively, but there
is not much point in doing it if there is no spare capacity to service the increased number of clients this would generate. In particular this consideration tends to inhibit serious attempts to encourage self-referral, because it would not be productive to stimulate demand that could not be met with the resources available.

3. Limited reference: Mainstream advisers seem to vary in their views about when they would refer a client to a DEA. Often this seems to happen only where a specific disability issue presents itself – and sometimes not always even then. Reference is constrained by two main kinds of factor:

- DEAs are known to be busy, and are only available on certain days in some Jobcentres.
- There is often some lack of clarity in the minds of receptionists and mainstream advisers about DEA roles, and the circumstances that should trigger a reference.

F: ‘The advisers don’t have a knowledge of what we have to offer – which is unfortunate, because I think we could help quite a few of their clients.’
(DEA staff, South coast)

This lack of clarity can sometimes cause people to be referred needlessly to DEAs, as well as excluding other cases where their help might be valuable. Some people who have or have recently recovered from disabilities may be well able to cope with job-finding without special help.

M: ‘What we’re trying to get over to staff on the front line is that if a person has a health problem or a disability, it doesn’t necessarily mean that they need to have the additional services of a disability service. At our initial assessment interview we will decide whether or not that person needs our facilities.’
(DEA staff, Urban/rural)

Conversely they sometimes see people who want to work but just do not seem ready for it, and they may then get involved in assessments and support activities of various kinds.

M: ‘Unfortunately we do get self-referrals where perhaps the client is not ready for return to work, but they feel they want to do something. It might mean we’ve got to get a consultant’s reports if perhaps there’s a psychiatric problem, so we need more information. The fact that the individual has said to us, ‘I want to do something’, doesn’t always follow that we can just say, ‘OK, right, let’s get you on a work preparation programme’.
(DEA staff, Urban/rural)

Some DEAs feel that mainstream colleagues tend to pass ‘difficult’ cases across to them – including people who ‘just don’t want to work’, rather than being really impeded by their disability.
4. Detached status: DEAs work to a separate command, which can set them slightly apart from the team of mainstream advisers. The relations of DEAs with their mainstream colleagues seem variable – differing between offices and individuals.

5. Off-putting title: The title ‘Disability Employment Adviser’ has some limitations. Many claimants did not associate themselves with the word ‘disability’ – or want to do so. The term ‘disabled’ tends to be understood as referring to severe physical disability – it tends to conjure up a picture of people who are wheelchair-bound. Having a ‘disability’ is sometimes recognised to cover a somewhat wider range of cases, but still often carries similar connotations to ‘disabled’. Where mainstream advisers do refer clients to DEAs some say that on occasions they have to reassure them about the job title.

F: ‘I don’t like that word, disabled. I don’t mind being sick, everybody gets sick, but I don’t think of myself as disabled. A disabled person is somebody who needs full-time care and will never be able to function on their own.’

I: ‘Would you have thought of yourself as having a disability at that time, or is that the same as disabled?’

F: ‘No I didn’t have a – I had a problem, I had a health problem – but, no, it wasn’t a disability.’

(ES staff, South coast)

F: ‘Sometimes you say to someone, ‘I think it could help if you saw our Disability Employment Adviser’ – ‘Well I haven’t got a disability’.’

M: ‘Yeah, I’ve had that where people say, ‘No, I’m not disabled’, they associate somebody blind, deaf, can’t walk.’

F: ‘In a wheelchair, ‘I’m not in a wheelchair’, they say. So it’s perhaps a re-naming – wouldn’t have such a negative view.’

F: ‘When I’m on reception, rather than say, ‘Do you have a disability?’, I tend to ask them, ‘Do you have any health problems that might affect the way you look for work?’, which is a softer approach.’

(ES staff, South coast)

37 It was interesting that all our attempts to recruit DEAs to attend groups with other Jobcentre staff failed, and we had to make separate arrangements for interview. This was not due to lack of co-operation, because the people concerned were usually very helpful. The difficulties partly seem to reflect the work pressures and limited availability of DEAs, but also their separate status. For example one Jobcentre manager felt unable to organise the attendance of people who were not members of his own staff, and asked us to make arrangements direct with the DEA.
M: ‘Some people get a bit scared as soon as you mention the word ‘disability’. I try and bring it round the other way and say, she’s a lady that helps people with any sort of health problem and not just disabilities, but I think the word disability for some people is –.’

F: ‘I think it should be called occupational health adviser or something. I don’t like the title really.’

M: ‘Some people have been on sickness benefit but they don’t regard themselves as having any sort of disability.’

(ES staff, Rural)

Some advisers say that they can only suggest courses of action to their clients rather than making mandatory references, and to this extent any client reluctance to seeing a DEA could further depress the level of usage of the service.

6. Not involved in assessing incapacity: DEAs have a good deal of experience with people who have been sick or disabled, but they are not currently allowed to bring this to bear on benefit entitlement decisions, such as whether someone meets the IB criteria. They can commission medical reports, but they are careful to say that these are purely intended to advise on the claimant’s medical capacity to undertake specific types of employment. These reports cover different issues to the PCA and are not used to challenge the PCA ruling even if their medical adviser’s opinion is that the claimant may not be fully fit for work (as apparently sometimes happens).

M: ‘We’ve got contracted GPs who we use for occupational health assessment. For instance if an individual says, ‘I’d like to retrain in such and such an area’, and we say, ‘Well we're not so sure that’s the right thing because of your back problem’, so we might send the guy to see our doctor, and he will do a full health check, and assessment and he also would get information from the client GP … We’re not supposed to use the services too obviously to go against anything the BA doctors –.’

(DEA staff, Urban/rural)

The outcome of all the above appears to be that claimants who move between JSA and IB/ISS and who might benefit from seeing a DEA do not often actually get to see one. This means that the potential value of DEAs in dealing with the kinds of problem outlined in Section 7.3 is often not realised in practice. For example, when people moving from IB/ISS to JSA go along to their Jobcentre they commonly seem to see a normal mainstream adviser, and are often not then referred to a DEA. As we have seen, this applies even where they have failed the PCA and are feeling confused or unhappy about their status (see Section 7.5.3).

We have already remarked that ES advisers in general often have a limited knowledge of the details of benefit regulations, and this was particularly true of some DEAs, who have a wider range of activities to cover, and who are probably even less directly connected to benefit administration.
It seems to us that DEAs could potentially play a larger role in dealing with some of the problems we have identified in connection with moving between IB/ISS and JSA. They could provide a sympathetic, supportive and yet positively work-focused perspective – and one which is aware of the health issues and other impacts involved in moving back to work after a period of incapacity, but has the tools for helping to deal with these.

Some DEAs said that their mainstream adviser colleagues are not always sensitive to the health needs of people who have disabilities. They reported that some advisers simply tend to push people towards jobs that may prove unsuitable – which may either land them back on the job market fairly quickly – or precipitate a move to IB/ISS if the work worsens the client’s health condition or aggravates their symptoms. This is another reason for trying to involve DEAs wherever health or disability seems to be an actual (or even a potential) issue.

However if DEAs were to play the kind of role outlined above this would first of all require a broader remit and broader targets, since they would need to spend time with some people who would not seem good prospects for immediate placement. There would also need to be more of them, with more time and resources to devote to the job.

Some DEAs said that their service is available to those still on IB/ISS, and not merely to people on or transferring to JSA. This was not generally known to claimant participants in the study, and there is otherwise no mechanism for achieving this. Under the proposed new Jobcentre Plus arrangements these claimants would have a Personal Adviser, and all new claims will have a work-focused interview. This could help deliver support to those not currently getting it.

It is worth quoting the conclusion from a parallel piece of research, ‘Well enough to Work?’, carried out by the Centre for Research in Social Policy, Loughborough University and the Policy Studies Institute, London.38 This was based on quantitative analysis of benefit records and follow-up questionnaires, and it paints a picture largely congruent to the present study. The authors’ conclusion was as follows:

‘The broad policy context of this report was ‘work for those who can, security for those who cannot.’ The results seem to suggest there exists

a group of people whose health is such that they cannot compete effectively in the labour market for work, a situation compounded by their tendency to experience multiple disadvantage in the form of lowered levels of human capital resources. Moreover, their job opportunities appear further compromised if they live in areas with high unemployment levels, presumably making competition for available work even more intense.’

**Possible action points**

- Review DEA roles, resources and title.
- Improve promotion of, and access to, DEA services and facilities.
- More extensive work with employers to create tolerance and more disability-friendly jobs.

7.6 Therapeutic and voluntary work

7.6.1 Therapeutic work

‘Therapeutic work’ is work that has therapeutic value to the client in helping their recovery or rehabilitation. Approved therapeutic work can be done without compromising eligibility for IB/ISS, or affecting the benefit paid.

It seems a potentially important concept, and one that some clients might find helpful. Apart from any medically therapeutic value it could also help rebuild confidence, and in some cases help set someone on their path back to work.

However it doesn’t seem to be widely used at present. The concept of therapeutic work seemed largely unfamiliar to most claimants, and was not often mentioned spontaneously by staff, other than DEAs.

From our conversations with a few DEAs it appears that there may be some barriers to more use of therapeutic work, as follows:

- It has to be originated by doctors, who may not always be aware of the opportunities for work of this kind, and who may not give a lot of thought to the employment aspects of ill health.
- Opportunities do not arrive often from the employer end – perhaps because of many employers’ misgivings about employing people with disabilities.
- The approval procedures for therapeutic work seem cumbersome. It has to be approved by BA – sometimes allegedly reluctant to give approval, and/or slow to respond to requests. A DEA who has a chance to place someone in a therapeutic vacancy usually needs a rapid go-ahead, or the opportunity may simply vanish.
F: ‘We have so many problems with therapeutic work. I’ve got a few clients that have applied for therapeutic work which would have been absolutely brilliant for them, however the Benefits Agency has turned them down. Normally, ‘Oh it’s not suitable for you’. One case, a man who’d had to finish work, nice person, needed some therapeutic work, and he’d got to be outside, and eventually we found him a part-time job on the crossing patrol – but the Benefits Agency didn’t think it’d be therapeutic for him. Now it was therapeutic inasmuch as it would get him out of the house.’

(DEA staff, Rural)

F: ‘The doctor thought it would be therapeutic but because he didn’t word it properly on the letter they stopped her benefits.’

(DEA staff, South coast)

7.6.2 Voluntary work

‘Voluntary work’ is unpaid work, for example for a charitable organisation. JSA claimants can engage in voluntary work without compromising their eligibility for benefits, providing they remain available for work in line with their JSAg, and could start work or attend for interview within 48 hours.

Jobcentre staff sometimes spoke favourably of voluntary work for people who are or have recently been on IB/ISS. It provides recent experience of work, which will be a useful addition to the CV when the individual is able to return to work (especially if their track record is sparsely furnished on account of their disability). It may also provide some evidence of motivation to prospective employers, enhance job-readiness, and prevent skills going rusty from disuse.

F: ‘Doing voluntary work in Sally Army. I’m just here till something comes up. I went for an interview for childcare, but I need two more references, if I do that I’ll get it.’

(Claimant, London)

F: ‘To me it feels like it’s giving me back – instead of me sitting at home doing nothing, I’m like out doing, like building myself up.’

(Claimant, London)

M: ‘If someone comes in and says, ‘I’m going bananas at home, I need to get out and do something’, then we might kick off with a work preparation just to see how they would cope – and perhaps when you’ve finished your six weeks on work preparation, what about doing some voluntary work?’

(DEA staff, Urban/rural)

Not many of the claimants in the sample had engaged in voluntary work while on IB/ISS – some might have been unable to do it, but in many cases the idea did not seem to have occurred to them.
Those who had done voluntary work were sometimes motivated more by a desire to keep active and get out of the house than by the notion that it might help them back to work – but this is still a step away from passive vegetation.

Some claimants also seemed unsure whether voluntary work might either affect benefit, or be taken by Social Security as evidence of fitness for work, and hence undermine their IB/ISS entitlement status. Many people with disabilities suspect that the government intends to push people off sickness benefits where possible, and voluntary work can easily seem like a trap for this purpose.

