HOUSE OF LORDS

Economic Affairs Committee

Corrected oral evidence: Economic inactivity: welfare and long-term sickness

Tuesday 12 November 2024

3 pm

Watch the meeting

Members present: Lord Bridges of Headley (The Chair); Lord Blackwell; Lord Davies of Brixton; Lord Griffiths of Fforestfach; Lord Lamont of Lerwick; Lord Layard; Baroness Liddell of Coatdyke; Lord Londesborough; Lord Razzall; Lord Turnbull; Baroness Wolf of Dulwich.

Evidence Session No. 3 Heard in Public Questions 42 - 65

Witnesses

I: Dr Sean Phillips, Head of Health and Social Care, Policy Exchange; Louise Murphy, Senior Economist, Resolution Foundation; Edward Davies, Policy Director, Centre for Social Justice.

USE OF THE TRANSCRIPT

1. This is a corrected transcript of evidence taken in public and webcast on www.parliamentlive.tv.

Examination of witnesses

Dr Sean Phillips, Louise Murphy and Edward Davies.

Q42 **The Chair:** Good afternoon. Welcome to this session of the Economic Affairs Committee looking at inactivity and the welfare system. We have three witnesses today. Can you briefly to introduce yourselves, and then I will ask the first question?

Dr Sean Phillips: I am the head of health and social care at the think tank, Policy Exchange.

Louise Murphy: I am a senior economist at the Resolution Foundation think tank.

Edward Davies: I am the policy director at the Centre for Social Justice.

Q43 **The Chair:** Thank you all very much for coming in. I know that each of you has written a lot about this subject. We have a lot to get through. If I rudely cut you off, please forgive me. It is because we want to hear from all of you on a number of topics.

I will start with a scene-setting question. Can you briefly give us an overview, almost just to get it on to the record, your sense of the impact that long-term sickness is having on the economy and the risks it poses to the sustainability of our public finances?

Edward Davies: At a fundamental level, the financial cost to the Exchequer of the benefits bill is getting very serious. From the beginning to the end of the decade, you are seeing a doubling up towards £76 billion for incapacity health benefits. So the major question is: how do we afford to keep going on the status quo? The secondary part is that so many people are now falling out of work through ill health. They are not contributors but net detractors from the economy; they are not paying taxes or earning an income. That is a major problem.

There is a third part, and possibly the most serious part, which is different. The strange phenomenon at the moment is the number of younger people who are dropping out of work and inactive. That has a long-term scarring impact on both them and the economy. Seeing young people come straight out of university and jumping on to benefits means that they are not just costing something now but, if they are out of work for 6 or12 months, they might be costing for the rest of their lives. There is a financial cost to the Exchequer, a huge scarring effect on that individual, and a loss of potential for the country.

Louise Murphy: I broadly agree with that. We tend to think about this as broadly three areas. First, although it might not be what we will focus most on today, there is direct health spending, which is obviously going up, as well as the impact on the benefit system of people being out of work. We should also reflect that we have more working-age people who are reporting disability, with multiple health conditions, and that will have pressures on the health system in and of itself. But, as we have heard,

we are also seeing knock-on impacts on the benefit system and the labour market.

In the first of those, the benefit system, the increase is sizeable. For example, the bill for all working-age health-related benefits as a proportion of GDP has risen from around 1.2% a decade ago in 2013-2014. In the latest outturn year, 2022-23, that figure stood at around 1.6%. If we look at the OBR projections to the end of this decade, that figure is set to be 2.1% of GDP. Those are sizeable increases, and I am sure we will go on to talk about the details. Some of the increases among young adults and children are also striking. Real-term spending on children's disability benefits—so for people under 16—has more than doubled in the past decade. That is often missed.

The final area is the impact on the labour market, which is important for the economy overall. It means that we have fewer people working, which contributes to labour supply. That is particularly important, because in the previous decade, the 2010s, we were worrying about lots of things in the economy, including pretty poor productivity growth. One thing that we relied on in that decade was rising labour supply, with more people entering work or increasing their working hours. It is particularly troubling that we are seeing this inactivity issue now, because a positive thing that we relied on can no longer be used to prop up our economy. As Edward said, there are also the impacts on the individual, their living standards and life chances, which we should be worried about.

Dr Sean Phillips: I absolutely recognise what Louise and Ed have said. Fundamentally, the cost of this is a vicious cycle. Inactivity is reducing productivity and lowering growth meaning higher taxes are needed to pay for public expenditure, et cetera. To comment on the cost to employers, sickness absence has not been referenced yet but is now costing on average £780 for every member of staff. So ill health generally is a significant cost for employers. Some of that is short-term absence, but there is also longer-term absence.

In thinking about the cost overall, I would highlight to the committee the work of Oxera, which was commissioned by the Times Health Commission to investigate underlying costs. It estimated that the cost of lost output due to ill health among those of working age was around £150 billion per annum. Others may have other estimates, but that figure is significant. It was, until recently, the annual budgetary allocation for NHS England, for instance. That is the size of the challenge that we are dealing with.

Q44 **Lord Davies of Brixton:** An issue that has arisen in almost all the studies that we have carried out in the past couple of years is the quality of the statistics. We can have endless discussions about the problems that we face and their solutions, but if we cannot believe the figures, where does that leave us? Who wants to lead on the statistics?

Louise Murphy: I am happy to give that a go. It is a really important issue. The main issue is that the ONS's Labour Force Survey, which is the main source of data for labour market information, shows that the

employment rate, the rate of economic inactivity and so on have suffered. That is quite a well-publicised and acknowledged issue, and the ONS is upfront about it.

There are two things broadly going on. First, the response rate to the survey has plummeted since the pandemic. Secondly, there is a bit of an issue with the population estimate; there is an acknowledged issue that the ONS's estimate of the number of people in the country might be off, which has a big impact when working out how many millions of people are or are not in employment. We should take the ONS's economic inactivity rate over the past couple of years very much with a pinch of salt. Particularly when looking at subgroups, whether small geographic areas or age groups where the sample sizes are very small, we should be a little sceptical.

We are mainly talking today about the benefit system and people in receipt of health-related benefits. The good news is that we can rely on DWP administrative data. This is not a survey, so it does not suffer from any of the sample size issues that the Labour Force Survey does. We can use data that just shows how many people are being paid these benefits, where they live, what age they are and so on. That is credible and accurate, so we can feel confident with the trends there.

We just need to make sure that we are interpreting that data correctly. Not everyone who is out of work will be claiming a benefit, not everyone who is claiming a benefit will be out of work, and so on. We need to make sure that we are being accurate with language, but certainly, when we are referring to DWP data, as the three of us will mostly be doing today, we should remember that it is large-scale administrative data that does not suffer from the survey issues that the Labour Force Survey does.

Dr Sean Phillips: I have a minor point to add to that. One of the challenges that we have with the data published by the Department for Work and Pensions on universal credit work capability assessments is with respect to the information gap when it comes to health conditions. Look, for instance, at the publication of the statistics today. By its own assessment, the DWP says: "Coverage is not complete for data on medical conditions for the universal credit work capability assessment". Indeed, of the "decisions in the period January 2022 to February 2024 (1.6 million in total) 81% have a medical condition recorded on the Medical Services Referral System".[1]

In most cases, we have that information, but there is a gap in terms of a really detailed, primary understanding of the case load that we are dealing with from a health perspective. There is a greater gap and bigger

[1] https://www.gov.uk/government/statistics/universal-credit-work-capability-assessment-statistics-april-2019-to-march-2024/universal-credit-work-capability-assessment-april-2019-to-march-2024#:~:text=for%20UC%20WCA%20.-,Of%20all%20WCA%20decisions%20in%20the%20period%20January%202022%20to,for%20an%20interview%20based%20WCA%20

challenge with 'fit notes'. We might come on to that, but it is important to highlight it.

