



# Sustainability and transformation in European Social Policy

Valencia 8-10 September 2011

## 9th Annual ESPAnet Conference **Sustainability and transformation in European Social Policy**

Valencia, 8-10 September 2011

### **Stream 9: “Positive welfare” in practice: transformation, trends and dilemmas in European welfare states**

Stream convenors: Marion Ellison (Queen Margaret University) and Menno Fenger (Erasmus University Rotterdam)

**Universitat de València - ERI POLIBIENESTAR.**  
Edificio Institutos-Campus de Tarongers. Calle Serpis, 29. 46022. Valencia.  
Phone: (+34) 96.162.54.12- C.I.F. Q4618001-D  
Email: [espanet2011@uv.es](mailto:espanet2011@uv.es)

## **Assessing capacity for work: Employment and Support Allowance in the UK**

Dr Jackie Gulland

Paper presented to the ESPAnet conference, Valencia, September 2011

Stream 9 'Positive welfare in practice': transformations, trends and dilemmas in European welfare states

Employment and Support Allowance (ESA) was introduced in the UK in 2008 as the new social security benefit for people who are unable to work because of illness or disability. Qualifying tests for ESA are tougher than those used for previous incapacity benefits so that fewer people qualify for the benefit. Also new types of conditionality were introduced so that most recipients are expected to prepare themselves for work and to undertake 'work related activities'. This conditionality follows the pattern in many European countries of introducing work incentives to social security benefits and of widening the net to include people with health problems and disabilities.

However, since its introduction in 2008, it has become increasingly clear that the main concern with ESA is not this conditionality but the very large numbers of people who fail to qualify for the benefit at all and who are instead found to be 'fit for work'. The policy intention was to reduce the number of successful claims but critical reports from a range of organisations suggest that the decision making processes for determining who is and is not 'fit for work' is unfair. As an example of 'new welfare' the principle behind the benefit has moved from one of providing insurance protection against work-limiting illness to one of protecting only those with the most severe health problems and disabilities. As a result it has fuelled a discourse of malingering against those who claim sickness benefits.

This paper, based on a small piece of empirical research will consider the question of how we might judge what is a fair mechanism for assessing capacity for work in relation to social security benefits. It is hoped that the paper will enable participants in the stream to consider possible future cross-national collaborative research in relation to this question.

**Universitat de València - ERI POLIBIENESTAR.**  
Edificio Institutos-Campus de Tarongers. Calle Serpis, 29. 46022. Valencia.  
Phone: (+34) 96.162.54.12– C.I.F. Q4618001-D  
Email: [espanet2011@uv.es](mailto:espanet2011@uv.es)

## KEY WORDS

DISABILITY BENEFITS; WELFARE REFORM; ADMINISTRATIVE JUSTICE; ACTIVATION;

## Introduction

Countries across Europe and the OECD have been concerned with rising numbers of claims for sickness and disability benefits and have adopted policy measure to reduce these numbers. The focus of this paper is on how decisions are made about whether people are 'fit for work' or whether they are sufficiently ill or disabled to be entitled to benefit payments. All benefits for people with disabilities or work-limiting illness require some kind of definition of 'disability' or 'work limitation' although different countries define this in different ways. Some countries make a clear distinction between people who are 'able to work' and those who are not, while others include definitions of partial disability, where benefits are paid at different rates depending on the extent of disability (OECD 2010, p109). As Shima and Rodrigues (2007) argue, most countries use a medical model of disability and assess claimants according to their level of impairment, while others consider wider social elements which take account of the real-world barriers that people with disabilities and health problems face. The OECD reports that some countries, including Denmark, Hungary the Slovak Republic and New Zealand have adjusted their assessment mechanisms from a wholly medical focus to one which takes account of wider social factors in people's capacity for work (2010, p105).

Different systems also vary in how they assess individual claimants and make varied use of medical and other professionals in making assessments. The OECD describes the key role of the claimant's general practitioner in accessing sickness and disability benefits and raises concerns that too much power lies in the hands of general practitioners (2010, p140), arguing that better control mechanisms are needed to reduce this power. Although the role of the GP is important, many countries, including the UK, require claimants to undergo additional medical assessments by 'independent' doctors or other professionals before benefits are paid. Countries also vary in the extent to which benefits are administered by state, private insurance, employers or a combination of these. Despite these differences there have been attempts across Europe to reduce the numbers of claimants of disability and incapacity benefits and to redirect claimants into work. This paper describes how a recent welfare reform in the UK, the controversial 'Employment and Support Allowance', has been received

with criticisms of 'unfairness'. Although many commentators have supported the principle of welfare reforms for sick and disabled people: that people should not be abandoned on benefits and should be provided with support to return to work, there has been much concern that the mechanisms for assessing people are unfair.