*M: ‘I’m not sure really how that works – whether you’d be allowed or not.’*  
(Claimant, South coast)

**Possible action points**

Promote opportunities for therapeutic or voluntary work more proactively, and to remove attitudinal or procedural obstacles where possible, by:

- promoting the value of therapeutic and voluntary work to IB/ISS claimants;
- clarifying the benefit implications of these kinds of work, and make it clear that engaging in it will not compromise benefit entitlement;
- reviewing the routes and procedures for authorising access to therapeutic work, with a view to making it more (and more rapidly) available.
Key points

- There are two fundamental sets of issues which need looking at – the dual benefit system for sickness, and the way in which people move (or are moved) off IB and ISS.

- The dual IB/ISS benefit system should be reviewed with an eye to:
  - simplifying and clarifying the way it works;
  - using a joint-form single gateway rather than two separate applications;
  - preferably amalgamating the two benefits completely on the JSA model.

- Much of the pressure might be taken off the PCA if, instead of a rigidly two-stream ‘sudden-death’ decision, a third interim option was introduced for people with borderline or contested incapacity – a process of further assessment and support, which looks more deeply at their health and their employment prospects.

- But there is a preferable approach which might alleviate many of the current problems, and provide a mutually more satisfactory path towards work. This model takes everyone moving from IB/ISS to JSA into a ‘bridge’ process, designed to assess and support the individual, and to facilitate progress towards work as and when this appears the right outcome. The bridge should be work-focused, but should also contain the possibility of going back to sickness benefit where this seems the fairest and most effective course.

- More IB/ISS claimants might be able to move comfortably and confidently into work if:
  - the transition was differently managed, and less abrupt than it often seems in current disallowance cases;
  - more support was provided, on the personal as well as occupational level; and
  - more employers were willing to take a constructive and disability-tolerant approach.

- However, care is needed to avoid pressuring those whose state of health should continue to exempt them from the obligation to seek work.
The research has thrown up a number of issues which merit consideration, but there seem to be two major clusters of problems to address. Below we reprise the main issues, and sketch in some possible ways forward. These are simply ideas that arise from the concerns expressed in the present study, and we have not assessed their feasibility or broader policy implications.

8.1 Dual benefit system

The complex dual benefit system is poorly understood and confusing, and sometimes seems to cause problems for both staff and claimants (see Section 2.5). There would be advantages in having a single gateway to IB and ISS – at least having a single common application form, and preferably a more integrated approach along the lines of JSA, combining contributory and non-contributory aspects in a single package. This package should be clearly identified with incapacity in its title and presentation – and might well revert to the name ‘sickness benefit’, since that is what most people call IB/ISS anyway.

The Department has already taken some steps in this direction. ONE has piloted the use of electronic integrated claim forms – completed over the phone through a call centre. Findings from this part of the ONE evaluation have not yet been published – but it will be interesting to see how popular they are with IB claimants.

It would also be simpler and more comprehensible if the contribution rules were more symmetrical between sickness benefits and JSA, although we realise this may involve other policy considerations.

8.2 Moving towards work

8.2.1 Problems identified

Chapters 6 and 7 discussed various issues surrounding the way the system decides that an IB claimant is well enough to work, and what happens when it does so. There is a cluster of salient points which have implications for possible ways forward. These can be summarised briefly as as follows:

**Issues about the assessment of incapacity and disallowance**

- The aims and nature of the Personal Capability Assessment are not well understood, and the perceptions and assumptions of many movers and staff members do not line up with the way the system is actually supposed to work.
- The remit of the PCA as laid down in current regulations does not always accord well with some of the views and values expressed by claimants and staff.
- The PCA tends to have an unsatisfactory image for movers and staff, who feel that some of those who fail are really not well enough to work, and suspect that the process disadvantages certain types of case.
- Failure can sometimes have a big impact on disallowed claimants.
**Issues about employability**

- Some disallowance cases who are still affected by their illness or disability face considerable difficulties in finding suitable work.
- Disallowed claimants and their ES advisors are often pessimistic about their chances of finding work – and staff sometimes tend to see them as virtually unemployable, and effectively put them on the back-burner.
- After disallowance some claimants need a lot of support, on both the personal and/or occupational level – but in many cases they don’t seem to get it (few see DEAs, for example).

### 8.2.2 Possible approaches

One kind of response to the above problems might be simply to soften the PCA so that it gives more people the benefit of the doubt, and hence reduces the number of cases which might cause controversy or distress, or where subsequent employment might prove problematic. However this does not seem a satisfactory answer, and a more constructively work-focused approach seems called for. Getting the right kind of work at the right time can be beneficial in many ways (sometimes even from a health point of view), and some people can end up vegetating on sickness benefit if there is no impetus to spur them to grapple with the problems and barriers (both real and imagined) which face them if they go back to work. It therefore seems right in principle that people’s capacity for work should be reviewed and challenged from time-to-time while they are getting IB/ISS. Simply making it easier to stay on the sick would not help from this point of view.

Another possible response is to add another outcome stream to the PCA process. At present the PCA model looks like this (Figure 8.1).

**Figure 8.1 Current PCA model**

![Current PCA model diagram]

The PCA switches people on to one of two parallel tracks that do not connect (other than through reviews or appeals). Either someone can stay on IB/ISS, or they have to go to the market. There are three problems with this model:
a) It represents a ‘sudden-death’ benefit decision which (apart from the possibility of appeal) simply pitches a lot of people back on to a job market which they are not well able to cope with, and which may not have much to offer them.

It was notable in a recent CRSP/PSI analysis of data about people moving off IB that a month after leaving IB only 10 per cent of disallowance cases were in work, compared with 67 per cent of those who left voluntarily.39 The fact that there is such a difference is not surprising in itself, since some voluntary leavers have jobs to go to. It would be useful to know how the situation develops beyond the month – if a lot of the disallowance cases remained unemployed the effect would simply have been to transfer some potentially vulnerable people from one benefit to another, at a cost of considerable turmoil both for the individual and for the system.

b) There is no middle ground to provide flexibility for dealing with those variable or borderline cases that are perceived as important by both staff and claimants – in terms of scope for further assessment, or the claimant’s status while this is made.

c) When disallowed customers go to claim JSA they tend to be treated in much the same way as any other jobseeker, although they are likely to have special problems and needs. The skills and resources of DEAs do not commonly seem to be applied.

The system could be modified to provide some middle ground (see Figure 8.2) between the above two tracks. There would now be a transitional process consisting of two steps:

**Step 1:** Further assessment of their health, employment needs and prospects, on the basis of which their continued entitlement to IB/ISS could be re-examined. If entitlement was reinstated then they would go back to IB/ISS, and their spell would be deemed to be unbroken. Otherwise they would go to Step 2.

**Step 2:** On the basis of the Step 1 assessment any necessary support, training or job preparation would be provided, and they would then move on to JSA.

---

Under this arrangement people disallowed by the PCA would have an option – to accept the verdict or to enter the proposed transitional assessment. It would also be open to the PCA Decision Maker to leave their verdict open by referring difficult or borderline cases to the transition rather than immediately disallowing.

This would provide a better way of handling borderline or controversial disallowances, and would provide a more friendly and productive gateway back to the world of employment. However, it could have disadvantages – for example it might encourage people to appeal.

### 8.2.3 Bridge model

A better and more comprehensive solution might be called the ‘bridge model’ (Figure 8.3). This time all PCA disallowance cases go on to the bridge. This then becomes the normal gateway to JSA for people leaving sickness benefits. Those who are fit and confident merely pass through it if they need no special help, but other cases could be assessed and supported as appropriate, as under the three-stream model. The bridge itself consists (as before) of a two-step assessment and support process, with powers to send people back to continue on IB/ISS if they are confirmed as incapacitated.
In our view there are various advantages in this approach. It would:

- provide a more flexible basis for assessing difficult or contentious cases;
- take a lot of pressure off the PCA, because there would be scope for reviewing its findings in the light of wider evidence;
- reduce the number of appeals, because it would provide other ways of investigating and determining controversial cases – although appeal rights would still be necessary;
- bring relevant employment criteria to bear on decisions about incapacity where this is hard to assess;
- provide a supported and disability-friendly environment for the journey back to work – disallowance cases and other movers would be helped along the path to work, not thrown in at the deep end;
- ensure wherever possible that people who are well enough to work become job-ready and able to find suitable jobs.
F: ‘It could be a group of people that we need to identify properly and determine how we are going to help them. Whether, for example, there should be an alternative class of benefit where they could be assessed again or monitored, or a more in-depth form of medical report requested.’
(DEA staff, London)

F: ‘Where you know that their condition isn’t stable you need to work with them so they are stable and they can present themselves at an interview. You can go into the (record) system and look at submissions for that individual, and tell straightaway that they have gone for so many interviews there is a problem. And then you can ask, what is that problem? Is it because they can’t present themselves well at the interview, do they need additional support? And you have to look at that person from another angle. You therefore perhaps need a sympathetic employer. So as a DEA there are contacts that I have, employers that I know, symbol users or others, and it is down to me or one of my contractors to take time out and look for an employer.’
(DEA staff, London)

This process would take account of claimants’ personal and emotional as well as occupational needs. Emotional factors are important, partly because these clients are sometimes vulnerable people, and partly because people’s feelings can influence their approach to employment. The model would give access, as needed, to counselling or advice about their disallowance and their move back to work, or courses to boost confidence and motivation.

The bridge would need to be a shared responsibility between BA and ES. BA would still be the gatekeeper of benefit entitlement, but ES would make an input to the review, and would be able to carry out their own assessments. The process should probably be housed in the Jobcentre, and based round the kind of skills and facilities which Disability Employment Advisers deploy. This would provide a work-focused but disability-aware and disability-friendly environment.

Claimants would continue to need support during the process, which might be brief or extended. It seems to us that to avoid unnecessary moves entitlement to IB/ISS should continue during Step 1 assessments, but that once someone was judged fit to progress to Step 2 they would move on to JSA. There might need to be a special category under the Jobseeker’s Agreement to recognise their transitional status, and adjust their jobsearch obligations in the interim.

40 Under the proposed Jobcentre Plus, parts of the two Departments are to be amalgamated, so the present divisions will disappear. This is highly compatible with our suggested approach, as is the proposed new Personal Adviser. Jobcentre Plus should make this model easier to implement.
Both the ‘three stream’ and ‘bridge’ models have staffing and resource implications – particularly the number of people with the skills and resources of DEAs. However they also have the potential to save some staff time if they reduce the number of inappropriate moves and appeals, and if they provide advisers with more job-ready people who can be effectively placed.

F: ‘I think it would be helpful if we could have a presence in the Jobcentres, because they’re more accessible than the Benefit Agencies are for some kind of scheme like that, and then they’re not constantly bombarded by us to say, ‘You’ve got to find work’, and, ‘What are you doing to find work?’, but there’s a sort of a middle-ground area that can be discussed. Our problem, as we’ve said before, is we’ve got to reach targets, there’s no employee in the Jobcentre that doesn’t have targets to reach as in getting people into work. So if there could be an employee where they haven’t got that sort of pressure that, ‘I’ve got to get x amount of people into work, that is my target, that’s where I get my performance pay’, and they can concentrate on helping people – not necessarily getting a number into work.’

(ES staff, South coast)

We feel that either of the above models would operate more humanely with difficult cases than the present system sometimes does – and would be seen to do so. Yet at the same time they would be strongly work-focused. Indeed we feel that this kind of approach should increase movement into work because it would make it:

- easier to encourage people to take the path towards work if:
  - they felt they would be supported; and
  - there was scope for turning back if this proved to be a false step;
- more likely that they would find viable work at the end of the path, because of the support provided.

M: ‘We should be seeing these people and moving them along a process back to employment – but to say they would be fit for work wouldn’t be the case.’

(DEA staff, Urban/rural)

The bridge should also be made available to customers leaving IB/ISS voluntarily, where they felt they also needed help in getting back to work.

In both the three-stream and bridge models the eligibility criterion for sickness benefit would continue to be incapacity, but this would now be partly grounded in the real world of jobs as well as in ability to perform generalised tasks. The test should be whether it would be reasonable to expect them to be able to earn a living in the light of their state of health and the kinds of work that might reasonably be available to them.

People who are deemed fit for work but not job-ready would not be eligible for IB/ISS but would continue on to the preparation phase of
the bridge. They would need to be supported on JSA until they were ready to start active job search.

**8.2.4 In conclusion**

The foregoing suggestions are meant only as possible pointers for future development, and not as specific and tested recommendations. We realise that some of the ideas suggested have large implications, and some would entail changes in the conceptual basis of IB and the regulations that govern it. We are also conscious that they raise difficult issues – for example the Department is concerned that taking account of labour market issues and employability factors in decisions about IB eligibility might unbalance benefit provision between regions of higher and lower employment.