The Chair: Forgive me. My little brain is trying to keep up. Where did you say the gap is?

Dr Sean Phillips: In 81% of cases, a medical condition is detailed and identified.

The Chair: So within that 81% we absolutely know what the medical condition is. We will come on to the diagnosis point later, but I want to be clear about this.

Dr Sean Phillips: We will not necessarily have a primary medical condition at all, but we will get information about the range of conditions.

Lord Turnbull: You say that we know what the medical condition is. Is it not more accurate to say that we know how it is described?

The Chair: That is a very good point.

Lord Turnbull: Particularly with mental health, it is very difficult to know, because it is almost a self-declared position. If someone has a bad back, you can probably see it quite quickly. With depression, it is very difficult to know what is going on.

Dr Sean Phillips: There is a big challenge around the diagnostic criteria. I am not a medical professional, so I cannot comment on that in detail, but others will be able to reflect on it. One of the key challenges, for instance, is that claimants are reporting 2.7 health conditions in general on average. We are dealing with quite a complex mixture of different reported conditions, which is one of the reasons why it is difficult to state the primary condition.

Edward Davies: I just want to stress that granular data. It is great when you are understanding the picture. It is not perfect, but we get what is broadly going on. If you want to think about how to solve this, you have to understand it at a granular level, and we do not have that at the moment, particularly with the Labour Force Survey.

Lord Davies of Brixton: You say "at the moment". Does that imply that people working on this?

Edward Davies: I hope so, certainly on the response rates. That is the key thing. The survey, in theory, would be big enough to give you a granular answer if enough people responded. They are aware of this, yes.

Baroness Liddell of Coatdyke: I am starting to lose sleep at night because of some of these issues. What do we do about them? What is the path to get us out of this constant dilemma of what to do about benefits? It has to go beyond benefits, because there is an inbuilt suspicion of work. Do you have any ideas? You guys are moving around it all the time. Do you have any brilliant ideas about it?

The Chair: I am sorry, Lady Liddell. Can we maybe come back to that in a moment? I would like to hear a bit more about what the problem is. It was a brilliant question, but I want to go on.

Lord Davies of Brixton: No one has mentioned the irregular economy. Does that imply that it is not a significant element? There could be a lot of people out there being paid cash in hand, or whatever, which would not show up in the statistics. How significant is that? I suppose that, by definition, we do not know.

Edward Davies: By its nature, it is anecdotal. Part of our work is with a lot of small front-line organisations. We have a foundation of about 700 charities that we talk to and, anecdotally, I can definitely say that it is an issue. But, as you say, by definition, we do not know the data.

The Chair: We have a real problem. The data shows the trend is right—we all agree on that—but the granularity means that we do not absolutely know what is driving certain aspects. That is where I have got to so far, if that is right.

Q45 **Lord Razzall:** That was the first part of my question: what has been driving this increase in long-term sickness rates? Without wishing to bring in the *Daily Mail* again, would you comment on the idea that the UK has a sick-note culture, as is suggested by some of the tabloid press? Perhaps you could elaborate on the generational aspects of this problem, which Ed spoke about, and particularly young people.

Edward Davies: I would certainly say that "sick-note culture" is one of those headlines that is great for newspapers but is not a helpful phrase. It points to our unusually high levels of sickness in the UK compared internationally, so there is something going on here that is slightly different from other countries around the world. Whether or not it is a sick-note culture, it is certainly specific to UK culture.

On what is driving long-term sickness, the two big areas are musculoskeletal conditions in over-50s and mental health problems in younger people. Those are the drivers. As I mentioned at the beginning, we would expect musculoskeletal conditions in the over-50s and expect working life to be difficult. Even if it were higher, it would be logical.

The real worry is that we are seeing this in younger people now, people who should be fit to work, who have just come out of education. That is really different from what we have seen historically. It is a real change in the demographic. That is a driver and a concern.

Louise Murphy: I agree that the phrase is not particularly helpful. There is lots of nuance that may be missed by a phrase like that. First, although some of this is showing up in rates of sickness absence or benefit claims, across the UK and across society we are seeing a huge rise in reported disability and ill health. We box ourselves into a corner slightly if we jump to speaking just about the impact on the benefit system or the world of work without first thinking about how and why our society has had such a big shift.

Over the past decade, there has been an extra 3 million working-age adults reporting a disability. In 2012-13, around 16% of working-age adults in a survey would describe themselves as being disabled. That has now risen to almost a quarter. We really should stop and think about how and why that has happened.

Of course this is self-reported disability, and some people are quick to say that it could just be changing norms or changing language, and of course how we think and speak about disability has changed, but to dismiss it as just a change in language slightly misses the point, which is that if almost a quarter of working-age people feel that they are disabled and are living their life feeling and describing themselves as being disabled, that will have an impact on whether they feel able to work and the type of work they feel able to do.

More should be done to understand what is going on there. There is some evidence coming out on changes to underlying health. There is certainly some evidence that, for example, life expectancy trends are shifting. Over the past 20 or 30 years, we have seen fairly steady increases in healthy life expectancy, which, from the mid-2010s, was flattening out, even before the Covid pandemic.

There seems to be something physiological going on, such that people's health is worsening, but it also seems that something additional is going on that means that people are feeling or describing themselves as disabled. Perhaps society is becoming more disabling.

Lord Razzall: Why are we different from other countries in this area?

Louise Murphy: Other countries have also seen increases in reported disability, perhaps not to the same extent, but it is a good question. I do not claim to know exactly why the UK is different.

Lord Razzall: We have asked that of several people, and nobody seems to know.

Louise Murphy: We should all be working harder to understand it.

Lord Davies of Brixton: Just to be clear, the difference is in the quantity, not in the trend. There is a trend across the world towards greater reported disability.

Lord Razzall: But the quantity is bigger with us.

Lord Davies of Brixton: Yes.

Dr Sean Phillips: I partially agree with the categorisation of a 'sick-note culture'. First, for the benefit of catalysing this debate, allowing us to step back and think about this trend in long-term sickness. That encourages us to think about the role of employers. We at Policy Exchange have looked at the ways in which we might expand occupational health provision. That is not targeted at people who are currently out of work but mainly at people who are in work, but it is important.

If we look, for instance, at the changing burden of ill health that we will see over time; the increase in multiple conditions and the increase in major conditions, et cetera— I refer the committee to the Health Foundation's work on projecting ill health up to 2040—almost regardless of what we see in the statistics on long-term sickness, that is the direction of travel. So it is important that we look at this.

With regard to short-term absence, some of which will become long-term, if we look at the data from last year, 186 million working days were lost to sickness or illness. Compare that to just a decade ago, when a third fewer working days were lost. However, this is where I would challenge the 'culture' part of the phrasing and where it is not as helpful. Clearly this growth in sickness absence, particularly short-term sickness absence, is not a uniquely British phenomenon. French workers, for instance, took off 18 days on average last year. In Germany, employees were absent over 19 days in 2023, the highest number since 2000. Those are far more significant numbers. So, to that extent, we are not exceptional. However, exactly as Louise and Ed have said, this long-term trend is the most significant thing.