### **Employment and Support Allowance in the UK**

In the UK, financial support for people with work-limiting illnesses is divided between those who are 'in work' but sick and those who are out of work and unable to work. Those who are still in work are entitled to Statutory Sick Pay for the first 28 weeks of sickness. This is administered by employers and paid at a low rate although often topped up by employers' contractual arrangements. For those who are not in an employment contract and are unable to work, financial support is made through the social security system in a combination of insurance-based and means-tested benefits. Since 2008 the main benefit available to those who are unable to work is Employment and Support Allowance and prior to its introduction the main benefit was Incapacity Benefit. For both benefits there are two routes to claiming: one based on National Insurance contributions, which is not means-tested and on the whole relates to people who have recently been in work; and a second means-tested route, applied to people who have virtually no other household income, relating mainly to people with a background of unemployment or recent childcare responsibilities. Although the two routes to the benefit are rather different and tend to affect people with different demographic profiles, the basic entitlement rules: whether they are sufficiently 'unfit for work' apply equally to both groups.

Employment and Support Allowance (ESA) was introduced in 2008 for new claims, following concerns about rising numbers of Incapacity Benefit claimants and a general 'welfare to work' policy of the kind seen in many other countries. There were two policy intentions: to reduce the number of successful claims and to introduce to a new element of conditionality so that most of those who qualified would be expected to make efforts to return to the labour market. The basic mechanism for assessing a claim for ESA requires that the claimant first of all contacts the Department of Work and Pensions to make an initial claim, supported by a medical certificate from their GP. The claimant then fills in a claim form, in practice a 21 page booklet (the ESA 50 form). In most cases this is followed by a medical assessment carried out by an 'approved health care professional' run by a private agency, contracted by the DWP to carry out assessments. At this assessment the health care professional assesses the claimant's abilities according to the statutory 'Work Capability Assessment' (WCA). The WCA is based on a series of 'descriptors' which outline a range of functional impairments (either physical or mental). Each descriptor carries a range of points (between 6 and 15) which, if they add up to

15 or more, classify a claimant as having 'limited capability for work'. The WCA has tightened the descriptors severely compared to the previous system in order to raise the level of impairment necessary to qualify for the benefit. Once the assessor has completed this process the papers are considered by a decision maker based at JobCentre Plus who decides whether the claimant qualifies for the benefit or not. Although this decision maker should consider all the evidence provided, in the vast majority of cases the decision maker 'rubber stamps' the assessment provided by the health care professional (Harrington 2010, p48). Experience of the early implementation of the system has shown that overwhelming numbers of people are failing to qualify for the benefit at all. Statistics show that, of completed claims, 34% of people were awarded benefit, while the remaining 66% were found fit for work (DWP statistical release October 2010)<sup>1</sup>. This has been followed in 2011 by a policy of transferring all claimants for Incapacity Benefit, onto ESA. Over three years it is expected that all those currently on Incapacity Benefit will be processed through a similar route to those who make new claims for ESA: all claimants will have to fill in the ESA 50 form and most will be called for a medical assessment. Transfers to ESA will be based on the ESA Work Capability Assessment and early predictions suggest that around 33% percent of claimants will be found fit for work (House of Commons 2011, para 153).

This suggests that the most contentious aspect of ESA, so far, has not been with the new conditionality but with the initial assessment of 'capacity for work'. Third sector organisations have been vocal in their criticism of ESA assessments and the first independent review of the assessment procedure has confirmed that there are many problems with it (Harrington 2010). Some changes have been made to the assessment since the Harrington review but there are still many remaining criticisms. It is not surprising that large numbers of people have failed to qualify for ESA, since this was the policy intention. However, criticism of the implementation of ESA suggests that the mechanisms for assessing claims do not appear 'fair' (for further discussion of the fairness of the ESA assessment, see Gulland 2011). The current research is set in the context of these concerns about the complexity and unfairness of the assessment system and in the increasingly moral framing of people claiming sickness benefits as malingerers.

## Research methodology

The research which has informed this paper was a small scoping study on the early experiences of people claiming ESA<sup>2</sup>. It focussed on the experiences of welfare rights advisers who have a front-line role in advising claimants about ESA. Their experiences provide a useful overview of

---

<sup>1</sup> Note that these figures do not include a further 36% of all claims which are 'closed before assessment', some of which relate to short term illness but also include others where claimants have failed to provide information or attend medical examinations.