Points like these would have to be resolved and weighed against the possible gains. However we feel that there could be considerable advantages in some kind of move in the general direction suggested – not only for claimants, but for the employment and benefit system as a whole. To quote again the last sentence from the conclusions of the parallel *Well enough to Work?* report (see Section 1.2)\(^41\): ‘The results seem to suggest that there exists a group of people whose health is such that they cannot compete effectively in the labour market for work, a situation compounded by their tendency to experience multiple disadvantage in the form of lowered levels of human capital resources’.

It is pleasing to note that the models we have sketched above seem congruent with and complementary to much of the thinking behind ONE, NDDP and Jobcentre Plus. The appointment of a Personal Adviser for those on IB/ISS and the partial merging of BA and ES functions could help considerably.

Finally we should re-iterate that the aim of our suggestions is not to keep more people on sickness benefit. The report recognises the advantages of enabling people to work wherever their state of health permits, and we feel that much of the thrust should be towards making this possible in more cases. But we also feel it important to ensure that:

- more practical and effective support is given to helping those who move off sickness benefits in overcoming the real and perceived barriers they face, so that the transition can be positive and productive rather than negative and frustrating;
- increased effort is put into encouraging employers to take on people with health problems, and give them jobs suited to their limitations;
- care is taken to ensure that individuals whose state of health really makes it unreasonable for them to have to seek work can go on getting support without being inappropriately pressured in the drive towards employment.

---

APPENDIX A

Methods and Sample

Quota sampling methods were used. Claimant fieldwork was carried out in two waves – two areas then three. The target quotas were adjusted between waves, as understanding of the most productive approaches developed.

Names were drawn from a claimant database provided by DWP. There were originally 672 names on the database. This reduced to 638 once obviously ineligible people (died, gone abroad, in prison etc) were removed.

An opt-out procedure was carried out before approaches were made. 303 letters (see Appendix C) were sent out to claimants across the five areas. 23 people (eight per cent of those mailed) opted out and were removed from the list. 11 people (four per cent) spontaneously made contact to opt in, although not specifically asked to do so.

There were 43 people recruited for the claimant interviews, and 40 of these (93 per cent) were actually interviewed. This is a high success rate, particularly for a target group many of whom still have illnesses or disabilities. Once they agreed to take part they did not tend to drop out, or refuse to answer questions about their experiences of disability. Once per cent (were actually interviewed). This is a high success rate for people in this group.

45 Contacts

Recruited 43
No answer 29
Gone away 13
Refused, not willing 12
Wrong number 10
Named person out 6
Not known 4
Late opt-out 2
Died 1
Willing, but not able 1
Other outcome 7

A.1  Sampling method
A.2  Database
A.3  Opt out
A.4  Turnout
A.5  Contacts

Appendix A

Methods and Sample
The following notes give further details of method and approach. They are adapted and extracted from the instructions given to the fieldwork agency that recruited the claimants, Plus Four Market Research.

**Introduction**

Introduce the work as a survey being carried out for the Department of Social Security (DSS) among people who have recently claimed Incapacity Benefit (IB), Income Support for Sickness (ISS) and/or Jobseeker’s Allowance (JSA). The purpose of the study is to find out about:

- How well they understood the benefits available, and how they knew what to claim.
- Whether they had any problems, and how they handled them.
- People’s experiences in claiming benefits.

**Eligibility**

Lists of relevant people will be supplied. Anyone on the list will be eligible, providing they fit the quotas and other requirements specified. No-one who is not on the list is eligible.

**Opt out**

People were sent an attached letter explaining that the survey will happen, and asking them to write if they did not want to be approached. Those who opted out have been removed from the list, although you may also be notified about a few late opt-ers-out. It is extremely important that you do not bother people who say they don’t want to be approached.

**Confidentiality**

- It is entirely a fact-finding study, and will not affect them or their benefits.
- It is being carried out by independent researchers.
- The survey is completely confidential, and the names of those taking part will not be passed on to the Benefits Agency, DSS, the Employment Service, or any other organisation.
- It is being carried out by independent researchers.
- The survey is completely confidential, and the names of those taking part will not be passed on to the Benefits Agency, DSS, the Employment Service, or any other organisation.

For selecting people from the list (see figures below)

**No-one who is not on the list is eligible**. Those will also be guides elsewhere providing they fit the quotas and other requirements specified.

Feel free to answer any way.

- It is purely a fact-finding study, and will not affect them or their benefits.
- It is being carried out by independent researchers.
- The survey is completely confidential, and the names of those taking part will not be passed on to the Benefits Agency, DSS, the Employment Service, or any other organisation.
- It is being carried out by independent researchers.
- The survey is completely confidential, and the names of those taking part will not be passed on to the Benefits Agency, DSS, the Employment Service, or any other organisation.

Because some people are unsure about receiving benefits you will need to be tactful. Some may also be anxious that they are being personally ‘checked up on’, which is not the case. Reassure them (as necessary) that:

- It is being carried out by independent researchers.
- The survey is completely confidential, and the names of those taking part will not be passed on to the Benefits Agency, DSS, the Employment Service, or any other organisation.
- It is being carried out by independent researchers.
- The survey is completely confidential, and the names of those taking part will not be passed on to the Benefits Agency, DSS, the Employment Service, or any other organisation.

The following notes give further details of method and approach.
You should have copies of two letters (see Appendix C):

a) A letter of authority from DSS, which shows that this is a genuine study. The text is very similar to the opt-out letter, but has been altered to make it specific to this project. It can be shown to participants, and left with them.

b) An unaddressed copy of the original opt-out letter (see above), which was sent to participants before the address lists were issued. This can be shown to participants as a reminder where useful.

**Confidentiality**

The lists and sheets are highly confidential. They must not be shown to or discussed with anyone else, including respondents. You should not even show respondents any circumstances in which you have access to this information, or discuss it with them.

**Number of sessions**

40 depth interviews are to be recruited in all, over the five areas specified.

**Areas**

The lists and sheets are highly confidential. They must not be shown to or discussed with anyone else, including respondents. You should not even show respondents any circumstances in which you have access to this information, or discuss it with them.

**Confidentiality**

The lists and sheets are highly confidential. They must not be shown to or discussed with anyone else, including respondents. You should not even show respondents any circumstances in which you have access to this information, or discuss it with them.

Please ensure that:

- no-one has access to the lists who does not need to see them in connection with the project;
- the lists are kept secure, and transmitted securely – double envelope, with the inner marked ‘Confidential’, and use recorded delivery if posted. Don’t fax without ensuring that the recipient is there to receive it;
- all lists and copies are collected up after use, and are either returned to

When needed or (if needed for project archiving) are kept secure.

The lists and sheets are highly confidential. They must not be shown to or discussed with anyone else, including respondents. You should not even show respondents any circumstances in which you have access to this information, or discuss it with them.
The most important feature to control involves the sequence of benefits claimed:

- **Double sandwich**: people who have made two pairs of moves – eg IJIJ or JIJI. This is the most important category. Please get as many as you can, up to say 12 in total (target 9). There are only 16 on the list, so you probably won't get that many – but please try these as top priority and get as many as possible.

- **IB sandwich**: where a spell of IB/ISS is sandwiched between two or more spells of JSA. The next most important group. There is a lot more of these (76 altogether). We would like about 20 recruited for Isand and Dsand together – so Isand should be used to top up the Dsand interviews to about 20 in all. This is half the total to be recruited.

- **JSA sandwich**: where a spell of JSA is sandwiched between two or more spells of IB/ISS. JI: Stands for a sequence of JSA then IS. As far as possible you should go for people who have been claiming JSA for a long time – scoring at least 600 (and preferably at least 900) on JSA duration [total duration of JSA spells]. Half of this target group should be aged 55+.

- **Large**: stands for a large number of [unpatterned] claims.

- **IFT exempt** (see below) is sometimes [unpatterned] claims, but what we get is usually people who have failed the claimant test. The next is different from that we get. These are only 4 people in the exempt category, so just do your best to get as many as you can. But you'll have to do what's possible.

- **Appeal**: tells us if people have appealed [against the PCA outcome].

- **IFT exempt** (see below): stands for All Work Test [now PCA]. It's very important that we get enough people who failed this. Note this is different from 'IFT exempt' (see above).

- **Age group**: we need a good spread, and we want to boost the 55+ category by 55+ people.

- **Type of ailment**: it is important to get something like the kind of spread indicated on this, although precise numbers are not critical. It may be hard to get enough 'AD' [alcohol/drug] cases, but please try these.

- **Has phone**: where people have a phone they may be reached either by phone or by personal call. However it is less important to include people who have a phone they may be reached either by phone or personal call.
Now: This is the current benefit claimed at the time the lists were made up – IB, JSA or neither. Note that this is not necessarily what they are getting today (as asked on the recruitment questionnaire) – it was the situation when the lists were made up some months ago.

Direction: This relates to the direction of movement – I to J are people who started on IB and ended up on JSA. I to I are people who started on IB and came back to it after one or more periods on JSA. And so on. The exact numbers aren't crucial, but it's important to maintain something like the balance indicated in the quotas. In Wave 2 there is more emphasis on J to I and I to J. Where the I to I and J to J cases are concerned aim particularly for the 'Double sandwiches' identified in 'Sandwich' (see below). At Wave 2 the 'J to J' group should mainly be long-term JSA claimants on JSA duration (see above) – this means 2 years or more (730 days or over) on JSA. Ideally at least 5 of these should also be aged 55+. It is very important to get these older long-duration JSA claimants who have moved to IB.

IB/ISS duration: This works like JSA duration, but is slightly less important. However, try to keep the numbers in the two longest categories up to the target figures.

Type of sickness benefit: A lot of the addresses are 'Icred' [ISS] here, but aim to get some IB1, IB2 and IB3 as well. Please note that some of these addresses are 'inherited' [ISS] here.

Sex: We want a good spread, and you should aim for the target is 60%

Respondent sheet

There is space on the respondent sheet to record contacts with that individual. You may make up to three attempts to contact participants (but not more than one attempt at the same address). Record the first contact attempt in the first column, and any subsequent attempts in subsequent columns. There is space for logging up to four contacts on each sheet. Please note that if you have only one contact attempt, you may leave the other two columns blank.

How the attempt was made – whether by phone or in person

What the result of the attempt was

Recruitment questionnaire

A recruitment questionnaire is enclosed. This only needs to be completed for those recruited – the information is not needed for quotas. The questionnaire and respondent sheets are used for analysing the sample.
It is vitally important that:

- everyone recruited is asked all questions on the recruitment QQ, even though these are not used for quotas;
- a respondent sheet is filled in for every attempt at contact, whether or not it is a fruitful contact;
- the recruitment questionnaires and respondent sheets are clipped together and passed to the moderator – before interview if at all possible.

Note that 'Married' includes people who are living as married (ie have a partner). We do not need to know if they are legally married (and you should not ask this).

Timing

The interviews are likely to last up to about an hour each. Try to allow an hour and a quarter between start times, plus any necessary travel time.

Incentives

Incentives of £20 will be paid to all claimants taking part. The moderators will provide and pay these. You should mention this at recruitment (it is also mentioned in the two letters).

The sample achieved is given in the table below. The columns of figures show:

- Column 1: The achieved sample of the sample database, as actual numbers and as a percentage.
- Column 2: The number of people who received opt-out letters.
- Column 3: A target for the interviews, as actual numbers. Drawn up at the outset, and modified on the basis of wave 1 results. Blank cells in this column were not set as targets.
- Column 4: The achieved sample of the sample database, as actual numbers and as a percentage.
- Column 5: The surplus or shortfall of the sample against the target (negative numbers are shortfalls). An exact match was not expected, particularly because some of the categories were small on the database, and also because the targets were ambitious and covered a large number of variables.