We may well come on to this, but there is something important to say about underlying incentives and, for instance, looking again at the 'sick note', now called the 'fit note', and the extent of the role that could play, if it was working effectively, in triaging people to more effective support. That is important too in this debate.

Q46 **Lord Londesborough:** Edward, I would like to come back to your generational comment and the very disturbing trend that the fastest-growing cohort of long-term sick is the 16-to-24 age group. Can you help us to understand what is behind that? Mental health is mentioned. I imagine that it is not just mental health. Are there also physical health issues?

I am also interested that the majority of these people are being signed off as they leave education, whether it is school or university. Is that a different process from an adult or worker going from being employed to being inactive?

Edward Davies: First, on the mental health thing, it is really complicated. The reason given is mostly mental health. Taking it a step deeper, what is poor mental health is a much greyer area. To the point made earlier, some of the diagnostics around this are not clear.

We have seen a huge shift culturally to remove the stigma of mental health. That has definitely helped people to come forward who previously would not have done. There is a question as to whether that has gone too far. I do not know the answer to that. I definitely think there is overtreatment of a lot of mental health problems.

In terms of the prescribing of antidepressants, about 8 million and 9 million adults took antidepressants last year. For some people they are enormously helpful, but I struggle to believe that we are not treating what is often a social condition with a medical solution part of the time.

Coming back to the core of why so many children are struggling with mental health problems, whether they are diagnosable or not they are coming forward with some sort of distress. The fundamentals of all mental health research come back to relationships. Before doing this job, I worked for the Department of Health. We did a huge exercise and had about 5,000 responses to a consultation looking at the drivers of mental health. The top reason by far that came back was relationships, specifically family relationships, which came out top. When I asked the department what we were doing about this, the answer came back, "Nothing. There is nothing that we do in government to confront what we know to be the biggest of poor mental health in young people".

There is a real gap there. We know that this is a major driver and that it is going very poorly. We have the poorest relationships in the whole of Europe, certainly in terms of family stability, but it is so difficult and so sensitive that people do not want to talk about it. So we end up in the position where we can see this huge problem arising, particularly in the cohort who have experienced very fragile childhoods, but because the answers are so difficult for adults to cope with we are not really going there.

So, to your point, no one is telling us the answer. I think a lot of people realise that this is about how we have fundamentally changed childhood over the last 50 years, but we have done that to give adults more freedom and more choices, and children are bearing the cost of that.

Dr Sean Phillips: We recognise all that. One of the challenges with the diagnostic criteria is that, more often than not, we are dealing with a very complex interplay of medical and social conditions. Stepping back, some people will ask how possible it is to do a medical assessment when, fundamentally, it is social challenges that you are confronting head on, and, taking that a step further, how appropriate it is that our offer to people in this condition is a fiscal transfer rather than looking in a more nuanced way?

I would also highlight from work we have done at Policy Exchange the change that we are seeing in the lives and lifestyles of children and young people, and the extent of the role played by the use of the internet and social media in poor mental health, not necessarily as a causal factor but in terms of the amount of time spent on it and the type of content that is being accessed. It is difficult to weight the impact that will have, but it is a key thing for us to be thinking about as part of the discussion.

The Chair: I am conscious that we are opening a big Pandora's box here. We are the Economic Affairs Committee, not a health committee, and we have to mindful of that, but obviously I can see the linkage.

Louise Murphy: I am happy to comment on the young people aspects, which we have done quite a lot of work on. First, I would slightly caveat what we are talking about. We have certainly seen a sharp increase in the number of young people out of work due to ill health or claiming health-related benefits, but we should remember that they still make up

a very small proportion of the overall stock of people who are out of work or claiming benefits due to ill health. People aged 50 and over are far more likely to be out of work or claiming benefits due to ill health, so I do not think we should blow this out of proportion.

Over the past decade, for example, the number of 18-to-24 year-olds out of work due to ill health roughly doubled, reaching around 200,000, and we know that over 2.5 million people are out of work due to ill health. Older people, although they have not experienced as large a *proportional* increase, are still the biggest group who are out of work due to ill health.

When it comes to reasons, it is correct that mental health is the most prominent reason among young people. The first thing to say is that, within the DWP benefits data, the categorisation is "psychiatric disorders", and it is worth bearing in mind that that includes many things that we do not tend to think of as mental health conditions. It includes ADHD, autism, and lots of learning disabilities and learning difficulties. It is easy to speak about mental health and think of anxiety and depression but, when we look at disability benefit claims—personal independence payments— for young people aged 16-24, more relate to things like autism, ADHD and learning disabilities than to anxiety and depression.

That makes sense. We have heard a bit of discussion about how medicalised this should be. That is a debate to be had, but we should remember that, when it comes to the benefit system, to be awarded a disability or health-related benefit, it does not matter what your formal diagnosis is. You do not need a doctor to provide evidence that you have anxiety, depression or whatever it might be. You have to prove that your health condition or disability affects your day-to-day life in a significant way. To be awarded these benefits, that mental health condition would really have to impact you quite significantly.

Q47 **Lord Layard:** I want to go back to something that Sean said. The committee is mainly worried about people being sick and out of work. The main monitoring of that is by the DWP. We are worried about those trends, but there are also people off sick while in work. The monitor of that is different; it is the employer. Were you saying, Sean, that the trends in out-of-work sickness are similar to the trends in in-work sickness? Let me ask a general question: is there the same upward trend in absenteeism due to sickness that there is for being out of work due to sickness?

Dr Sean Phillips: There is definitely a trend for those in work but in receipt of a fit note and in long-term sickness absence. We definitely identify that trend, but how neatly the two overlap is more difficult.

Lord Layard: It is a kind of simple quantitative question. Maybe we do not have the answer today, but we ought to know whether, when it is monitored by one set of people, you get the same phenomenon to when it is monitored by a different set. Does anyone else want to comment?

Louise Murphy: I know the Labour Force Survey data, which we are taking with a pinch of salt, has shown a slight uptick in employees who are off work due to sickness absence, as you have spoken about. That and other data sources show a similar slight uptick. For example, in its payroll data, the NHS publishes how many of its employees are off work taking sick days, and that has ticked up. It stood at around 4% for most of the 2010s, and it now stands nearer 5%. It looks like employees taking days off sick has increased slightly, but I am not sure whether the pace of the increase neatly matches the pace of the increase in economic inactivity. The other thing is that we have more employees who are working with health conditions, but that goes without saying.

Q48 **Lord Griffiths of Fforestfach:** Mr Davies, could you be more explicit about some of the social factors at work when it comes to children's mental health?

Edward Davies: The really big one is quite simply that home life has collapsed in the last 50 years. It is hard to talk about but, 50 years ago, if you were sitting your O-levels this summer, there was a 90% chance that you were living with your mum and dad. For a child sitting their GCSEs this summer, it is about 50:50. That represents how basically half the children in the country at some point, either slightly before they are born or often after they are born, in their early years, see their family structure come apart.

The work that the IFS has done on this is very good, looking at how we are an outlier in family fragility. That is not the only factor, but it is a very considerable one, and that is repeated in a lot of the research. We have to be honest about that. I could have this conversation with an education or a justice committee, and it would be similar. We have similar conversations at every one I go to, and it is an awkward conversation, but it is the big change in society over the last 50 years.

The Chair: Very interesting. Thank you. On this data point and coming back to Lord Layard's excellent question, Louise, you rightly said at the start that the LFS has its problems, but are its trends for those who are inactive because they are suffering from mental illness or musculoskeletal problems in some shape or form reflected in the data for work capability assessments, even if they do not map directly?