<sup>2</sup> Expenses for this project were funded by a small grant from the Socio-Legal Studies Association

the issues, while providing in depth information on the everyday experiences of claimants. The research involved qualitative interviews with eighteen advice workers from fourteen organisations during June and July 2010. Organisations were identified using a snowballing technique to include a range of types of agency, including those that specialised in advising particular client groups and those with expertise in appeals work. Eleven of these agencies were local advice agencies based in different areas of Scotland and providing direct advice to the public. They included Citizens Advice Bureaux, local authority welfare rights advice teams, housing associations and voluntary sector organisations. Some organisations provided a generalist service while others specialised in advising particular groups such as lone parents, homeless people, people with learning disabilities, hospital patients, people with particular health conditions or people with mental health problems. Three interviews were also carried out with national organisations which have a 'second tier' advice or policy role. Interviews were based on a broad interview topic guide, were fully transcribed and analysed using a thematic analysis with the aid of NVivo software.

## **Findings**

### **Advisers' role**

Advisers in this study helped people at every stage of their claims: from advising about initial claims, through helping with filling in claim forms, explaining letters from the DWP, sometimes attending the medical assessments, advising about decisions letters and the options available to those refused the benefit, to drafting appeals, collecting additional evidence and representing at tribunal hearings. At every stage in this process, advisers emphasised claimants' confusion and stress as to what was happening to them and their own role in helping to ease this. This help ranged from explaining more clearly to claimants what their position, was as many claimants were very confused, to highly technical advice relating to getting medical evidence through the legal aid system and representing at tribunal hearings. They particularly stressed their role in explaining the complexities of the benefits system and claimants' confusion about the relationship between ESA, Jobseeker's Allowance, Disability Living Allowance and other benefits such as Housing Benefit and Working Families Tax Credits. However, their main role was in assisting claimants to present their case, either at the initial claim stage or at appeal, by helping people to show how their daily lives could be matched to the descriptors in the ESA legislation.

### **The principles behind ESA**

Advisers did not support the principle of tightening the conditions for the benefit as they felt that Incapacity Benefit was already sufficiently tough in this respect. They were concerned

that there is a built in assumption to the new assessment that people are not really ill. Many interviewees said that they understand the principles behind the 'support' element of ESA – that many people with disabilities and health problems would be able to do some work if given the right support, that no one should be left 'on the shelf' and that a system which emphasised what people could do rather than what they couldn't would be a good one in principle. However, although they saw this positive aspect to ESA, interviewees were concerned that the principle that 'most people can work' is being used to stigmatise people with genuine health problems rather than to help them. In particular they were concerned that the element of ESA which is designed to help people back to work only comes in when they qualify for the benefit, and given the high proportion of people who fail to qualify, no help is being provided to this group.

### **Administrative problems**

Advisers noted a range of administrative problems which are arising with ESA, ranging from poor advice from front-line staff, to difficulties with appointment systems for medicals and problems ensuring that people get the correct benefit during the appeal process. These problems might be the result of 'teething problems' of a relatively new system but some advisers believed that many problems have arisen because of the recent reorganization of DWP services which has led to large numbers of 'untrained' staff dealing with enquiries. Other problems arose as a result of the medical assessment rules which mean that benefit is refused if people fail to turn up for appointments. A further range of administrative problems has arisen with the transfer of Incapacity Benefit claimants to ESA (House of Commons 2011). Whatever the cause of these administrative problems, they create serious financial difficulties and stress for individual claimants.

### **Exemption from medical assessment**

One of the biggest changes introduced by ESA is the reduction in categories of people who qualify for the benefit, without having to undergo a medical assessment. Under Incapacity Benefit, a list of health conditions, including certain physical impairments, being registered blind, having a 'severe mental impairment' and being in receipt of the higher rate of Disability Living Allowance Care Component led to exemption from medical assessment. Under ESA this list has been drastically reduced to include essentially only people diagnosed with a terminal illness, people receiving certain types of chemotherapy and hospital inpatients. Advice workers noticed that this change to the exemption rules means that their clients are being subjected to the medical assessment, and sometimes 'failing' it, in cases where their health problems would have led to exemption under Incapacity Benefit. It is this reduction in the number of exempt categories which advisers considered was causing considerable distress and

'net widening', meaning that large numbers of people with serious health problems and disabilities are now subject to the medical test: and some of them are being found fit for work. This is particularly significant in relation to people with mental health problems or learning disabilities where the 'severe mental impairment' category is no longer applicable and where receipt of Disability Living Allowance no longer enables people to bypass the medical assessment. Advisers and claimants found it astonishing that people who had been assessed by many other professionals, including health services, community support services and the DWP itself as needing a high level of support, in some cases having an appointee to act on their behalf, are then being subjected to an additional medical assessment to determine their capacity for work. Some of these people do go on to qualify for ESA but they and their families are put through considerable stress and worry in the process. Whereas, in cases where people 'fail' the medical assessment, they then have to appeal the decision to get it overturned, leading to many months of stress and financial worry.