The sample represents a good spread of the different types of cases involved.
Table A.2  Sample achieved - figures

<table>
<thead>
<tr>
<th>Database</th>
<th>Opt-out</th>
<th>Target</th>
<th>Sample</th>
<th>Surplus/Deficit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>638</td>
<td>303</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Current</td>
<td>283</td>
<td>141</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Benefit</td>
<td>144</td>
<td>69</td>
<td>11</td>
<td>42</td>
</tr>
<tr>
<td>Type of</td>
<td>20</td>
<td>4</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Sickness</td>
<td>372</td>
<td>189</td>
<td>18</td>
<td>21</td>
</tr>
<tr>
<td>ISS</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SDA</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Reason</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spell continues</td>
<td>325</td>
<td>158</td>
<td>15</td>
<td>51% 38%</td>
</tr>
<tr>
<td>Closed certificate</td>
<td>143</td>
<td>50</td>
<td>10</td>
<td>22% 25%</td>
</tr>
<tr>
<td>IB/ISS claim</td>
<td>69</td>
<td>45</td>
<td>12</td>
<td>11% 30%</td>
</tr>
<tr>
<td>Request of claimant</td>
<td>38</td>
<td>19</td>
<td>3</td>
<td>6% 8%</td>
</tr>
<tr>
<td>Not incapacitated</td>
<td>33</td>
<td>18</td>
<td>0</td>
<td>5% 0%</td>
</tr>
<tr>
<td>Failed to attend medical</td>
<td>13</td>
<td>6</td>
<td>0</td>
<td>2% 0%</td>
</tr>
<tr>
<td>Failed to provide information</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>1% 0%</td>
</tr>
<tr>
<td>Other reason</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>1% 0%</td>
</tr>
<tr>
<td>Not incapacitated</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0% 0%</td>
</tr>
<tr>
<td>Return to work</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0% 0%</td>
</tr>
<tr>
<td>COOT</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>3% 10%</td>
</tr>
<tr>
<td>Other reason</td>
<td>3%</td>
<td>1%</td>
<td>9</td>
<td>8% 9%</td>
</tr>
<tr>
<td>Closed certificate</td>
<td>2%</td>
<td>1%</td>
<td>9</td>
<td>6% 15%</td>
</tr>
<tr>
<td>IB/ISS claim</td>
<td>1%</td>
<td>1%</td>
<td>9</td>
<td>6% 15%</td>
</tr>
<tr>
<td>Request of claimant</td>
<td>0%</td>
<td>0%</td>
<td>9</td>
<td>6% 15%</td>
</tr>
<tr>
<td>Not incapacitated</td>
<td>0%</td>
<td>0%</td>
<td>9</td>
<td>6% 15%</td>
</tr>
<tr>
<td>Failed to attend medical</td>
<td>0%</td>
<td>0%</td>
<td>9</td>
<td>6% 15%</td>
</tr>
<tr>
<td>Failed to provide information</td>
<td>0%</td>
<td>0%</td>
<td>9</td>
<td>6% 15%</td>
</tr>
<tr>
<td>Other reason</td>
<td>0%</td>
<td>0%</td>
<td>9</td>
<td>6% 15%</td>
</tr>
<tr>
<td>Not incapacitated</td>
<td>0%</td>
<td>0%</td>
<td>9</td>
<td>6% 15%</td>
</tr>
<tr>
<td>Return to work</td>
<td>0%</td>
<td>0%</td>
<td>9</td>
<td>6% 15%</td>
</tr>
</tbody>
</table>

Net movement

<table>
<thead>
<tr>
<th>Between periods</th>
<th>Database to database</th>
<th>Database to Spells</th>
<th>Spells to database</th>
<th>Spells to Spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>I to I</td>
<td>42</td>
<td>33</td>
<td>4</td>
<td>7%</td>
</tr>
<tr>
<td>I to J</td>
<td>193</td>
<td>69</td>
<td>10</td>
<td>30%</td>
</tr>
<tr>
<td>J to I</td>
<td>286</td>
<td>123</td>
<td>13</td>
<td>45%</td>
</tr>
<tr>
<td>J to J</td>
<td>117</td>
<td>78</td>
<td>11</td>
<td>18%</td>
</tr>
<tr>
<td>Benefit</td>
<td>Double sandwich movement ((\text{or} \text{JIIJ} \text{or} \text{JIJI} \text{or} \text{JIJI}))</td>
<td>16</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------</td>
<td>-----</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>Pattern</td>
<td>I Sandwich (eg (\text{JIJ}))</td>
<td>115</td>
<td>76</td>
<td>11</td>
</tr>
<tr>
<td>Pattern</td>
<td>I triplet ((\text{IIJ} \text{or} \text{JIJ}))</td>
<td>12</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Pattern</td>
<td>J Sandwich</td>
<td>43</td>
<td>34</td>
<td>10</td>
</tr>
<tr>
<td>Pattern</td>
<td>J triplet ((\text{JIJ} \text{or} \text{IJJ}))</td>
<td>70</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Pattern</td>
<td>Pair ((\text{IJ} \text{or} \text{JI}))</td>
<td>359</td>
<td>136</td>
<td>17</td>
</tr>
<tr>
<td>Pattern</td>
<td>Split four ((\text{JJII}))</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Outcome of</td>
<td>No pattern</td>
<td>21</td>
<td>19</td>
<td>3</td>
</tr>
<tr>
<td>Pattern</td>
<td>JJIJ</td>
<td>80</td>
<td>52</td>
<td>7</td>
</tr>
<tr>
<td>Pattern</td>
<td>JJJI</td>
<td>47</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Pattern</td>
<td>IJI</td>
<td>32</td>
<td>24</td>
<td>4</td>
</tr>
<tr>
<td>Pattern</td>
<td>IJJ</td>
<td>23</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Pattern</td>
<td>JIIJJ</td>
<td>17</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>JJJI</td>
<td>13</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Pattern</td>
<td>JJIJJ</td>
<td>12</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Pattern</td>
<td>IIJ</td>
<td>9</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Pattern</td>
<td>JIJI</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>IJIJ</td>
<td>6</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Pattern</td>
<td>IJJI</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>IJJJ</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>JII</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>JJJJJ</td>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>JJJJI</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pattern</td>
<td>IIJJ</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>IJJJI</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>IIJI</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>IJII</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>IJIJJ</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>IJJJI</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pattern</td>
<td>JIIJ</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>JIIJJ</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>JJJJJ</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pattern</td>
<td>JJJJJ</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

| Outcome of | Failed AWT (PCA) | 93 | 65 | 13 | 12 | 16% | 30% |
| Pattern | Appealed | 37 | 31 | 9 | 9 | 0 | 6% |
| Pattern | Exempt | 11 | 10 | 4 | 1 | -3 | 2% |

| Sex | Female | 181 | 178 | 3 | 3 | 45% | 80% |
| Male | 457 | 225 | 24 | 24 | 0 | 72% | 60% |
Database Opt-out Target Sample Surplus/Database Sample

<table>
<thead>
<tr>
<th>Age group</th>
<th>Database Surplus</th>
<th>Target Surplus</th>
<th>Database Sample</th>
<th>Target Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>114</td>
<td>47</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>18%</td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25-34</td>
<td>161</td>
<td>79</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>25%</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>35-44</td>
<td>144</td>
<td>71</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>23%</td>
<td>20%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>45-54</td>
<td>124</td>
<td>53</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>19%</td>
<td>28%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>55+</td>
<td>95</td>
<td>53</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>15%</td>
<td>23%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Whether has phone

<table>
<thead>
<tr>
<th>Whether has phone</th>
<th>Database Surplus</th>
<th>Target Surplus</th>
<th>Database Sample</th>
<th>Target Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>252</td>
<td>114</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>39%</td>
<td>13%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>386</td>
<td>189</td>
<td>35</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>61%</td>
<td>88%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Type of ailment

<table>
<thead>
<tr>
<th>Type of ailment</th>
<th>Database Surplus</th>
<th>Target Surplus</th>
<th>Database Sample</th>
<th>Target Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical problems</td>
<td>63</td>
<td>6</td>
<td>53</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical conditions</td>
<td>193</td>
<td>102</td>
<td>100</td>
<td>102</td>
</tr>
<tr>
<td></td>
<td>30%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute episodes</td>
<td>13</td>
<td>1</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>9%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic episodes</td>
<td>86</td>
<td>13</td>
<td>88</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>11%</td>
<td>11%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injury poisoning</td>
<td>111</td>
<td>37</td>
<td>110</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>18%</td>
<td>18%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other symptoms</td>
<td>114</td>
<td>57</td>
<td>114</td>
<td>57</td>
</tr>
<tr>
<td></td>
<td>25%</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infections</td>
<td>113</td>
<td>13</td>
<td>113</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>12%</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unclear</td>
<td>9</td>
<td>2</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diseases of Blood</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear and Mastoid</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnancy, Childbirth</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>1%</td>
<td>1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The quota specification, as we had hoped:

The quota specification was very demanding, particularly since some of the key categories were very few in number. The targets were not met precisely, but the fit was usually fairly good, and a good spread of interviews was achieved in most respects. There are, however, some points worth noting. We did not succeed in recruiting quite as many of the following groups as we had hoped:

- Mental health and substance abuse cases.
- People who had no listed phone (who were very hard to contact in spite of considerable effort).

"Double sandwich" movers – there were not many such cases on the spreadsheet."
Young people (16-24) were slightly down.

People who had been on IB/ISS or JSA for a long time.

We deliberately boosted the number of women recruited. Women were still only 40% of the sample, but even smaller proportion (38%) of the database.

Note that the above data comes from the database, and therefore describes the state of affairs at the end of the database period. Things had often moved on by the time of the interview – some were on different benefits, the size of agencies at the end of the database period. Things had often moved on by the time of the interview – some were on different benefits, or in work, more people had failed the PCA or appealed against its outcome, and so on.
We are carrying out a survey about people’s experiences in claiming benefits for the Department of Social Security. They sent you a letter a few weeks ago (show opt-out letter if not recalled, and letter of authority). Stress that it’s completely confidential, and won’t affect benefit entitlement in any way.

You should know from your lists whether they are eligible. Check willingness and availability, and complete the following:

<table>
<thead>
<tr>
<th>[ ] Never had</th>
<th>[ ] Got in past, not now</th>
<th>[ ] Get now</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Appointment made for interview to take place at:

<table>
<thead>
<tr>
<th>Where</th>
<th>Time</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>am/pm</td>
<td></td>
</tr>
<tr>
<td>[ ] At address below</td>
<td>[ ] At other venue (specify)</td>
<td>[ ] ID (from list)</td>
</tr>
</tbody>
</table>

Note: If in full details of where and when.

Could I just ask you a few background questions, please?

1. I’m going to read out a list of different benefits and tax credits, and I’d like you to tell me for each whether you are getting it now, whether you’ve had it in the past or never had it at all. Read out in turn, and tick one.

Get now
Got in past, not now
Never had

| Jobseeker’s allowance (JSA) | Income Support (IS) | Incapacity Benefit (IB) | Disability Living Allowance (DLA) | Sickness Benefit (SB) | Statutory Sick Pay (SSP) | Severe Disablement Allowance (SDA) | Working Families’ Tax Credit (WFTC) | Disabled Person’s Tax Credit (DPTC) |

If your answer was ‘Get now’, the interviewer should move on to the next box. If your answer was ‘Got in past, not now’, the interviewer should move on to the next box. If your answer was ‘Never had’, the interviewer should move on to the next box.

**Benefits Research: Recruitment Questionnaire**

---

**APPENDIX B**

**RECRUITMENT QUESTIONNAIRE**
1. Are you working or not at the moment?
   Working:
   - Working full-time for an employer
   - Working part-time for an employer
   - Working, self-employed

   Not working:
   - Not working but looking for work
   - Not working, in full-time education
   - Unable to work because of sickness or disability
   - Not working, not looking for work
   - Retired
   - Other (specify)

2. If working:
   What is your current job?

3. If not working:
   What was the last job you had?

4. If never worked:
   What kind of job were you looking for?

5. How many adults (aged 16+) are living in your household at present?

6. How old are you now?

7. What is your current job?

8. How many children (aged 0-15) are living in your household at present?

9. Married, widowed, divorced

10. Married or partnered

11. Other (specify)

12. Retired

13. Not working, not looking for work

14. Unable to work because of sickness or disability

15. Not working in full-time education

16. Not working but looking for work

17. Working

18. Working, self-employed

19. Working part-time for an employer

20. Working full-time for an employer

21. Are you working or not at the moment?
About how old were you when you finished your full-time education?

- Up to 16
- 17-20
- 21 or over
- Still in full-time education
- Other (specify)

How recruited:

- By telephone
- By personal call
- Other method
- Other (specify)

Area:

- Northern city
- South coast town
- Rural
- Mixed urban/rural
- London

When you finished your full-time education:

- Up to 16
- 17-20
- 21 or over
This appendix contains the text of the opt-out letter, and of a letter of authority shown to claimant participants on recruitment (both on DSS headed paper).