Louise Murphy: Exactly, yes.

The Chair: So within the inactivity basis, we are pretty sure that those trends are there.

Louise Murphy: Yes, we can be confident of those trends in mental health and musculoskeletal problems.

The Chair: I think Lord Layard is asking how that maps on to those who are still in work but off sick. If there is any chance that any of you could look at those databases, it would be very helpful.

Q49 **Lord Griffiths of Fforestfach:** We are the Economic Affairs Committee,

so we are obviously interested in economic incentives and, as we look at claiming benefits without any ethical judgment at all, we have seen that there has been a change in the ratio of the benefits you get by going down the jobseeker's route as opposed to the health route. We have asked previous witnesses this question, and by and large they have hinted at things, but not categorically said that changed economic incentives have led to what we are seeing with health claims and so on. Do you have any comments on that, or do you know of research that has been done that has helped you to see the issue more clearly?

Louise Murphy: As you say, the issue here is that it is very hard to prove that this is the thing at play, because there have been lots of changes over the past decade—the cost of living crisis and Covid, for example. But most people would agree that it is part of what is going on because, at the end of the day, it is in the interest of any rational person who is in receipt of benefits and who might be struggling with poor health or disability to try as hard as possible to receive a health or disability-related benefit, because the impact on their take-home income is transformational. For someone in receipt of Universal Credit (the standard adult element), their income can double if they are deemed to have limited capability for work-related activity—the too-ill-to-work group. So there is an incentive to do that.

We did some work on this. To try to understand it better, we did some interviews with welfare rights advisers who are on the ground working with people. We chatted to people who have been working in this area for many years, because we wanted to understand whether anything had changed to make this problem worse.

What came out first was that, by design, the benefit system has become more high stakes. The cliff edge is larger because, in the 2010s, under the previous Government, we removed the intermediate element from Universal Credit. You used to get a smaller financial award if you were deemed to have a moderate health condition but maybe able to do some job-search activity. We got rid of that. Now the option is to be deemed fit for work, get zero extra pounds, have all the work-search conditionality and be expected to meet with a job coach, or to get an extra £400 and no work-search conditionality. That has changed.

The other thing that has changed is that the benefit system has become less generous overall. We squeezed other parts of the system gradually through the 2010s, for example through the benefit freeze and the introduction of things like the benefit cap. That just means that people feel worse off overall.

If you are feeling financially vulnerable, the incentive to get that extra £400 is greater. That came out very clearly when we were speaking to advisers on the ground, who said that the introduction of the benefit cap, for example, has had a big impact on people's decision-making.

Dr Sean Phillips: A member of this committee last week—I think it was Lord Turnbull, but apologies if it was not—referred to a "hunter-gatherer

culture". To some extent, that is an apt description of the way people approach it. The incentives really do matter here.

One of the things that has been quite interesting to look at when thinking about incentives and the assessment modality for health-related benefits is the research publication that was commissioned by the Department for Work and Pensions, which was published last month. That looked at the changing nature of channels and the impact that has on the likelihood of people claiming. We know that 80% of assessments were face to face prior to the pandemic. That has obviously reversed substantially.

The Chair: What are the actual figures now?

Dr Sean Phillips: That is a good question. This is based on a response to a Written Question in the Commons in June last year 2023, which revealed that 72.6% were remote (so phone and/or video); 7.7% were face to face; and 19.7% were paper-based. That is universal credit assessment modality for May/June 2023.[2] I can provide the committee with the pie chart that was produced in the publication, but that is on the record in *Hansard* as well.

The report I have cited which examines health assessment channels said: "A greater proportion of people claiming PIP (17%) said that the assessment being conducted in-person made them less likely to apply than those claiming ESA (10%) … Younger participants were most likely to say that having a face-to-face assessment would make them less likely to apply. About three in ten (31%) of those aged 18-24 (25%) … ".

So there is weighting and significance there, but there is also the nature of the assessment, in both the diagnostic criteria and the channel of the approach that people have.

Louise Murphy: I think it is true that there has been a big change in the method of assessment in recent years, but, as far as I know, there is no current evidence that the change in assessment method has made it easier to be awarded these benefits.

We did some research on this in the summer. We tried to get this information and ended up using FOI data from the department, because there was nothing publicly available. We were provided with data for PIP, the disability benefit, not for Universal Credit. We found that although remote assessments—largely phone-based assessments—are much more prevalent than face to face, that has had little effect on the award rate. Award rates are fairly constant over time, and just under half of claims for PIP, be it face to face or on the phone, end up being awarded.

The Chair: That is for PIP.

Louise Murphy: Yes.

[2] These figures relate to the proportion of Personal Independence Payment assessments which were conducted remotely.

Edward Davies: On the incentives, conditionality and things like that, we hear several things coming back from the organisations we work with. When you go into unemployment, you find yourself at the bottom of this V looking up. On one side, you have incapacity benefit, and on the other side you have work. You can lean into one or the other. The organisations we work with say that they look up at the work side a lot of the time and say, "Do you know what? This is poor-quality work. It's a bit more money, but it's not much, and I may or may not be in that job in six months' time. Looking up at the other side of incapacity benefit, if I get on to that I've got security".

They are making the rational decision—Louise used the word "rational"—that it is the lesser of two evils to lean in that way. It is about leaning in, more than doing anything particularly mischievous. They are saying, "There is something wrong with me. Maybe I've got a slight musculoskeletal problem or a mental health problem, but I'll lean into that rather than lean into the world of work"

Those incentives do make a difference, but what you do about it is a harder question.

Lord Griffiths of Fforestfach: Can I conclude from that that you are saying that the present incentives and structures in the benefit system are not a very good incentive for getting people back to work?

Edward Davies: By themselves, no, but the work itself is also not a good incentive for getting people back to work. The quality of work, particularly in poorer parts of the UK, is really not great.

Q50 **Lord Turnbull:** We have the distinction between LCW and LCWRA. The second, which is the more severe cases, seems to me to be basically writing people off: we give you a fit note, we give you some money, and we do nothing more about you at all.

My proposition is that DWP has entirely failed to see this crisis coming. It entirely failed to see that what is required is not what a management consultant will tell you to do, which is to go online, use the phone, use paper, cut down face to face because that is the most expensive.

DWP has promoted all these remote workings and reduced the number of face-to-face workings. It is beginning to tinker with a few trials here and there, but there is this fundamental view that if we cannot get you back into work quickly, we are not going to bother with you; we are just going to fund what is a kind of appeasement of this problem. Rather than tackling it, it is appeasing; it is just putting some money in, keeping people alive, and then saying, "We can't deal with it".

Somehow or other, someone has to take a whole-department view that getting out of work is not an exogenous variable; it is all part of why people are sick or why young people cannot get a job, or they look at one side of your V and cannot see anything worthwhile there and become despondent. That morphs into mental illness of various kinds. Yet interventions such as getting person to person with people who can

mentor, encourage, tell people not to lose hope are the bit that has been cut down. I think of the metaphor that you do not steer into a skid. DWP is doing precisely the thing that is making the whole thing worse.

Edward Davies: I absolutely take that point. First, conditionality has become a dirty word sometimes. People are worried that conditionality means asking terminally ill people to come in and prove that they are terminally ill. It does not. Job coaches really like conditionality, because it means that they can speak to people. They have people come in and talk to them, people who they might not have seen for a long time. We probably have good conditionality in unemployment, but we need a bit more conditionality in the inactive group as well so that they have the opportunity to come in.