### **Assessing 'capacity for work'**

Another concern about the ESA policy related to the way that the new descriptors and points system was set up. In the field of mental health and learning disabilities advisers said that they had been optimistic that the new system would be better, that the points system appeared to be more flexible and that it would take better account of the realities of people's lives. However they felt that this did not seem to be happening in practice: although the descriptors appeared on paper to be more appropriate, their clients were failing to meet the criteria in cases where they were clearly 'unfit for work'. Another concern was with the 'higher barrier' which claimants have to get over to score any points. This can make it more difficult for people with a range of relatively minor impairments to score any points at all. This means that no account is taken of the combination of a range of impairments in the assessment. Advisers argued that this has negative consequences for people with complex and variable conditions which cannot easily be fitted in to the points system. Their overall objection to the new points system was that there is no evidence that the higher barrier is a better measure of people's 'capacity for work' than the old one: in other words people who have work-limiting health problems are being unfairly refused benefit.

### **Medical Assessments**

By far the biggest criticism of ESA held by advice workers lay with the medical assessments carried out by ATOS Origin Healthcare. Advice workers' general experience of the medicals was that they are perfunctory, inadequate and that they fail to take account of the claimant's

own account of their problems or of any supporting evidence provided by GPs or other professionals. Many gave examples of cases where they had been astonished at the contrast between the ATOS medical report's assessment of the claimant compared with what they knew about the person's health problems.

Explanations for the inadequacy of the assessments fell into the following categories

- Qualifications and expertise of assessors
- The 'tick box' approach to assessment, whereby assessors follow computerised forms and do not spend sufficient time with claimants
- Failure to take account of information provided by the claimant or additional evidence provided by medical or support professionals
- Misinterpretation of claimants' accounts of their daily lives

### ***Qualifications and expertise***

There was some concern at the level of qualifications and training held by the medical assessors, with many examples cited where assessments of people with severe mental illnesses or addictions were being made by assessors with no expertise in this area.

### ***The 'tick box' approach to assessment***

Another, related, criticism of the medical assessments was that they were driven by 'tick boxes', referring to the computerised form used by most medical assessors. Advisers argued that medical assessors were clicking on boxes on the form, without adding any explanation for their assessment and that this would lead to a computerised calculation of the number of points awarded and ultimately to a refusal of benefit. They argued that a more nuanced approach would lead to a better understanding of the claimant's difficulties. Advisers also offered numerous examples of 'mistakes' being made in this process, where the assessor *had* apparently understood about a problem (evidenced by a statement somewhere else on the form) but then had ticked the wrong box. The following interviewee described the problem:

In one respect you almost feel sympathy for the medical examiner because they've got a set form that they have to follow and there seems to be no space to give opinion. It's ticking boxes and when they read the script and tell the appeal tribunal this is in the script and even the medical examiner has said something, but they can't change it. The paperwork then goes back to the decision maker and they make the decision only on the basis of the score, not on any comments.

[interview 7]

Most advisers had not actually attended medical assessments (although some had) and their observations were based on what they saw in the medical reports which were provided with appeal papers, combined with what clients told them about the experience.

Another interviewee described how advisers' approach to helping people with claim forms differed from the approach taken by the medical assessors:

We've been trained, you know, if you ask a question and you get a response, there's maybe another three questions you should be asking. Whereas the doctor's asking a question and it's black and white. [interview 13]

Another general observation was that the clients were often happy with what happened at the medical because they had not been badly treated but then were stunned to see the decision and the, all too often, award of zero points. This had led some advisers to consider advising clients to put in complaints about the medical assessments but many had found difficulty in persuading clients to make a complaint because they had not been badly treated as such. One adviser had however been more successful in encouraging clients to make complaints but felt that they hit a brick wall when they were considered by ATOS and would in any case make no difference to the outcome of the claim.