Text of opt-out letter

Dear

I am writing to ask for your help with an important research study. The Department of Social Security would like to find out more about people’s experiences of claiming different benefits and whether they understand the benefits available. We have therefore asked Alan Hedges and Wendy Sykes, two independent researchers, to talk to some people who are receiving benefits, or have done so recently.

Your name has been randomly selected from DSS records. It is entirely up to you whether you decide to take part, but I very much hope you will do so – the value of the research depends on people’s willingness to help. Alan and Wendy will ask a few questions and invite some people to take part in a one-to-one interview with Alan and Wendy. The full interview will last about an hour – just a simple and friendly conversation that can take place in your own home. The names of people who take part will not be passed to the DSS or anyone outside the research team.

If you are approached by Plus Four Market Research, they will ask a few questions and invite some people to take part in a one-to-one interview with Alan and Wendy. If you do decide to take part, you will receive £20 as a ‘thank you’ gift for helping with the study. This will not affect your benefit entitlement in any way.

The full interview will last about an hour – just a simple and friendly conversation that can take place in your own home. The names of people who take part will not be passed to the DSS or anyone outside the research team. Whatever your current circumstances, anything you tell the researchers will be treated in strict confidence. Their report will not identify you or anyone else.

If you are approached by Plus Four Market Research, they will ask a few questions and invite some people to take part in a one-to-one interview with Alan and Wendy. If you do decide to take part, you will receive £20 as a ‘thank you’ gift for helping with the study. This will not affect your benefit entitlement in any way.

I do hope you decide to help with this research, but if you don’t want to take part, please write to us now using the enclosed FREEPOST envelope. You don’t need to use a stamp, but please include your own name and full address.

If you would like to know more about the research, please call me, Jo Bacon, on 0207 962 8003, or the researcher, Alan Hedges, on 01525 372516. We would be pleased to answer any questions you may have.

Yours sincerely

Jo Bacon
Research Officer

Appendix C
Copies of Claimant Letters
Dear Sir or Madam

I recently wrote to you to ask for your help with an important research study. The Department of Social Security would like to find out more about people's experiences of claiming different benefits and whether they understand the benefits available.

We have therefore asked Alan Hedges and Wendy Sykes, two independent researchers, to carry out some one-to-one discussions with people who are claiming one or more benefits, or have done so recently.

Your name has been randomly selected from DSS records. Your participation is, of course, entirely voluntary. However, the value of this research depends on the co-operation of all those selected and I very much hope you will agree to take part. We are interested in your views and experiences, whatever your current circumstances.

You will receive an initial contact from Plus Four Market Research - an independent research company - giving you a brief introduction to the research. Some of those contacted will then be selected to take part in a one-to-one interview lasting about an hour. This is just a simple and friendly conversation that can take place in your own home. If you do decide to take part in the interview, you will receive £20 as a 'thank you' gift for your help with this study.

I do hope you decide to take part in the study. If you would like to know more about the research, please call me, Jo Bacon, on 0207 962 8003 or the researcher, Alan Hedges, on 01525 372516. We would be pleased to answer any questions you may have.

Yours faithfully

Jo Bacon
Research Officer

PS You may be interested in our current research that explores the reasons why some people choose to claim benefits and whether they understand the benefits available. We are also interested in your views and experiences of claiming different benefits, and whether you would like to find out more about people’s experiences of claiming different benefits. The Department of Social Security would like to find out more about your help with an important research study. The DSS would be pleased to answer any questions you may have.
This guide: This guide is a menu of issues from which we shall choose relevant topics for individual sessions. There will not be time to look at every question from every angle in every interview. It is a game-plan not a questionnaire - questions will not usually be asked in this form, and some information will emerge in conversation without direct questioning. The way we approach the task will also evolve across the sessions - the early interviews will show us the most profitable ground to concentrate on. The topics overlap, because there are many ways into a given issue – but this does not mean duplication in the interviews themselves.

A. Background
Use as warm-up, and amplify as necessary from recruitment QQ
1. Family, personal and demographic characteristics:
   a) Family composition
   b) Working status

B. Understanding and perceptions of benefit system
1. Awareness of relevant benefits
   a) What benefits are thought to be available to people with health-based incapacity?
   b) Awareness of JSA, IB, SDA, ISS?

2. Perceived role and basis of relevant benefits
   a) Perceived eligibility criteria and role for each of these?
   b) Circumstances when people:
      • should claim each?
      • should switch between them?

3. Signs of relevant:
   a) Gaps in awareness?
   b) Misunderstandings or misinformation?

4. Have they seen literature about disability/sickness/incapacity benefits?
   a) How useful was this?

5. Do they understand (and how do they perceive):
   a) The different types of IB:
      • Including credits only
   b) The different types of JSA
      • Including credits only
   c) The entitlement to stay on JSA for short periods of sickness?
   d) Income Support for Sickness (ISS)
   e) Different contribution rules?
   f) Different rates of benefit?

6. How far are they aware of in-work support?
   a) Disabled Person’s Tax Credit (successor to Disability Working Allowance)?
   b) Working Families’ Tax Credit (successor to Family Credit)?
   c) Back to Work Bonus?
   d) Extension of Housing Benefit?

C. Attitudes to the benefit system
1. In general
2. In relation to specific benefits for unemployment and for health-related incapacity (particularly JSA, IB, ISS):
   a) What do they feel about each of these benefits?
   b) What are the pros and cons of each?

3. How is the system seen to treat people who are sick or disabled?
4. Sense of being fairly or unfairly treated in relation to their own incapacity?
   a) Why and in what ways?

5. How do these attitudes affect switching behaviour?

D. Histories and personal characteristics
1. History of movements between work and benefits, and between different benefits.
2. Benefit history?
   a) What benefits have they claimed at different periods?
   b) How long on each?
   c) Why did they change when they did (see E)
   d) Which of these benefits have they claimed? (Refer also to recruitment QQ, but may need to develop answers)
      • Incapacity Benefit (or former Invalidity Benefit)?
      • Disability Living Allowance?
      • Disability Working Allowance?
      • Disabled Person’s Tax Credit?
      • Attendance Allowance (or former Mobility Allowance)?
      • Invalid Care Allowance?
      • Income Support (with and without disability premium)?
      • Sickness Benefit?

   e) Did they claim both IB and IS at the same time:
      • What prompted them to do this?
      • Do they understand why, how it works how the claims interact?
      • Do they understand IB Credits?
      • Which did they feel they were ‘really’ claiming?
      • How did they feel about dual claims?
      • What was the outcome, and how did it affect them?
3. Employment history:
   a) What kinds of work have they done?
   b) What did they feel about their work experiences?
   c) How did they get the work?
   d) Why did they stop?
   e) How suitable was it for them? Why or why not?
   f) Experience of therapeutic work:
      • Do they understand this?
      • What do they feel about it?
   g) Experience of voluntary work:
      • Attitudes to taking voluntary work

4. History of health conditions:
   a) How have these have changed?
   b) How do they interact with work/benefit history?
   c) How has their state of health affected their ability to work?
   d) How is this changing over time?
      • Fluctuations and trends

5. Entitlements and disqualifications:
   a) Do they have a contributions record which entitles them to IB?
      • Do they understand how this works, and what happens if not?
   b) Do they have savings which would disqualify or limit them for IS?
      • Do they understand how this works, and what happens if not?

E. Switching between benefits
1. When and why have they stopped claiming one benefit and started claiming another?
   Cover benefits in general, but focus on IB, JSA and IS
2. What has brought this about:
   a) Specific switching triggers?
   b) General influences that have affected it?
3. Are there any signs that IB is seen as:
   a) A soft option compared to JSA?
   b) A route to early retirement?
4. Are there any signs that claimants see financial advantages or disadvantages in being on particular benefits:
   a) How do they perceive it?

5. Explore permutations of IB and JSA claims:
   a) Why did these happen?
   b) Were they:
      • Appropriate responses to health changes?
      • Due to misunderstanding of the way benefits work?
      • Due to insecurity about:
         - Their incapacity?
         - The availability of work?
         - The availability of benefits, wanting to defend their benefit status?
      • An attempt to avoid or reduce pressure to find work?
      • Responses to an AWT/PCA or other test?
      • Instructed or advised to switch by BA/ES?
      • The result of other advice given (and by whom)?
      • Due to other causes?
   c) What did they feel about the switches?

6. How much of a problem is it to switch benefits?
   a) Why and how?
      • Delays or hiatus in payment (eg JSA to IS?
      • Filling in more forms?
      • Uncertainty, insecurity?
      • Other?

7. What happened as a result of switching?
   a) Did they gain or lose out?
      • Why and in what ways?
F. AWT/PCA, tests and sanctions

What was previously called the All Work Test (AWT) is now to be called the Personal Capacity Assessment (PCA). The former may be not as well recognised and used. Claimants may have had more than one experience of AWT/PCA. Focus on latest, and then work backwards, comparing earlier experiences.

1. Understanding, perceptions and experience of the AWT/PCA:
   a) What is their picture of the assessment process when someone claims IB/ISS on grounds of medical incapacity for work?
   b) How well do they understand the AWT/PCA?
      • What do they think happens?
      • Do they know the term AWT/PCA?
      • Do they understand the initial 7-day self-certification period?
   c) How many times have they been through the AWT/PCA?
   d) How far does the operation of AWT/PCA explain or affect movements between JSA and IB/IS/SDA?
   e) Are they exempt from the AWT/PCA?
      • Do they understand what this means?
      • Do they know if they are exempt – and how?
      • What do they feel about it?
   f) What actually happened in their AWT/PCA(s)
      • Were there any problems:
         - With the questionnaire?
         - With getting Med4 from their GP?
      • Did they have to have a medical examination?
         - From a BA/DSS doctor or their own GP?
         - What did they feel about this?
         - Were there any problems?
         - How did the examiner treat them?
         - What outcome? What happened as a result?
   g) How do they react to the AWT/PCA?
      • Did they understand what was to happen?
      • Did it seem clear or muddling?
      • Did they feel confident or insecure – and why?
      • Did it seem fair?
      • Did they agree with or accept the outcome?
         - If not did they appeal, see also K)
      • How did they react to the outcome?
         - Did they get any advice or guidance about this?

2. Experiences of benefit sanctions or benefits disallowed:
   a) Reactions to this?
   b) Effects on movements between benefits?

G. Medical advisors

1. Involvement and role of their own medical advisors (MAs) (GP, consultant etc):
2. What approach did their MAs take?
   a) Comments made or advice given by them?
   b) Are they felt to be supportive in relation to employment incapacity?
   c) Did MAs encourage them to get back to work or stay off work?
      • Why?
   d) What approach would they like their MAs to take?
      • Why?

3. Do their views seem to carry weight with BA/ES?

H. Attitudes to work

1. What kinds of work:
   a) Are they doing now (if any)
   b) Have they done?
   c) Would they like to do?
   d) Are suitable to their incapacity or disability?
2. Desire to work or not work:
   a) Reasons for this? How far are these related to health?
3. Is/was the disability that led to claiming IB:
   a) More or less permanent, medium term or short term?
   b) Continuous in effect, or cyclic/recurrent?
   c) Now ended, in remission, or still affecting them?
4. Ability to work:
   a) What affects or conditions this?
      • Availability of suitable jobs?
      • Employer attitudes?
      • State of health, disability?
      • Geographical location?
      • Transport or mobility problems?
      • Problems with literacy and numeracy?
      • Limited skills, training, qualifications?
      • Fear of losing IB status if appear able to do some work or to look for work?
      • Lack of self confidence,
      • Other barriers?
   b) How do these barriers arise from or interact with health problems?
   c) How far do the barriers appear to be real or perceived?
5. How do their own assessments of ability to work match with official judgements?
6. Confidence in prospects of:
   a) Finding a job suitable to their disability?
   b) Being able to carry out or hold down a job in the light of their disability?
7. Economic implications of work, whether would be better or worse off in work?
8. Hopes, fears and aspirations for future employment?
9. How much of a handicap do they feel the disability which led to claiming IB is or was:
   a) In the job market, in finding a job?
   b) In in-work performance?