It is not that we are being brutal to these people. There are hundreds of thousands of them who tell us that they want to work, and if they could get access to that help they would work. So saying, "Come in in three months' time and talk to me. We might have something that, even though you have a condition, you might be able to do", is one side of it.

The second side is that we have done a lot of work looking at how you get those relationships. The big thing we have come up with is devolving this away from DWP and getting it down into local communities. It is not more money; it is using money differently. It is sending it down into your local mayoralty, your local council, which knows the different organisations on the ground that can build those relationships; that knows, for example, that a local leisure centre has opened up in Scunthorpe that needs 12 new lifeguards, which is a week's training.

DWP does not know that, but the local bodies might. It might be a young mother who has lost her confidence, having spent three or four years out the labour market. What she might need is another young mother to go alongside her and say, "I did this. You'll be fine". It is very hard to do that from the DWP. So we would say: devolve that money. There is about £6 billion that could be devolved right down to local councils and be made a much more relational thing.

Lord Turnbull: Sean Phillips gave the figure of 7.7% of individuals getting face to face. That is a shockingly low number, I would have thought.

The Chair: Are you saying, Louise, that that 7.7% makes no impact?

Louise Murphy: I am not sure whether that figure is for universal credit or for personal independence payments.

The Chair: Which benefit is that related to? Is it personal independence benefit? Is it IIDB? Which is it?

Dr Sean Phillips: That is the UC work-capability assessment. It is the overall total, I believe. There may well have been a breakdown in *Hansard.*[3]

The Chair: We just need to be clear which benefit we are talking about. I just want to clarify in my own mind which one you are talking about, Louise.

Louise Murphy: For somebody on PIP, certainly a minority of the assessments are face to face. The vast majority are done online or on the phone. When it comes to the outcome of those assessments, they are very similar. So, when it comes to your chances of going through that assessment and that assessment ending up in a positive award, there is no evidence that it is easier or harder depending on the method.

Lord Davies of Brixton: How is it decided? The implication of what you said is that the two groups are similar, but the 7% face to face may be chosen for particular reasons that do not apply to the other 93%.

Louise Murphy: That is a good question. I do not think that there is much evidence of that, because the change largely resulted from the Covid pandemic when the vast majority of assessments were over the phone. It is not that all people with X conditions do them in person and that all people with Y conditions do them through other methods.

Q51 **Baroness Wolf of Dulwich:** This also follows up the argument that the mode of assessment is not critical. It came out clearly from the OBR's welfare trends analysis that a large part of the rise is not because of an increase in applications, but because of an increase in the approval rate. If it is not as simple as the mode of assessment, do you have any thoughts—maybe guesses—about the critical changes that mean that we are getting much higher approval rates?

Louise Murphy: It is something that we have looked into a little. The first thing we tested was whether there has been a change in approval rates for mental health versus physical health conditions, but actually the trends are fairly stable over time. There is a bit of a difference between the two, but it is not as though there has been a very striking change in recent years.

A few things stand out when it comes to the overall caseload and spend. One is that people are remaining on health-related benefits for longer. The best data we have is for PIP—personal independence payments. It is hard with universal credit because, over the past decade, we have had this move from ESA on to universal credit, but we can speak about personal independence payments and we know that a large number of people stay on them for multiple years. There is a very striking chart published by DWP showing that, every year, the proportion of people who stay on that benefit for multiple years is getting higher and higher. There seems to be something going on, as off-flow rates are decreasing.

Also relevant when it comes to increasing welfare spend rather than case load, we are seeing trends for an increase in benefit claims for some types of health conditions. For example, there is a big uptick among

[3] The figures cited in fact relate to the Personal Independence Payment (PIP). – Dr Sean Phillips

young people with some learning difficulties and learning disabilities. Those claimants tend to get quite high disability benefit awards, so they receive higher elements or basically a higher financial award. That means that, even if the overall number of claimants is the same, the overall welfare spend goes up.

Baroness Wolf of Dulwich: My question was really about approval rates, not about total spend. Are you also saying that certain types of claim are approved at a higher rate?

Louise Murphy: Exactly—the type of award they get is higher. When it comes to claim rates, it is worth distinguishing between disability benefits and incapacity benefits. It is true that among incapacity benefits, so largely universal credit, we are seeing a higher proportion of people in the LCWRA group, who are deemed too ill to work. That has increased significantly. A lot of the thinking is that that relates to the removal of the middle group (the LCW group), which means that more people are ending up in the LCWRA group.

On the flip side, we have not seen an increase in the approval rate for disability benefits like PIP, so it is worth bearing in mind that some trends for these two benefits look different.

Q52 **Baroness Liddell of Coatdyke:** That was very interesting. Is there a risk that some people might be gaming the system? They develop or promote a health condition that they know is going to get them better benefits? Is there any evidence of that?

Edward Davies: It is all shades of grey, really. As with almost any profession, individual or system in the world, you will have people who are absolutely white and white and people who are really not, and every shade in between. There is certainly some evidence, as we have talked about, of a rational leaning into a health condition or leaning into work. There is a slightly grey area in the middle. There are obviously some people who will nefariously try it, but it is important to say that they are probably a minority. We do not meet many of them, but they will try it.

What we do see though is people definitely claiming where the incentive is there. We spoke to a woman recently who had been helping her son, who has very severe ADHD. Someone said to her, "As a carer, you can claim £800 a month, because you are his carer and you give him his medicine". She had never even thought of that. She was a fairly well-off individual and, in her case, she was like, "I've been doing this for years and I don't need to claim", but if you were slightly less well off, you might lean into that and say, "Absolutely—£800 a month. I will take that for something I'm doing already". That does happen.

Q53 **Lord Blackwell:** Can I go into more detail on the fit note and that process? Maybe I will direct these questions first to Dr Phillips, because I know that Policy Exchange has done a lot of work on this.

As I understand it, the fit note is the entry point into all this. It is the thing that gets people into sickness benefits and then the further

evaluation, which have to be issued by a medical practitioner. To look at some of the data on this, we have seen that the number of fit notes has gone up, since 2015, from just over 200,000 to over 800,000. Almost 40% of those were for mental conditions. Dr Phillips, your report notes that, in 70% of cases, there was no diagnosis coding—in other words, the doctor did not specify the reason for the fit note—and that 70% of GPs felt that the patient's judgment had to be relied upon, so it was, in effect, a system of self-certification, because in a 10-minute interview they could not properly check it. Would you elaborate on whether you think the fit note is a valid check at the entry point?

Dr Sean Phillips: There were a few different points there. Lord Turnbull posed a question about responsibility and how much of this we lay at the door of DWP. The fit note is almost, as you say, the first entry point. It is more important in the discussion about individuals who are in-work. To be clear, the health-related assessment [for benefits] is done on behalf of DWP by functional assessors, who can use the fit note as medical evidence for the case, but they will be conducting the assessment on their own terms. It is not the case that there is a direct line between providing a fit note and this being [the sole piece of] evidence for health-related benefits, which is an important clarification.

The fit note is important both symbolically and in terms of the incentive. It speaks to the wider challenge that we are trying to grip. Policy Exchange's assessment was that the fit note is not fit for purpose. We came to that judgment after looking at what the fit note was meant to do when reforms were introduced in 2010. It was to change the system from: "Are you fit to work—yes or no?" to "What could you do with the right type of support? What reasonable adjustments could be made to assist you?"