### ***Failure to take account of additional evidence***

Several advisers described cases where people had also provided evidence from medical professionals or other specialists which appeared to have been ignored in the medical assessment. The following interviewee gave an example:

Somebody who had been very ill and had had a breakdown and then they did know all that because it was in the report as was a letter from their GP describing that the person, you know, giving a full account that the person had been in touch with psychiatric services etc and was getting quite closely monitored by the crisis team. Now they don't visit people lightly, you need to be like proper ill before they're coming

to your house! That was all in the medical report, but then they described the person as having mild depression. [interview 12]

### ***Misinterpretation of claimants' accounts***

There was a concern that assessors ask questions about people's daily lives and then translate an answer into a statement that the claimant can carry out a whole range of other activities, without probing further into the realities of the claimant's life. Examples given by advisers included:

But in fact they're still doing this thing where they use certain answers time and time again to answer certain descriptors, you know, things come up frequently, you know, things like that somebody uses their mobile to phone somebody, is then taken as evidence of social interaction. And this is used time and time again. [interview 3]

They [the medical assessors] are working a computer and 'do you watch TV?' 'yes', but there's nothing on that to say 'what did you watch last night?' 'how long do you watch it?' 'what are you doing?' [interview 14]

Other advisers explained that claimants will sometimes overemphasise their abilities because they do not wish to appear 'inadequate' in front of the assessor and that this problem was particularly acute with people with mental health problems or learning disabilities. One adviser, specialising in mental health, described an assessment which he had attended:

It was something like 'well, how do you spend your day, what do you do?' 'can you do this/can you do that?' and quite often in these situations where people are in a medical interview, they do emphasise what they can do rather than what they can't do ... So they tend to present well, better than they would if there was more detailed medical assessment ...somebody can hold themselves together for 15 minutes for an interview, and then come out and collapse in a heap, you know. And I think the people that are doing the assessments just don't pick up on that, which surprised me. [interview 5]

This adviser was surprised that the medical assessor was not familiar with the problem of 'presentation' and many others also argued that a proper medical assessment, carried out by people with the right expertise would be able to take account of these realities of people's lives. Another adviser explained why people are unwilling to discuss the realities of their lives when it might appear to make them look inadequate. She described the problem as 'dogs and children, always dogs and children'. The assessors would ask:

'So what about the dog, who takes it for a walk?' you're not going to say 'I open the back door and throw it out and let it come back in' because you're frightened they're going to come and take your dog away. [interview 14]

This example summed up the problem with assessors taking activities from people's everyday lives out of context and using them as evidence of capacity for work.

### **Decision making**

The final concern expressed by advice workers was the way that decisions are made by the DWP. Although the medical assessments are carried out by ATOS Healthcare, the legal decision as to whether someone qualifies for the benefit lies with the DWP, who ought to consider all the evidence before making a decision. The overwhelming view of advice workers was that decisions were being made solely on the basis of the ATOS assessment, where the computerised form would generate a total number of points and benefit would be awarded if that came to 15 or more. The advice workers did not believe that decision makers took any other evidence into account or that they would ever consider doubting the medical assessment. The following interviewee gave an example:

The decision makers are just going on what the healthcare professional says. I've got this woman who's on methadone and the final conclusion was that she had no drug problem. I don't see how that decision could have been made if they'd read the ESA 50 or the doctor's certificate. [interview 1]

This is backed up by the recent Harrington Review which found that in 98% of cases, decision makers follow the advice of the medical assessors (Harrington 2010).

Even when an appeal was lodged it was rare that the DWP would overturn a decision, on the basis of additional evidence supplied by the claimant or her/his adviser (although there were a couple of advisers who said that this did happen occasionally). This meant that most challenges would go to a full appeal and tribunal hearing, which advisers argued, they would usually win.

## Appeals

All of the advisers interviewed for this project had experience of appealing decisions on ESA, with varying degrees of success. Overall, appeals against refusal of ESA have a 40% success rate (DWP Statistical Release, April 2010) but advisers reported much higher rates of success, ranging from 'about 70%' to 'most'. This probably reflects the general pattern that appellants who attend their appeals have higher levels of success than those who do not and that those who receive advice are more successful than those who do not. Advisers' view of the appeals system was that it was a much fairer assessment of people's circumstances because the tribunals take account of a much wider variety of evidence. The ATOS assessment would be only one strand along with the claimants' own description of her/his condition and any additional evidence provided by medical professionals or support workers. This, the advisers argued, leads to more accurate decisions. In most cases the appeal tribunal would consider all the evidence carefully, usually leading to an overturning of the decision. Some advisers gave examples of appeal tribunals which had expressed considerable concern at the original decision, sometimes allowing the appeal without going so far as hearing, or by awarding as many points as possible to emphasise how wrong the initial decision had been:

So he said 'well in that case we'll allow the appeal, we won't bother going through the tribunal, we'll just allow the appeal now', and the tribunal Chairperson signed off on it on the spot without having to go through the process or presenting the evidence to the tribunal. [interview 5]

We went to the tribunal and the Chairman apologised. We sat down and the chap couldn't even... his [disability] is so severe he couldn't go to the tribunal himself, so I went with his mum ..the Chairman apologised, 'you shouldn't have to be here'. [interview 7]

Although representatives tended to win most appeals, they were very concerned at the knock-on effects on claimants. Their experience was that appeals were taking around 6-9 months to

come to a hearing, causing considerable financial worry and stress to claimants in the meantime, even if they were successful eventually.