I. Experiences while looking for work
1. Does suitable work seem to be available for them?
   a) If not, what are the barriers?
   b) How far does/did this relate to their disability?
2. Jobsearch activity while on JSA
3. Perceptions and experiences of interactions with ES/BA
   a) Help offered by ES:
      • How good, effective, useful?
      • Did they see a specialist disability advisor?
   b) Experience of a New Deal
      • What happened?
      • How useful, what effect/result?
      • If not experienced, do they think there is a New Deal available to them:
         - And would they like that kind of help:
         - Why or why not?
      • What do they understand about New Deals?
4. Have they done any therapeutic work while on IB?
   a) What experiences?
   b) How did they feel about it?

J. Awareness and understanding
This is a check-list of items, many covered elsewhere
1. How far do customers know and understand enough about:
   a) The relevant benefits (as above)?
   b) The different types of each benefit?
   c) The circumstances in which they ought to claim or move between them?
   d) Eligibility rules, including contributions?
   e) Rates of benefit (including IS premiums)?
   f) Rules about part-time, therapeutic and voluntary work
   g) The way incapacity is assessed?
   h) The dual claim situation?
   i) Their rights, including appeals?
   j) Who they deal with about what?
2. Are there any apparent misunderstandings?
3. Is there anything they feel puzzled or unsure about, or want explained?

K. Appeals
1. Have they appealed against a decision?
   a) In relation to IB?
   • About the AWT/PCA or medical assessment? Or other judgments about fitness for work?
   • About other factors?
   b) In relation to JSA?
   c) In relation to IS?
   d) In relation to other benefits?
2. What did they query, and why?
3. When did they appeal?
4. Did the client attend the tribunal?
   a) Did they attend alone?
   b) Did they have a representative to attend for them?
   c) What did they think of it?
5. What did they do while waiting for the result?
   a) Jobsearch or other activity? Why?
   b) What did they claim in the interim?
      • Why?
         - Already claiming it?
         - More money?
         - Avoid having to register for work?
         - Told to claim it?
         - Other reason?
      • Were they given advice by BA/ES?
      • Which agency were they dealing with?
6. What was the outcome?
   a) What was the judgement?
   b) Did they think it was fair?
   c) What happened as a result?
   d) Implications for benefit switches?

7. What did they feel about it? How did they react?
   Concentrate particularly on appeals about IB, PCA, All Work Test, judgements about fitness of work.

8. Do they understand their rights of appeal?

9. Are there any factors which inhibit people from appealing where they disagree with an assessment?

L. Help or advice
   1. How far have people sought advice or help with any aspect of the claims process?
   2. From what sources?
      a) BA/ES? Advice agencies? Disability interest/support groups? Friends and relations?
   3. What advice was given?
   4. How has advice affected:
      a) Types of benefit claimed?
      b) Claiming of benefits for sickness/disability?
      c) Switches between benefits?

M. Improving the system
   1. Can they suggest any ways of improving the benefit system or claiming process in order to make it:
      a) More satisfactory from their point of view?
      b) More relevant to their situation and needs in terms of health and work?
      c) More comprehensible in terms of which benefits to claim in what circumstances?
      d) Easier to dealing with changes in disability, condition, ability to work?
      e) More flexible in terms of activities allowed while claiming?
         • Eg more voluntary work?
      f) More help with training and education?

N. Satisfaction
   1. How satisfied are they with the way they have been dealt with by the employment and benefits systems?
      a) Why or why not?
      b) What problems encountered?
         • With claims process?
         • With assessment/decisions about medical incapacity?
      c) What would have needed to happen differently?

O. Sub-group differences
   1. Are there important differences between different claimant types, or between demographic groups or areas?
      a) Age groups, particularly those aged 50+?
      b) Sexes?
      c) Different types of disability?
      d) Different socio-economic, educational or skills levels?
      e) Ethnic groups?
      f) Areas?
IB/JSA flows research: \textbf{Staff} topic guide JN 772

\textbf{This guide:} This guide is a menu of issues from which we shall choose relevant topics for individual sessions. There will not be time to look at every question from every angle in every interview.

It is a game-plan not a questionnaire - questions will not usually be asked in this form, and some information will emerge in conversation without direct questioning. The way we approach the task will also evolve across the sessions - the early discussions will show us the most profitable ground to concentrate on.

The topics overlap, because there are many ways into a given issue – but this does not mean duplication in the interviews themselves.

\textbf{P. Background}
1. Brief account of staff background experience, roles, responsibilities

\textbf{Q. Experience of switching}
1. What experiences do staff have of people switching between the relevant benefits?
2. Do they feel this movement is excessive, or just part of the normal flux of life?
3. Is it seen as a problem?
   a) And if so who takes ownership of it?
4. Why do they think people move between the benefits?
   a) What causes, triggers and/or aggravates movement?
5. Do the causes differ between IJ and JI switches?
   a) How and why?

\textit{We probably need to have separate conversations about JI and IJ switches, since these may be different in nature or dynamics. After some general discussion of switching, aim to focus on one direction at a time – 'Why do people move from JSA to IB?', then why from IB to JSA. This may help clarify a complicated subject. But don’t let a uni-directional focus inhibit general consideration of serial switching.}

6. How far is switching seen as:
   a) Appropriate behaviour?
   b) Resulting from misconceptions or mistakes?
   c) An attempt to:
   \hspace{1cm} \cdot Make their benefit status feel more secure?
   \hspace{1cm} \cdot Maximise benefit income?
   \hspace{1cm} \cdot Avoid pressures to find work?
   d) A form of abuse or fraud?

7. What triggers switches?
   a) Changes in health?
   b) Changes in other circumstances?
   \hspace{1cm} \cdot What kinds of change?
   c) Responses to jobssearch pressures?
   d) Perceptions that benefit rates are better on some benefits? And how?
   e) Other factors? What?

8. Is there any sign that some older JSA claimants see IB as a route to early retirement?
   a) What could be done about this?

9. Are there some people who persist in claiming JSA even though ill health or disability makes them hard to place in work?

\textbf{R. Movement cases}
1. Do they recognise cases where people move back and forth between the relevant benefits?
2. Is it usually a single move, or do some shuttle back and forth:
   a) If the latter, is this identified?
   \hspace{1cm} \cdot And what then happens?
3. Where people make repeat claims for IB do they mention the same incapacity/illness/disability each time?
   a) If not how is this handled?
4. In what kinds of case does it happen most?
   a) Particular age groups, disability types, occupational or socio-economic groups, ethnic groups, personality types?
5. How do ES/BA staff deal with clients moving between these benefits?
   a) What are the processes and procedures involved.
6. How do claimants announce they’re leaving JSA for IB?
   a) And to whom?
   b) What then happens?
   \hspace{1cm} \cdot Does anyone:
   \hspace{1cm} \hspace{1cm} \cdot Find out why?
   \hspace{1cm} \hspace{1cm} \hspace{1cm} \hspace{1cm} \cdot Give them advice?
7. What are the attitudes of staff at the BA and in the ES towards the movers – eg:
   a) Helping them with their jobssearch?
   b) Dealing with their claims for IB?
   c) Handling interim claims while an appeal is pending.
8. Are claimants driving the switches or driven by them?
   a) Is it something they feel the system obliges them to do, or an attempt on their part to control or manipulate the process?
U. Dual claims
1. How are they advised about dual claims of IB/IS?
   a) Is it always made clear:
      • That separate claims should be made for IB and IS?
      • That this should be done immediately?
   b) How is this explained to customers?
      • And do they seem to understand it?
2. What do claimants actually do, and why?
3. What is the implication of doing or not doing this?
   a) Is there any difference between the actual and perceived implication?
4. What is the outcome?
5. Are there any problems arising from dual claims?
   a) For claimants?
   b) For staff?

V. Assessment of incapacity
1. How do decision makers assess the level of claimants’ level of incapacity?
2. Are there problems in this?
   a) If so, what are they?
3. How do they:
   a) Decide whether to call for a medical examination?
   b) Assess input from the claimant’s GP or consultant?
4. Are there thought to be people with genuine incapacity problems who are not
   recognised as such by the system?
   a) Why?
   b) What kinds of case? Any particular types of person or incapacity?
   c) What can be done about that?
5. How do staff see the operation of the All Work Test (AWT)/Personal Capacity
   Assessment (PCA)?
   a) How does it work, and how is it operated?
   b) Does it work well, or are there problems?
   c) How could it be made to work better?
   d) Has the transition from AWT to PCA made any difference:
      • Or will it do so in future when the Capability Report comes in?
6. Do claimants understand how incapacity is assessed?
   a) How is this explained to them?
   b) Do they understand:
      - The sequence of events?
      - The questionnaire?
      - The role of their GP/consultant?
      - The fact there will be a medical test?
      - The way the AWT/PCA works?
      - Rights of appeal and the appeal process?

7. How do claimants:
   a) Feel about incapacity assessment?
   b) React to the result?
      - Positive or negative?
      - Are they given advice or guidance about it?

8. What happens when an IB/ISS applicant is assessed as fit to work?
   a) How are they notified?
   b) What happens next?
      - Are they given advice and guidance about the outcome?
   c) How do they react?

9. Some people don’t turn up for the AWT/PCA:
   a) Is this a big problem?
   b) Why do staff think it happens?
   c) How are they invited and notified?
   d) Are there problems with communications, delays, venues etc?

10. What is the role of the claimant’s medical advisor (MA)?
    a) What input do they make?
    b) What do their attitudes seem to be?
    c) Do MAs seem to understand the system?
    d) What weight is attached to their views in assessment?

W. The appeals process
1. How well does the appeals process work?
   a) Does it distance clients from the labour market?
      - How and why?
   b) What happens during an appeal?
      - What benefits do people claim?
      - What influences whether they claim JSA or continue IS in the interim?
      - How would staff advise them about this?
   c) How do BA and ES staff interact with clients during an appeal?
      - Who is dealing with the client at this time?
      - What is supposed to happen in terms of claiming?

2. What decides claimants to appeal or not appeal?
   a) What happens if they don’t agree with the decision but don’t appeal?

3. Do many people win their appeals?
   a) Why or why not? What does this imply?

4. What happens when the appeal is determined?
   a) How do customers react and behave?
      - If they win their appeal?
      - If they lose their appeal?

5. Appeals can take a long time to determine:
   a) How important is this?
   b) Why does it happen, and can anything be done to improve it?
   c) How does it affect claimants?
   d) How does it affect the process?

X. Liaison between offices
1. Explore information flows and liaison between ES /BA
2. How do BA and ES staff liaise about movement cases?
3. Who does what between BA and ES in relation to:
   a) IB/ISS/SDA claims?
   b) JSA claims?
   c) Switching behaviour?
4. Are there gaps or discontinuities between BA and ES staff in terms of (eg):
   a) Identification of switchers?
   b) Dealing with switches?
   c) Information transfer?
   d) Consultation about cases?
5. Are there any issues or problems relating to liaison between BA and Medical Services?
Y. Reducing switches
1. Do staff think it would be a good idea to try to reduce switching?
   a) How important is it to tackle it?
   b) How feasible would this be?
   c) Who needs to do what to bring this about?
      • Improving customers’ understanding of what to do?
      • Changing procedures or documentation?
      • Changing benefit structures or regulations?
      • Other actions?
2. What suggestions do staff have for improving service to claimants who need to switch?
   a) Again, who needs to do what to bring this about?
3. What could be done about the above:
   a) By ES? By BA? By claimants themselves? By others?

Z. Disability and incapacity?
1. How much of a disadvantage does disability present to the individual in the labour market?
   a) Do they have problems in:
      • Finding work at all?
      • Finding work they can do?
      • Finding attractive jobs?
      • Keeping jobs?
   b) Do their jobsearch problems seem to be:
      • Objective difficulties caused by their particular disability?
      • Related to confidence, insecurity or motivation?
      • Arising from employer attitudes or prejudices about disability?
2. What different types of disability are recognised?
   a) How are they categorised?
   b) How do these differ in terms of:
      • Employment needs and prospects?
      • Claiming behaviour?
      • Switching behaviour?
   c) Are there differences between:
      • Physical, mental or substance abuse cases?
      • Long and short-term incapacity?
      • Intermittent versus stable or permanent disability?
   d) What types of disability pose particular problems:
      • Hard to assess incapacity?
      • Hard to place in work?
      • Hard to deal with?
3. How (and well) are disability cases handled by the system?
   a) What weaknesses or problems?
4. How are disability cases handled in the Jobcentre?
   a) When and why would they see a DEA or another advisor?
   b) What are the different roles of different types of staff?
      • Eg BA/ES, staff with different functions etc
5. Who sees the Disability Employment Advisor (DEA) etc?
   a) In what circumstances?
   b) What is the DEA’s role:
      • In general;
      • In relation to switching?
6. Are there disability specialists at BA?