In over 90% of cases, individuals today are signed off as not fit for work. In terms of [the] certification of fit notes, you are absolutely right: in over 90% of cases, it is a GP who certifies the fit note, but over the past three years we have expanded the range of professionals who are able to certify fit notes. There is consultation and consideration into whether that might be expanded further. A question for the future would be whether you would expand that, for instance, to paramedics and podiatrists on top of the physiotherapists and others who have been added.

We say that it is 'not fit for purpose', because in the vast majority of cases—over 90%—we are not directing people towardssupport or providing information that would support their return to work. The other challenge is the tension between what employers want, what individuals need; and – to some extent – what healthcare professionals do. From looking at the evidence, in 70% of cases no diagnostic is given on a fit note, so we are able to identify the condition for which someone has been signed-off in only 30% of cases. As we cite in the report, since 2015 there has been an increase of around 7% in specified diagnoses of mental or behavioural conditions on the fit note.

So there is a significant information gap, and employers will say, "Potentially we want to do more. We may be willing to buy occupational health services, but we don't have the information to support people effectively". Looking to the healthcare professionals, general practice is trying to funnel a lot into a 10-minute appointment. We had that discussion earlier: often we are not dealing with just a health diagnosis here; we are dealing with a very complicated set of social and occupational factors that will determine someone's fitness for work.

We have said that there is something about the importance of primary care in trust and the trusted relationship that people have e.g. with their GP, so taking the 'fit note' andsickness certification out of that setting altogether might not be the right step. To some extent, you do not necessarily want to change the mechanism before you change the supportive services behind it, but we should think about giving the healthcare professional who is doing the certification of sickness the ability to refer somebody to 'further' or 'ongoing assessment'. If the case is complicated, if there is a clear indication of mental ill-health, or if it is more to do with the vocational challenges, further assessment would be good. The employer could provide that through occupational health.

'Ongoing assessment' is another category that we thought it would be helpful to introduce. This is for individuals who are managing long-term conditions or conditions that may exacerbate over time. In effect, they know that they will have to return, come for repeat fit notes, et cetera. Can we find a different way of more effectively monitoring them over time?

As a mechanism that sits at the centre of this Venn diagram between employers, the welfare system and the individual, we think it is important to rethink it the fit note so that it achieves its original objective. We were supportive of the previous Government looking at that and thinking about what we could do to reform it, so we hope that that work is taken forward.

I caveat the specific discussion that we are having about the benefit system and welfare by saying that the fit note plays a small part and is often not the critical piece of evidence used to determine someone's eligibility for health-related benefits. The role of the functional assessor and the report that they provide to the Department for Work and Pensions is the key thing. We have not, for instance, referred to recent changes with the Health Assessment Advisory Service, which is now the range of providers who provide these functional assessment services for the department. That big change was rolled out in September and is a big change to consider.

Lord Blackwell: Just to clarify, if I am in work and fall sick, I can go to the doctor and get a fit note. If I am currently inactive, unemployed and on jobseeker's allowance or universal credit, and I want to claim sickness

Dr Sean Phillips: My colleagues will hopefully correct me if I get this wrong but, if you are already in receipt of benefits, that is not used as

evidence, or would form one part of the evidence base that a functional assessor was using.

Lord Blackwell: What follows that, as I understand it, is self-certification—filling in a questionnaire—which is then usually checked by phone, as we have discussed. This is potentially the only point at which a medical practitioner is involved. Is that correct?

Dr Sean Phillips: There are two stages, I suppose. You are absolutely right about those stages but, as I said, the key part that might be done over the phone or potentially by video or in person is done by a functional assessor. They too are a healthcare professional: a doctor, nurse or physiotherapist are just three of the professionals who do that work for a provider.

The Chair: Is this the assessor part?

Dr Sean Phillips: That is correct. On the key point that Louise made earlier, to some extent I am looking at these challenges through a health lens but, ultimately, the overarching approach that DWP takes is of a functional assessment. There is a health component, but it is not conducting a medical assessment to determine eligibility for benefits. The functional component is the key thing.

Lord Blackwell: In that functional assessment, the individual who wants to claim long-term sickness benefit fills in a form. As we have seen in the evidence, a lot of these claims are for mental illness—depression, anxiety, whatever. It has questions like, "Can you meet people without feeling anxious or scared? Can you cope with changes to your routine? Can you remember to do things and concentrate to finish them?" If people know what answer will get them off jobseeker's allowance or off conditional benefits on to sickness, it is pretty easy to know how to answer those questions. I just wonder whether any of you have really understood the effectiveness of the assessment of those mental health claims.

Edward Davies: This is anecdotal but very real: you can just go on TikTok and find influencers who tell you how to do this—to say the right words in order to get your benefits. On the point about whether there are nefarious actors in the system, yes there are, and you can literally search for them on TikTok. If you are allowed TikTok here, you can find people who will tell you which words to use to get through an assessment like this. I am not saying that it is widespread, but it absolutely happens.

Lord Blackwell: There are clearly people who, as everyone has said, genuinely need help and believe they have these conditions. If you put together the 10-minute fit note, which has been described as largely self-assessment, and then a self-assessment form, you would question whether there are effective checks on claimants' self-diagnosis.

Louise Murphy: Those are definitely valid points. The impact of social media is a big one; how people hear about things and how information is

shared have definitely changed. At the same time, there are still professionals whose job it is to go through those assessments. They speak to people every day and probably have a fairly good sense of whether someone is reading off an internet chatroom. The idea is that it is a fairly thorough conversation, although I am not saying that it is faultless. Those people's jobs are to probe people as much as possible and the conversation is free flowing. It is not a list of questions that people can prepare for and read off a script.

Lord Blackwell: You mentioned earlier that the move to telephone had not affected the approval rate for PIP. Do we have similar evidence for universal credit?

Louise Murphy: I am not aware of it. I am happy to check afterwards but, as I said, we had to access that PIP information via a freedom of information request, so I do not think it is widely available.

Lord Blackwell: You also said earlier that you had spoken to advisers about this. One of the advisers that a lot of people go to is Citizens Advice. At least historically, it has seen its mandate as ensuring that people understand the maximum benefits to which they are entitled and whether they are better off on benefits than in work. Have any of you spoken to Citizens Advice about how it is advising people on their benefits entitlement and whether they could apply for sickness benefits?

Louise Murphy: In the project that we did, we spoke to a range of advisers—some Citizens Advice, some independent charities or local authorities. The overwhelming sense was that advisers are often working with people, as you say, in trying to maximise their income. Often, that is through work but, sometimes, exactly on the point that Edward made, getting people disability or health-related benefits is a guaranteed way to get a secure income. Particularly if people come to them with debt or rent arrears, it is a rational thing to do.

The other point that came out very strongly, as I mentioned, was the impact of things like the benefit cap. Rising in-work conditionality meant that someone who might have a mental health condition or just lots of things going on in their life—maybe caring for children or elderly relatives, for example—often did not have a safe or stable feeling about the benefits system, and people often had to hunker down, as it were.

Q54 **Lord Davies of Brixton:** The term "online" is ambiguous to me. Does it mean online through Zoom or ticking boxes in a form online?

The Chair: Just to build on that very good question, for clarification, when the work capability assessment health professional is looking at this, what will they come to me as a claimant for? If I have to do something online, do I just click on it? Are they going to talk to me via Zoom? If I have neither of those, what is the telephone option? Just remind us, therefore, how many of these take place at all in person? Perhaps start with the final question and work from there.