### **Conditionality**

Much of the recent debate on Incapacity Benefit and ESA has surrounded the proposed increased conditionality that ESA would involve: that is that claimants who were considered 'capable of limited work' would then be expected to participate in 'work focussed interviews' with the threat of sanctions if they failed to attend interviews. The expectation was that most successful claimants would be in this group. There was some concern that this new condition attached to claims would cause problems for some people. However this small project revealed very little about conditionality as such. Few of the advisers interviewed reported any experience of people having problems with work-focussed interviews or the conditionality that these involve. Their concern was almost wholly with the difficulties claimants were experiencing in being awarded the benefit at all.

Those that had experience of clients attending work focussed interviews tended to be surprised that the interviews were rather more helpful than they had expected although they were somewhat cynical that the interviews would actually help people to get jobs. Research on the earlier pilot 'pathways to work' programmes confirms that this cynicism is appropriate, given that this type of programme tends to help those closest to the labour market and is of little help to those who have greater disadvantages in terms of health, education, social disadvantage or other complexities in their lives (National Audit Office 2010).

### **Effects on claimants**

Advisers were concerned about the effects on claimants at every stage of the process. The problems they highlighted included the obvious ones of shortage of money while decisions were being investigated but they also emphasised the effects on claimants' health because of the severe stress that the process creates, even for 'successful' claims. Another serious effect is the financial problems brought about by the relationship between ESA and other benefits, particularly Housing Benefit. Many advisers gave examples of people who had found themselves in rent arrears because their Housing Benefit had stopped when their ESA stopped, only to be reinstated once an adviser had untangled the mess that had arisen. Other advisers had become involved in complex 'better off' calculations for people who potentially had a choice of benefits to claim. Many advisers talked about people 'boomeranging' between ESA and JobsSeekers' Allowance (JSA) (the main benefit available to those who are unemployed), because they were advised by the DWP to claim JSA. This led to confusion for the claimant as well as another benefits tangle:

sometimes by the time I've seen them, maybe what they've tried to do is then follow the advice of what it says in the letter and go 'oh right, okay, I've to sign on then for Job Seeker's Allowance. They try to do that and get told that they're too ill and should really be on ESA, and then they're utterly bewildered at this point because they think... because also these acronyms JSA and ESA... And then folk are just all in a bit of a quandary about... and then at that point that's a bit... people are starting to get a bit panicked about it. [interview 12]

Advisers also pointed out that people are often upset because the decision to refuse them ESA implies that they are lying about their health condition:

they don't know what's happening, they maybe think 'they don't believe me, I've got this condition, my doctor is telling me this but this other doctor's saying...' they don't necessarily know what the person who they're assuming that they saw isn't a doctor, is in fact an OT or a physio or a nurse, they don't know that so they sit for the next six months thinking 'what does that say about my condition? Am I as bad? Is this right, does my doctor know what they're talking about?' [interview 2]

Many advisers pointed out that people often feel perfectly satisfied with the medical examination at the time but are shocked when they are then refused the benefit. Again they often take this as an insinuation that they have been attempting to cheat:

I think some people come out feeling quite angry, a bit disbelieved and quite upset. Other people think it's gone great, they've come out and said 'oh that'll be no problem, he or she was really, really nice and that'll be fine', and then they can't believe it when they get a report that says 'I'm sorry but you've not scored enough points', and they're quite flabbergasted because lots of information that they gave isn't there. [interview 12]

Some of these claimants then feel pushed into claiming JSA because they feel that nobody believes them:

I am hearing people say to me after an appeal that's maybe been unsuccessful 'I'm just not fit but financially I'm not going to go through all that process again, that medical was humiliating, I'll just need to claim Job Seeker's'. [interview 2]

These concerns about the emotional effects on unsuccessful claimants have been picked up by a recent official report on the transfer of Incapacity Benefit claimants to ESA, which recognises that 'failing' the ESA Work Capability Assessment test 'does not equate to a denial or disbelief about the existence of an illness or health condition' (House of Commons 2011, para 34) and that the Government should put more effort into communicating the meaning of the decision and that the media should be more responsible in reporting statistics in relation to claims. Unfortunately the media reaction to this recent report suggests that tabloid journalists have chosen to ignore this, with reactions to the report including headlines such as 'Sick benefits: 75% are faking' (Daily Express 27/7/11). This kind of reporting highlights the way in which decisions about sickness benefit claims become morally charged.