AA. Sanctions and directions
1. What powers of sanction or direction do staff have where a person in receipt of IB or classified as disabled for JSA purposes is suspected of trying to abuse/manipulate the system by switching or claiming incapacity inappropriately?
   a) If none, should they be introduced?
2. How and when are such powers used?
3. How well do they work?
4. Is there a need for:
   a) Having more or different powers?
   b) Using them differently?

BB. Different types of staff
1. What differences are there in views, experiences, attitudes, approaches or procedures:
   a) Between offices and areas?
   b) Between BA and ES?
   c) Between different types of staff?
      • DEAs and other advisors?
      • Front-line and back office staff?
      • Advisors and decision makers?

CC. Scenarios
   Explore scenarios if available. Use to unpack difficult situations and produce specific responses.
### OTHER RESEARCH REPORTS AVAILABLE:

<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>ISBN</th>
<th>Price</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Thirty Families: Their living standards in unemployment</td>
<td>0117616834</td>
<td>£6.65</td>
</tr>
<tr>
<td>2.</td>
<td>Disability, Household Income &amp; Expenditure</td>
<td>0117617555</td>
<td>£5.65</td>
</tr>
<tr>
<td>3.</td>
<td>Housing Benefit Reviews</td>
<td>0117618217</td>
<td>£16.50</td>
</tr>
<tr>
<td>4.</td>
<td>Social Security &amp; Community Care: The case of the Invalid Care Allowance</td>
<td>0117618209</td>
<td>£9.70</td>
</tr>
<tr>
<td>5.</td>
<td>The Attendance Allowance Medical Examination: Monitoring consumer views</td>
<td>0117618195</td>
<td>£5.50</td>
</tr>
<tr>
<td>6.</td>
<td>Lone Parent Families in the UK</td>
<td>0117618683</td>
<td>£15.00</td>
</tr>
<tr>
<td>7.</td>
<td>Incomes In and Out of Work</td>
<td>0117619108</td>
<td>£17.20</td>
</tr>
<tr>
<td>8.</td>
<td>Working the Social Fund</td>
<td>0117619523</td>
<td>£9.00</td>
</tr>
<tr>
<td>9.</td>
<td>Evaluating the Social Fund</td>
<td>0117619531</td>
<td>£22.00</td>
</tr>
<tr>
<td>11.</td>
<td>Customer Perceptions of Resettlement Units</td>
<td>0117619766</td>
<td>£13.75</td>
</tr>
<tr>
<td>12.</td>
<td>Survey of Admissions to London Resettlement Units</td>
<td>0117619779</td>
<td>£8.00</td>
</tr>
<tr>
<td>13.</td>
<td>Researching the Disability Working Allowance Self Assessment Form</td>
<td>0117618349</td>
<td>£7.25</td>
</tr>
<tr>
<td>15.</td>
<td>Preparing for Council Tax Benefit</td>
<td>0117620610</td>
<td>£5.65</td>
</tr>
<tr>
<td>17.</td>
<td>Employers’ Choice of Pension Schemes: Report of a qualitative study</td>
<td>0117620734</td>
<td>£5.00</td>
</tr>
<tr>
<td>18.</td>
<td>GPs and IVB: A qualitative study of the role of GPs in the award of Invalidity Benefit</td>
<td>0117620777</td>
<td>£12.00</td>
</tr>
<tr>
<td>19.</td>
<td>Invalidity Benefit: A survey of recipients</td>
<td>0117620874</td>
<td>£10.75</td>
</tr>
<tr>
<td>No.</td>
<td>Title</td>
<td>ISBN</td>
<td>Price</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------------------------------</td>
<td>------------</td>
<td>--------</td>
</tr>
<tr>
<td>20</td>
<td>Invalidity Benefit: A longitudinal survey of new recipients</td>
<td>0 11 762088 2</td>
<td>£19.95</td>
</tr>
<tr>
<td>21</td>
<td>Support for Children: A comparison of arrangements in fifteen countries</td>
<td>0 11 762089 0</td>
<td>£22.95</td>
</tr>
<tr>
<td>22</td>
<td>Pension Choices: A survey on personal pensions in comparison with other pension options</td>
<td>0 11 762091 2</td>
<td>£18.95</td>
</tr>
<tr>
<td>23</td>
<td>Crossing National Frontiers</td>
<td>0 11 762131 5</td>
<td>£17.75</td>
</tr>
<tr>
<td>24</td>
<td>Statutory Sick Pay</td>
<td>0 11 762147 1</td>
<td>£23.75</td>
</tr>
<tr>
<td>25</td>
<td>Lone Parents and Work</td>
<td>0 11 762147 X</td>
<td>£12.95</td>
</tr>
<tr>
<td>26</td>
<td>The Effects of Benefit on Housing Decisions</td>
<td>0 11 762157 9</td>
<td>£18.50</td>
</tr>
<tr>
<td>27</td>
<td>Making a Claim for Disability Benefits</td>
<td>0 11 762162 5</td>
<td>£12.95</td>
</tr>
<tr>
<td>28</td>
<td>Contributions Agency Customer Satisfaction Survey 1993</td>
<td>0 11 762220 6</td>
<td>£20.00</td>
</tr>
<tr>
<td>29</td>
<td>Child Support Agency National Client Satisfaction Survey 1993</td>
<td>0 11 762224 9</td>
<td>£33.00</td>
</tr>
<tr>
<td>30</td>
<td>Lone Mothers</td>
<td>0 11 762228 1</td>
<td>£16.75</td>
</tr>
<tr>
<td>31</td>
<td>Educating Employers</td>
<td>0 11 762249 4</td>
<td>£8.50</td>
</tr>
<tr>
<td>32</td>
<td>Employers and Family Credit</td>
<td>0 11 762272 9</td>
<td>£13.50</td>
</tr>
<tr>
<td>33</td>
<td>Direct Payments from Income Support</td>
<td>0 11 762290 7</td>
<td>£16.50</td>
</tr>
<tr>
<td>34</td>
<td>Incomes and Living Standards of Older People</td>
<td>0 11 762299 0</td>
<td>£24.95</td>
</tr>
<tr>
<td>35</td>
<td>Choosing Advice on Benefits</td>
<td>0 11 762316 4</td>
<td>£13.95</td>
</tr>
<tr>
<td>36</td>
<td>First-time Customers</td>
<td>0 11 762317 2</td>
<td>£25.00</td>
</tr>
<tr>
<td>37</td>
<td>Contributions Agency National Client Satisfaction Survey 1994</td>
<td>0 11 762339 3</td>
<td>£21.00</td>
</tr>
<tr>
<td>38</td>
<td>Managing Money in Later Life</td>
<td>0 11 762340 7</td>
<td>£22.00</td>
</tr>
<tr>
<td>39</td>
<td>Child Support Agency National Client Satisfaction Survey 1994</td>
<td>0 11 762341 5</td>
<td>£35.00</td>
</tr>
<tr>
<td>40</td>
<td>Changes in Lone Parenthood</td>
<td>0 11 7632349 0</td>
<td>£20.00</td>
</tr>
<tr>
<td>41</td>
<td>Evaluation of Disability Living Allowance and Attendance Allowance</td>
<td>0 11 762351 2</td>
<td>£40.00</td>
</tr>
<tr>
<td>42</td>
<td>War Pensions Agency Customer Satisfaction Survey 1994</td>
<td>0 11 762358 X</td>
<td>£18.00</td>
</tr>
<tr>
<td>43</td>
<td>Paying for Rented Housing</td>
<td>0 11 762370 9</td>
<td>£19.00</td>
</tr>
<tr>
<td></td>
<td>Title</td>
<td>Code</td>
<td>Price</td>
</tr>
<tr>
<td>---</td>
<td>----------------------------------------------------------------------</td>
<td>------------</td>
<td>--------</td>
</tr>
<tr>
<td>44.</td>
<td>Resettlement Agency Customer Satisfaction Survey 1994</td>
<td>011 762371 7</td>
<td>£16.00</td>
</tr>
<tr>
<td>45.</td>
<td>Changing Lives and the Role of Income Support</td>
<td>011 762405 5</td>
<td>£20.00</td>
</tr>
<tr>
<td>46.</td>
<td>Social Assistance in OECD Countries: Synthesis Report</td>
<td>011 762407 1</td>
<td>£22.00</td>
</tr>
<tr>
<td>47.</td>
<td>Social Assistance in OECD Countries: Country Report</td>
<td>011 762408 X</td>
<td>£47.00</td>
</tr>
<tr>
<td>48.</td>
<td>Leaving Family Credit</td>
<td>011 762411 X</td>
<td>£18.00</td>
</tr>
<tr>
<td>49.</td>
<td>Women and Pensions</td>
<td>011 762422 5</td>
<td>£35.00</td>
</tr>
<tr>
<td>50.</td>
<td>Pensions and Divorce</td>
<td>011 762423 5</td>
<td>£25.00</td>
</tr>
<tr>
<td>51.</td>
<td>Child Support Agency Client Satisfaction Survey 1995</td>
<td>011 762424 1</td>
<td>£22.00</td>
</tr>
<tr>
<td>52.</td>
<td>Take Up of Second Adult Rebate</td>
<td>011 762390 3</td>
<td>£17.00</td>
</tr>
<tr>
<td>53.</td>
<td>Moving off Income Support</td>
<td>011 762394 6</td>
<td>£26.00</td>
</tr>
<tr>
<td>54.</td>
<td>Disability, Benefits and Employment</td>
<td>011 762398 9</td>
<td>£30.00</td>
</tr>
<tr>
<td>55.</td>
<td>Housing Benefit and Service Charges</td>
<td>011 762399 7</td>
<td>£25.00</td>
</tr>
<tr>
<td>56.</td>
<td>Confidentiality: The public view</td>
<td>011 762434 9</td>
<td>£25.00</td>
</tr>
<tr>
<td>57.</td>
<td>Helping Disabled Workers</td>
<td>011 762440 3</td>
<td>£25.00</td>
</tr>
<tr>
<td>58.</td>
<td>Employers' Pension Provision 1994</td>
<td>011 762443 8</td>
<td>£30.00</td>
</tr>
<tr>
<td>59.</td>
<td>Delivering Social Security: A cross-national study</td>
<td>011 762447 0</td>
<td>£35.00</td>
</tr>
<tr>
<td>60.</td>
<td>A Comparative Study of Housing Allowances</td>
<td>011 762448 9</td>
<td>£26.00</td>
</tr>
<tr>
<td>61.</td>
<td>Lone Parents, Work and Benefits</td>
<td>011 762450 0</td>
<td>£25.00</td>
</tr>
<tr>
<td>62.</td>
<td>Unemployment and Jobseeking</td>
<td>011 762452 7</td>
<td>£30.00</td>
</tr>
<tr>
<td>63.</td>
<td>Exploring Customer Satisfaction</td>
<td>011 762468 3</td>
<td>£20.00</td>
</tr>
<tr>
<td>64.</td>
<td>Social Security Fraud: The role of penalties</td>
<td>011 762471 3</td>
<td>£30.00</td>
</tr>
<tr>
<td>65.</td>
<td>Customer Contact with the Benefits Agency</td>
<td>011 762533 7</td>
<td>£30.00</td>
</tr>
<tr>
<td>66.</td>
<td>Pension Scheme Inquiries and Disputes</td>
<td>011 762534 5</td>
<td>£30.00</td>
</tr>
<tr>
<td>67.</td>
<td>Maternity Rights and Benefits in Britain</td>
<td>011 762536 1</td>
<td>£35.00</td>
</tr>
<tr>
<td>68.</td>
<td>Claimants’ Perceptions of the Claim Process</td>
<td>011 762541 8</td>
<td>£23.00</td>
</tr>
<tr>
<td>69.</td>
<td>Delivering Benefits to Unemployed People</td>
<td>011 762553 1</td>
<td>£27.00</td>
</tr>
<tr>
<td>No.</td>
<td>Title</td>
<td>ISBN</td>
<td>Price (£)</td>
</tr>
<tr>
<td>-----</td>
<td>----------------------------------------------------------------------</td>
<td>------------</td>
<td>-----------</td>
</tr>
<tr>
<td>70</td>
<td>Delivering Benefits to Unemployed 16–17 year olds</td>
<td>0 11 762557 4</td>
<td>£20.00</td>
</tr>
<tr>
<td>71</td>
<td>Stepping–Stones to Employment</td>
<td>0 11 762568 X</td>
<td>£27.00</td>
</tr>
<tr>
<td>72</td>
<td>Dynamics of Retirement</td>
<td>0 11 762571 X</td>
<td>£36.00</td>
</tr>
<tr>
<td>73</td>
<td>Unemployment and Jobseeking before Jobseeker’s Allowance</td>
<td>0 11 762576 0</td>
<td>£34.00</td>
</tr>
<tr>
<td>74</td>
<td>Customer views on Service Delivery in the Child Support Agency</td>
<td>0 11 762583 3</td>
<td>£27.00</td>
</tr>
<tr>
<td>75</td>
<td>Experiences of Occupational Pension Scheme Wind–Up</td>
<td>0 11 762584 1</td>
<td>£27.00</td>
</tr>
<tr>
<td>76</td>
<td>Recruiting Long–Term Unemployed People</td>
<td>0 11 762585 X</td>
<td>£27.00</td>
</tr>
<tr>
<td>77</td>
<td>What Happens to Lone Parents</td>
<td>0 11 762598 3</td>
<td>£31.00</td>
</tr>
<tr>
<td>78</td>
<td>Lone Parents Lives</td>
<td>0 11 762598 1</td>
<td>£34.00</td>
</tr>
<tr>
<td>79</td>
<td>Moving into Work: Bridging Housing Costs</td>
<td>0 11 762599 X</td>
<td>£33.00</td>
</tr>
<tr>
<td>80</td>
<td>Lone Parents on the Margins of Work</td>
<td>1 84123 000 6</td>
<td>£26.00</td>
</tr>
<tr>
<td>81</td>
<td>The Role of Pension Scheme Trustees</td>
<td>1 84123 001 4</td>
<td>£28.00</td>
</tr>
<tr>
<td>82</td>
<td>Pension Scheme Investment Policies</td>
<td>1 84123 002 2</td>
<td>£28.00</td>
</tr>
<tr>
<td>83</td>
<td>Pensions and Retirement Planning</td>
<td>1 84123 003 0</td>
<td>£28.00</td>
</tr>
<tr>
<td>84</td>
<td>Self–Employed People and National Insurance Contributions</td>
<td>1 84123 004 9</td>
<td>£28.00</td>
</tr>
<tr>
<td>85</td>
<td>Getting the Message Across</td>
<td>1 84123 052 9</td>
<td>£26.00</td>
</tr>
<tr>
<td>86</td>
<td>Leaving Incapacity Benefit</td>
<td>1 84123 087 1</td>
<td>£34.00</td>
</tr>
<tr>
<td>87</td>
<td>Unemployment and Jobseeking: Two Years On</td>
<td>1 84123 088 X</td>
<td>£38.00</td>
</tr>
<tr>
<td>88</td>
<td>Attitudes to the Welfare State and the Response to Reform</td>
<td>1 84123 098 7</td>
<td>£36.00</td>
</tr>
<tr>
<td>89</td>
<td>New Deal for Lone Parents: Evaluation of Innovative Schemes</td>
<td>1 84123 101 0</td>
<td>£26.00</td>
</tr>
<tr>
<td>90</td>
<td>Modernising service delivery: The Lone Parent Prototype</td>
<td>1 84123 103 7</td>
<td>£26.00</td>
</tr>
<tr>
<td>91</td>
<td>Housing Benefit exceptional hardship payments</td>
<td>1 84123 104 5</td>
<td>£26.00</td>
</tr>
<tr>
<td>92</td>
<td>New Deal for Lone Parents: Learning from the Prototype Areas</td>
<td>1 84123 107 X</td>
<td>£29.00</td>
</tr>
<tr>
<td>93</td>
<td>Housing Benefit and Supported Accommodation</td>
<td>1 84123 118 5</td>
<td>£31.50</td>
</tr>
</tbody>
</table>
94. Disability in Great Britain 1 84123 119 3 £35.00
95. Low paid work in Britain 1 84123 120 7 £37.00
96. Keeping in touch with the Labour Market 1 84123 126 6 £28.50
97. Housing Benefit and Council Tax Benefit delivery: Claimant experiences 1 84123 127 4 £24.00
98. Employers’ Pension Provision 1996 1 84123 138 X £31.50
99. Unemployment and jobseeking after the introduction of Jobseeker’s Allowance 1 84123 146 0 £33.00
100. Overcoming barriers: Older people and Income Support 1 84123 148 7 £29.00
101. Attitudes and aspirations of older people: A review of the literature 1 84123 144 4 £34.00
102. Attitudes and aspirations of older people: A qualitative study 1 84123 158 4 £29.00
103. Relying on the state, relying on each other 1 84123 163 0 £27.00
104. Modernising Service Delivery: The Integrated Services Prototype 1 84123 162 2 £27.00
105. Helping pensioners: Evaluation of the Income Support Pilots 1 84123 164 9 £30.00
106. New Deal for disabled people: Early implementation 1 84123 165 7 £39.50
107. Parents and employment: An analysis of low income families in the British Household Panel Survey 1 84123 167 3 £28.50
108. Evaluation of the New Deal for Lone Parents: Early lessons from the Phase One Prototype Synthesis Report 1 84123 187 8 £27.50
109. Evaluation of the New Deal for Lone Parents: Early lessons from the Phase One Prototype Findings of Surveys 1 84123 3190 8 £42.50
110. Evaluation of the New Deal for Lone Parents: Early lessons from the Phase One Prototype Cost-benefit and econometric analyses 1 84123 188 6 £29.50
111. Understanding the Impact of Jobseeker’s Allowance 1 84123 192 4 £37.50
112. The First Effects of Earnings Top-up 1 84123 193 2 £39.50
<table>
<thead>
<tr>
<th>113.</th>
<th>Piloting change: Interim Qualitative Findings from the Earnings Top-up Evaluation</th>
<th>1 84123 194 0</th>
<th>£28.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>114.</td>
<td>Building Up Pension Rights</td>
<td>1 84123 195 9</td>
<td>£33.50</td>
</tr>
<tr>
<td>115.</td>
<td>Prospects of part-time work: The impact of the Back to Work Bonus</td>
<td>1 84123 196 7</td>
<td>£29.00</td>
</tr>
<tr>
<td>116.</td>
<td>Evaluating Jobseeker’s Allowance</td>
<td>1 84123 197 5</td>
<td>£16.00</td>
</tr>
<tr>
<td>117.</td>
<td>Pensions and divorce: The 1998 Survey</td>
<td>1 84123 198 3</td>
<td>£36.00</td>
</tr>
<tr>
<td>118.</td>
<td>Pensions and divorce: Exploring financial settlements</td>
<td>1 84123 199 1</td>
<td>£24.00</td>
</tr>
<tr>
<td>119.</td>
<td>Local Authorities and Benefit Overpayments</td>
<td>1 84123 200 9</td>
<td>£26.50</td>
</tr>
<tr>
<td>120.</td>
<td>Lifetime Experiences of Self-Employment</td>
<td>1 84123 218 1</td>
<td>£31.50</td>
</tr>
<tr>
<td>121.</td>
<td>Evaluation of the Pension Power Power for you Helpline</td>
<td>1 84123 221 1</td>
<td>£28.50</td>
</tr>
<tr>
<td>122.</td>
<td>Lone Parents and Personal Advisers: Roles and Relationships</td>
<td>1 84123 242 4</td>
<td>£29.00</td>
</tr>
<tr>
<td>123.</td>
<td>Employers Pension Provision</td>
<td>1 84123 269 6</td>
<td>£35.00</td>
</tr>
<tr>
<td>124.</td>
<td>The Changing Role of the Occupational Pension Scheme Trustee</td>
<td>1 84123 267 X</td>
<td>£25.00</td>
</tr>
<tr>
<td>125.</td>
<td>Saving and Borrowing</td>
<td>1 84123 277 7</td>
<td>£28.50</td>
</tr>
<tr>
<td>126.</td>
<td>First Effects of ONE</td>
<td>1 84123 281 5</td>
<td>£38.50</td>
</tr>
<tr>
<td>127.</td>
<td>Why not ONE?</td>
<td>1 84123 282 3</td>
<td>£25.00</td>
</tr>
<tr>
<td>128.</td>
<td>The British Lone Parent Cohort 1991 to 1998</td>
<td>1 84123 283 1</td>
<td>£34.00</td>
</tr>
<tr>
<td>129.</td>
<td>Housing Benefits and the Appeals Service</td>
<td>1 84123 294 7</td>
<td>£26.00</td>
</tr>
<tr>
<td>130.</td>
<td>Pensions 2000 (Attitudes to retirement planning)</td>
<td>1 84123 295 5</td>
<td>£33.00</td>
</tr>
<tr>
<td>131.</td>
<td>Earnings Top-up Evaluation: Effects on Unemployed People</td>
<td>1 84123 289 0</td>
<td>£38.00</td>
</tr>
<tr>
<td>132.</td>
<td>Earnings Top-up Evaluation: Employers’ Reactions</td>
<td>1 84123 290 4</td>
<td>£29.50</td>
</tr>
<tr>
<td>133.</td>
<td>Earnings Top-up Evaluation: Qualitative Evidence</td>
<td>1 84123 291 2</td>
<td>£30.00</td>
</tr>
<tr>
<td>134.</td>
<td>Earnings Top-up Evaluation: Effects on Low Paid Workers</td>
<td>1 84123 292 0</td>
<td>£37.00</td>
</tr>
<tr>
<td>135.</td>
<td>Earnings Top-up Evaluation: The Synthesis Report</td>
<td>1 84123 293 9</td>
<td>£27.50</td>
</tr>
<tr>
<td>136.</td>
<td>Modernising Service Delivery The Better Government for Older People Prototypes</td>
<td>1 84123 300 5</td>
<td>£28.00</td>
</tr>
</tbody>
</table>
137. The Verification Framework:  
   Early Experiences of Implementation  
   1 84123 303 X  £27.00