Louise Murphy: I do not know the exact figures. I think we heard earlier that for a minority of claims for health-related benefits the assessment with an assessor is in person. In 2024, most are done on the telephone or through an online video call. A minority are purely paper-based applications, but, as far as I know, that is largely people who might be terminally ill or people who are migrating from previous benefits where there is lots of evidence. That would be if we can very clearly see that someone has a cancer diagnosis, for example, and we do not need to go through this assessment.

For the majority of people who do a phone assessment, that is a conversation with an assessor who is ranking them. They have quite strict criteria where they are given points based on different criteria. Some, for example, are whether you can walk unaided, whether you can leave the house—things like that. Based on conversations, they will ask that person about their life and the types of things they do, and the assessor will make a judgment on that. As Sean said, if that person has submitted other information like a fit note, that can be taken into account as well. I have tried to summarise it, but feel free to come in, Sean.

Dr Sean Phillips: I would not disagree with that at all. That is completely as I understand it. These functional assessors, who work for a provider on behalf of DWP, are there to conduct the assessment in person; they are the person who sits behind 'Attend Anywhere', the video conferencing software that is often used; and they are the ones who conduct the telephone assessments. It may vary a little bit by provider, but each assessment takes about 45 minutes. It is sometimes longer, but that is roughly the amount of time that they are taking.

Often, although again not always, it will depend on the provider, but these functional assessors will have a target for the number of assessments that they will conduct by the day. I understand that for one of the providers that is six per day.

Lord Layard: If somebody is found to have given a dishonest answer, what are the penalties?

Louise Murphy: I do not know in detail. I would say that the most basic thing—

Lord Layard: We obviously have statistics on people whose application is refused, and statistics on people's sanctions, and so on. We certainly have statistics on people who are sued or prosecuted for benefit fraud. What are the categories of benefit fraud, and do they include things like answering these questions dishonestly?

Louise Murphy: That distinction between someone saying something and the assessor disagreeing is probably much more common—when the assessor just says, "Given what you've said, I take a different approach and I think you are fit for work". That will be much more common. It is probably a fine line between overt dishonesty and people just feeling a certain way, and the assessor feeling a different way. I am sure there are

some cases where someone has been overtly dishonest and actively given incorrect information. I have not seen up-to-date statistics, so I could not give you an idea of how big or small that is.

The Chair: I am still grappling with this as a layman; I am obviously not a medical practitioner. Picking up on Lord Layard's point, let say you are suffering from a slipped disc—many of us in this room have suffered from a slipped disc, me included—and you are literally unable to move, how do you know just how bad that disability might be if you are not doing the assessment face to face? You have been talking to practitioners in this field. How do they do this? Certainly, how do you know that this paper-based submission is factually correct? I just do not see how it is possible. Maybe someone could enlighten me.

Edward Davies: I suppose it is a bit like the tax system: it relies on honesty, to a degree. For most people, it works fairly well for some of that stuff, but there will be an element of that.

On the question of whether it has made a fundamental difference, I have not seen evidence that going online has made a huge difference, but what Sean was saying is interesting: that some people are less likely to push their luck face to face but that, at the same time, the assessors are apparently more likely to take sympathy on someone face to face. So there may be a bit of a push-pull that means that you end up with the same thing.

Q55 **The Chair:** Right. Good point. I should know this, but I think I read somewhere that there are several private providers of the assessment. Correct? Do we have data showing how many assessments they are each making, and the difference in outcome of the assessments? I just want to see whether there is any divergence between the provision in these services. Have you seen anything like that?

Dr Sean Phillips: I have not. Under the current configuration of the Health Assessment Advisory Service, by and large we have four providers who cover a particular geography across the country, which is effectively where they have won the contract. That service in its current form only began on 7 September, so it is very days to have a slightly longer-term longitudinal assessment of it. Even if it had been in place for five or ten years, it might still require a freedom of information request. I do not know whether that information will come forward for us to be able to make a comparison.

Lord Griffiths of Fforestfach: If they have responsibility for a certain area, is there competition between them within that area, or do they have exclusive rights in that area?

Dr Sean Phillips: My understanding is that they have won the contract for a period to be the exclusive provider in that particular geography.

The Chair: Are there any KPIs or incentives for them in that contract?

Dr Sean Phillips: I am afraid I have no line of sight on the details of any of the contracts and expected outcomes, for instance.

Q56 **Baroness Wolf of Dulwich:** This is on another point of information that has probably been made clear and I have missed it. In the past, you got reassessed on things like this. My impression is that with long-term benefit now, reassessment is quite rare. Is that correct?

Louise Murphy: During the Covid pandemic, it certainly became rarer, because the system was under pressure, so we saw reassessments decrease. It is certainly not clear to an outsider exactly how often they are happening or when it is expected that they will get back to pre-pandemic levels of reassessment. In theory, at the time of the assessment, what people will be told depends on the health condition. The assessment might be, "We don't expect this to change for a long time, so you won't have a reassessment for many years", or, "In six months, or a year, you're expected to have a reassessment". That should still be happening, but the issue is that the system is under pressure.

Lord Londesborough: So there is no set timetable for reassessment.

Louise Murphy: Exactly. Not everyone will have a reassessment at the same frequency.

The Chair: The DWP, from May 2021, started to issue reminders that their fit note evidence was due to expire, so they had to get some reassessment. Is that correct?

Louise Murphy: I believe that they have started doing exactly that, but I do not know the exact frequency of the reassessments.

Edward Davies: Anecdotally, the capacity of the system is very low at the moment. You find people who, even though they will be reassessed in theory, are sometimes waiting years for that reassessment.

Baroness Wolf of Dulwich: That is my impression too.

Lord Londesborough: Is there no reliable data on how many people are reassessed and with what frequency? Is that a total void?

Louise Murphy: That is an issue with the universal credit data. We had much better data under ESA, the previous legacy benefit, whereas we are very limited now.

Baroness Liddell of Coatdyke: As this conversation has gone the distance, it caused me to remember that in the late 1990s—I do not know whether this was an exclusively Scottish thing—a work space was created by local authorities and jobcentres to cope with young people who claimed they had disabilities or were out of work. It was for their personal development and it worked very well, but I suspect it would be unbelievably expensive to do that over time. Are there any experimental programmes going on to see if there is a way of moving forward with this?

Louise Murphy: There definitely are. Something that looks promising for young people is DWP youth hubs. As Edward said, they can vary quite a lot between different areas, because the need in London looks different to somewhere very rural, for example. The evidence so far is that they can be very effective because, put simply, young people are much more likely to want to go to these places than to a jobcentre. That came out loud and clear from the work that we have done.

A second thing that is important when you think about young people, which we have not spoken about, is education and qualifications. Four out of five young people aged 18 to 24 who are not working due to ill health do not have a qualification above GCSE level, so they are doubly disadvantaged when it comes to getting into work. Not only do they have some health condition that might prevent them working but, even if that health condition improves, they are still very disadvantaged in getting a good-quality job, because they have low levels of qualifications. These sorts of schemes that might help people get an apprenticeship, for example, or on to a college course seem like they will be much more effective than off-the-shelf jobcentre support.

The Chair: Before we move on to the next question, can I clarify one point? Sean, I think your paper cited how physiotherapists certify only 0.7% of all fit notes and are less likely to sign "not fit for work"—only 70% of cases. My question is not so much about outcome; it is more about the efficiency of the process. Is it a good idea to extend the number of people who can issue fit notes and the assessment, so that more people are involved in this process? Fit notes would not be purely on GPs and assessments would be done by a wider number. What is your view on that?