## Discussion

This small piece of research highlights some of the problems that can arise when new stricter rules are applied to claimants of sickness benefits. It is not at all surprising that advisers in this study were critical of the changes, given that the policy intention was to find a considerable proportion of claimants 'fit for work'. However this study shows that the way in which assessments are carried out can be seen as unfair if they are seen as bureaucratic form-filling exercises which fail to take account of the everyday realities of people's lives. Sainsbury reminds us that assessments of fairness in administrative decision making depends on how far we trust the decision makers (Sainsbury 2008, p326). He argues that we are more likely to accept decisions made by professionals because they are professionals, while we are less likely to accept bureaucratic decisions, which do not carry the same level of respect. In the case of ESA, which depends on a medical judgment, the bureaucratic process *may* be acceptable so long as it relies on trustworthy professional judgements at the assessment stage. It is clear from the evidence that claimants and advisers do not trust these professional judgements. This raises questions about how decision making in relation to sickness benefits can be improved in a way which enables both efficiency (from the point of view of administration) and trust (from those whose livelihoods depend on the decision).

Despite the implied objective nature of these assessments, it is clear that the concept is a social construction. Decisions on benefits eligibility are usually made by administrators but the evidence to support these decisions takes a variety of forms, crucially including medical

evidence from claimants' doctors or other medical assessors. The history of sickness benefits shows a high level of mistrust of GPs in this process, with frequent attempts by policy makers to find better and more 'objective' methods of assessment. Meanwhile claimants' challenges to negative decisions rely on emphasizing the value of the GP's evidence and a concern to consider 'real world' knowledge. Legal decision makers, dealing with appeals, are constrained by the legislation which may discount this real world knowledge but appear to value medical evidence more highly than administrative decision makers. The different values held by claimants, doctors, decision makers and legal bodies reflect Mashaw's (1983) 'models of justice' and illustrate how a bureaucratized form of 'medical' evidence comes to be privileged over the personal experience of claimants, or the professional opinions of doctors who know them<sup>3</sup>. At the same time, the way in which this medical evidence is collected appears to rely on morally weighted judgements about appropriate behaviour.

### **Conclusion: comparative perspectives**

I would like to conclude this paper by considering how these findings can be considered in a wider comparative context and to propose some suggestions for possible future research. Patterns of disability benefit retrenchment and activation of disabled people have been replicated across Europe and across OECD countries, while the detail of schemes varies considerably. European policy scholars have studied social security benefits for those with disabilities or work-limiting illnesses from a variety of perspectives: in terms of rising numbers (Kemp et al 2006, OECD 2010) activation (OECD 2010), cost (OECD 2010), the degree of convergence between countries (Van Gerven 2010) and adequacy of benefit levels (Shima and Rodrigues 2007).

Much of the literature on this topic has followed the assumption that the work-first principle is the best, although some writers have been more critical. A typical example of work-first is the recent report by the OECD which says;

'Until the mid 1990s ... policies were biased towards generous and easily accessible disability benefits with little or no emphasis on the latter goal [providing incentives and supports to work for those who can]. This is neither in the interest of the worker nor of society at large' (OECD 2010, p11)

---

<sup>3</sup> For further discussion of this, see Gulland 2011

To be fair, the OECD argument is that activation policies and restrictions on the availability of disability benefits should be accompanied by better support mechanisms for both disabled jobseekers to find and keep work and for employers to employ and retain disabled workers. Following this principle, The 2010 report assesses OECD countries along two dimensions: compensation (relating to generosity and accessibility of benefits) and integration (relating to policies supportive of disabled people's employment) (OECD 2010, p85). However, there is a worrying assumption that 'generosity' and 'accessibility' of benefits is to be discouraged.