138. Low-income families in Britain  
   Work, welfare and social security  
   in 1999  
   1 84123 312 9  £53.00

139. Recruiting benefit claimants  
   A survey of employers in  
   ONE pilot areas  
   1 84123 349 8  £26.50

140. Moving towards work:  
   The short term impact of ONE  
   1 84123 352 8  £27.50

141. Incapacity Benefits and Work  
   Incentives  
   1 84123 350 1  £28.00

142. Cross-country comparisons of  
   pensioners’ incomes  
   1 84123 351 X  £33.00

143. Evaluation of the New Deal for Disabled  
   People Innovative Schemes pilots  
   1 84123 353 6  £36.00

144. Evaluation of the New Deal for Disabled  
   People Personal Adviser Service pilot  
   1 84123 354 4  £44.00

145. ‘Well enough to work?’  
   1 84123 360 9  £31.00

146. Payments of pensions and benefits:  
   A survey of social security recipients  
   paid by order book or girocheque  
   1 84123 370 6  £34.50

147. Evaluation of the Minimum Income  
   Guarantee Claim Line  
   1 84123 381 6  £27.50

148. The role of GPs in sickness certification  
   1 84123 389 7  £28.50

149. The medium-term effects of voluntary  
   participation in ONE  
   1 84123 393 5  £34.50

150. Recruiting Benefit Claimants:  
   A qualitative study of employers who  
   recruited benefit claimants  
   1 84123 394 3  £25.00

Social Security Research Yearbook  
1990–91  
0 11 761747 4  £8.00

Social Security Research Yearbook  
1991–92  
0 11 761833 0  £12.00

Social Security Research Yearbook  
1992–93  
0 11 762150 1  £13.75

Social Security Research Yearbook  
1993–94  
0 11 762302 4  £16.50

Social Security Research Yearbook  
1994–95  
0 11 762362 8  £20.00

Social Security Research Yearbook  
1995–96  
0 11 761446 2  £20.00
Further information regarding the content of the above may be obtained from:

Department for Work and Pensions
Attn. Paul Noakes
Social Research Branch
Analytical Services Division 5
4-26 Adelphi
1–11 John Adam Street
London WC2N 6HT