Other writers have considered the 'fairness' of assessment procedures, for example Van Aerschot's work on Denmark, Finland and Sweden (Van Aerschot 2011) and work on the reassessment of claims for disability benefits in the Netherlands (Van der Burg and Prins). Van der Burg and Prins (2010) describe the Dutch process which appears to take more time and effort to consider claims: a one hour interview with a doctor, with second opinions sought in 'medically unexplained conditions', followed by an assessment by a 'vocational expert' who focuses on the client's vocationally relevant abilities (p149). Van der Burg and Prins argue that people generally seemed to accept the shift in emphasis from assessment of sickness to one of work capability, although they note that 'client organisations still oppose the scheme' (p150). Van Aerschot has used Lipsky's notion of street level bureaucracy (Lipsky 1980) and Mashaw's notion of models of justice (Mashaw 1983) to consider individual legal rights across activation policies in three Scandinavian countries while Adler (2008) and Sainsbury (2008) have consider activation in the UK in terms of 'justice'. Clearly benefit systems operate within particular administrative and legal cultures but concepts of 'fairness' can perhaps be applied within these cultures. Hohnen's (2006) work on policies for 'work disabled' people in the Netherlands and Denmark from the perspective of citizenship, has a focus on rights and obligations rather than directly on decision-making. Hohnen also provides a useful framework for understanding citizenship rights within what she describes as the 'political and cultural discourse' of the policies concerned.

### **Future research**

This paper has highlighted the criticisms aimed at a recent welfare reform policy in the UK and has considered these criticisms in relation to similar issues in other European countries. While research on ESA in the UK and on welfare reform in general will continue across Europe, there is scope for further comparative work on the specific issue of decision making, trust and the role of professional judgement in relation to disability benefits. I welcome the opportunity to discuss these concerns with other European colleagues.

## References

Adler, M. (2008), 'The Justice Implications of 'Activation Policies in the UK', in Erhag, T., Stendhal, S. and Devetzi, S. (eds.), *A European Work-First Welfare State*, Goteborg, University of Goteborg: Centre for European Research.

Borghouts-Van De Pas, I. (2010), 'Labour Market Participation of the Disabled: Policies and Practices in Europe', *European Journal of Social Security*, 12, 2, 121-143.

Department of Social Security (1998), *New ambitions for our country: a new contract for welfare*, London, The Stationery Office

Gulland, J. (2011), 'Ticking boxes: understanding decision making in Employment and Support Allowance', *Journal of Social Security Law*, 18, 2, 69-86.

Harrington, M. (2010), *An Independent Review of the Work Capability Assessment*, London, The Stationery Office.

Hohnen, P. (2004), 'Experiences of Participation Citizenship: a bottom-up analysis of the social rights and obligations of work-disabled employees in Denmark and the Netherlands', *European Journal of Social Security*, 6, 3, 205-228.

House of Commons (2011), *Work and Pensions Committee Sixth Report. The role of the incapacity benefit reassessment in helping claimants into employment*, London, House of Commons.

Kemp, P., Sunden, A. and Bakker Tauritz, B. (2006), *Sick societies? Trends in disability benefits in post-industrial welfare states*, Geneva, International Social Security Association.

Lipsky, M. (1980), *Street Level Bureaucracy: dilemmas of the individual in public services*, New York, Russell Sage Foundation.

Mashaw, J. (1983), *Bureaucratic Justice: Managing social security disability claims*, New Haven, Yale University Press.

National Audit Office (2010), *Support to incapacity benefits claimants through Pathways to Work*, London, The Stationery Office.

OECD (2010), *Sickness, Disability and Work: breaking the barriers. A synthesis of findings across OECD countries*, Paris, OECD.

Sainsbury, R. (2008), 'Administrative justice, discretion and the 'welfare to work' project', *Journal of Social Welfare and Family Law*, 30, 4, 323-338.

Shima, I. and Rodrigues, R. (2007), *The implementation of EU social inclusion and social protection strategies in European countries with reference to equality for disabled people.– VT/2007/005*, Academic Network of European Disability Experts (ANED),

Van Aerschot, P. (2011), 'Administrative justice and the implementation of Activation legislation in Denmark, Finland and Sweden', *Journl of Social Security Law*, 18, 1, 33-57.

Van Der Burg, C. and Prins, R. (2010), 'Employment Instead of Benefit Receipt? Process and Outcomes of Reassessment of Dutch Disability Benefit Recipients', *European Journal of Social Security*, 12, 2, 144-155.

Van Gerven, M. (2008), 'Converging Trends of Social Policy in Europe: Social Security Benefit Reform in the UK, the Netherlands and Finland', *European Journal of Social Security*, 10, 3, 207-225.

Dr Jackie Gulland

Lecturer in sociology

School of Applied Social Science

University of Stirling

Scotland

UK

FK9 4LA

E-mail [Jackie.gulland@stir.ac.uk](mailto:Jackie.gulland@stir.ac.uk)

**Universitat de València - ERI POLIBIENESTAR.**

Edificio Institutos-Campus de Tarongers. Calle Serpis, 29. 46022. Valencia.

Phone: (+34) 96.162.54.12– C.I.F. Q4618001-D

Email: [espanet2011@uv.es](mailto:espanet2011@uv.es)