Dr Sean Phillips: If we think about the changes that are occurring more broadly in primary care and specifically in general practice, we see that there is more multidisciplinary working and evolution of people's roles in that context. There is support, if we look at consultation responses to that expansion. I support that – in principle, let us say for the case load of individuals with musculoskeletal conditions – for whom a physiotherapist would often be the best-placed person in a practice to conduct the assessment, offer advice, think about the next steps for treatment, if appropriate.

The key thing in the evidence that you are citing from Policy Exchange's report is that, in the vast majority of cases—over 90%—it is still the general practitioner who is certifying the fit note. The smaller proportions of other health professionals conducting the assessment, interestingly, are difficult to extrapolate, because they are such small numbers. Where a physiotherapist is doing the assessment, for instance, they are more often using options that think about types of adjustments and support that someone might need to help them remain in work. If the evidence supported the fact these professionals were using this tool in a different way, that would be a good thing, but it must be caveated by the fact that

very small numbers have a limited time to make that assessment. We will have to see, but I am not against it in principle.

Q57 **Baroness Wolf of Dulwich:** I will come back to the structure of the benefits system. We have heard from your earlier answers that, for many people, it is really very rational to go on to long-term benefit. The problem is that the longer you are on, the less likely you are to come off and that being out of work is bad for people. I am also aware of the clear evidence that there are real changes in the health of the nation but, if we were focusing just on how to increase the number of people who go back to work, what would be your two proposals to change the benefit system such that, in a concrete and doable way, it reduced the rationality of staying on long-term benefit for ever and got more people back on that work route?

Edward Davies: I would think about a couple of things. I briefly alluded to the first earlier. We have done a big piece of work looking at the devolution of employment support and lifelong learning. We looked at international examples where it seems to work much better. Holland has had about three times the success rate we have had in getting the inactive into work.

Baroness Wolf of Dulwich: My question is: how much would it cost?

Edward Davies: It would cost nothing. It would take the existing money administered by DWP and put it right down close to the ground, so it is a much more relational thing.

On your point about people taking rational decisions to go on to incapacity benefit, it is not necessarily that they want to be there; it just offers security. There are lots of people doing that who do not want to be there, but they do not have the support to get out of it. We would put the support right down at a local level and say, "Okay, you're on incapacity benefit, but what can you do, where can we support you and what do you need?" This personal support does exist and there are things out there already, but it is not well targeted and it is very broad. We would say to offer that at a local level and make it very relational.

The Dutch have done this very well and Norway has a very relational model of worker. They are given a lot of freedom to go right across everywhere; rather than being siloed into different departments, you have one person who looks at you in the whole and says, "What are your issues?" Maybe it is an addiction or maybe you are a victim of domestic abuse. There may be lots of different factors, but they can negotiate the local landscape much better for you. By doing that, you would get a much more tailored approach to getting people who are on incapacity benefit back into work.

The golden thing is that people do not drop out of work in the first place. There is something about the occupational therapy side of this—the people who are in work and at risk of dropping out. Big businesses have already seen the benefit of doing this; they have huge occupational

therapy departments. If you have a mental or physical health problem—whatever it may be—you can go to them quite early. In fact, even my own small organisation has an online GP, whom I can get in contact with whenever I want. It is a privately provided thing. Can the state replicate that to keep people in work? Would that be a bigger win?

Fit for Work—I may have got the name wrong—sort of did this in the past, but the take-up rates were terrible because people did not know about it. We did some surveying on it and found that only 16% of employers had ever heard of it. So, if you are going to do this, make sure that people use it, because you cannot just have this white elephant. Those are my two areas.

Baroness Wolf of Dulwich: What would your two suggested changes be?

Louise Murphy: I will stick to the benefits system. The first is working to remove this cliff edge, so that we derisk movements into work. To me, the fundamental issue is that people, rationally, will be thinking, "Even if I will perhaps be better off in the long term if I find a higher-paying job, I immediately risk losing £400 a month". For people on low incomes who are likely to be in receipt of benefits, that will be at the front of their minds.

There are ways you can do that. Either you can move to a slightly more gradated system, so that, rather than it being zero or £400, there are levels depending on whether you are able to do part-time work, full-time work and so on. Or you just increase the level of benefits for everyone slightly to make the overall level of benefits seem a bit more generous, but significantly decrease the amount for people who are out of work due to ill health. There are pros and cons, but I certainly think that there are ways to remove the all-or-nothing scenario.

Relatedly, the second is thinking hard about how we can incentivise people to do part-time work, which has basically been the opposite of the way that universal credit has been thinking over the past decade. Its aim has been to encourage people to work and to increase their hours, which may have made sense if we thought that the group we were looking at were people without health conditions or caring responsibilities. There is a tension for people who are capable of doing a full-time job, because we want them to be doing that, but we certainly need to think about the system as a whole and recognise that, for many people, a full-time, nine-to-five job is probably not possible. Certainly, with our ageing population and the rising state pension age, there will be lots of people aged 60 and above in receipt of universal credit; we should think about how we can encourage them to do some work without them feeling pressured into doing a full-time job.

Dr Sean Phillips: I have a couple of things to highlight. It is about having a more cohort-based and nuanced approach. We talked about young people who may have just come out of an apprenticeship or higher education and then become dependent on welfare. Could we look, for

instance, at the approach that they took from the late 2000s in Sweden? They developed a concept called a rehabilitation chain, where you basically front-load support and rehabilitation for someone at quite an early stage. To some extent, a lot of that is exactly as has just been said: if that could be devolved and tailored appropriately, it would be beneficial. That is definitely one thing to think about and is, in effect, setting out a new timeline, but of course that would not be appropriate for all cases. There are instances where reassessing will not be effective, but I think that more constant relationship-based approach would be effective.

There is an example from Finland, which might be something to think about in terms of the cliff edge that Louise has talked about. They have something called the rehabilitation supplement. In that period when claimants would be on the rehabilitation chain that I just talked about, there is an uplift for a set period of time that takes you above the incentive to remain on welfare. That is something to think about, notwithstanding the already quite pressing fiscal challenges that we have in this space.

I just encourage us to make sure that we step back in this discussion and think about the long-term approach and the challenge of the relationship between employment and health. More broadly, the previous Government were looking at tax incentives on occupational health. There is a lot that we could do in that space. For instance, at Policy Exchange, we encourage the development of an annual allowance; in effect, you take the £500 cap that we have on medical treatments and increase it substantially. We suggested £2,500 per employee. In thinking about incentives, we know, exactly as Edward was saying, that the big employers already either provide these services or have the ability to do it, but the things that enable small and medium-sized enterprises to do this are key, precisely because people managing more conditions in work will be a feature moving forward. Let us make sure that we really look at this in the round.

Q58 **The Chair:** I am hearing that there is no silver bullet here, at all. One could take a multifaceted approach to those who are currently inactive or are in the category of claiming long-term sickness benefit, in some shape or form, and put your arguments together. First, we should rapidly increase the number of face-to-face assessments. Secondly, we should introduce more conditionality. Thirdly, therefore, we should try to identify those who are really needing help for a number of different reasons and give them, as Ed was saying, some tailored support in the round.

Similarly, I think the Cameron Government took the troubled families approach of multiple agencies through one individual, so you would have access to multiple agencies through one point of contact and would not have to know how to navigate a complex system. As a number of my colleagues were saying earlier, that has the attraction of weeding out those who are potentially defrauding the system and focusing your efforts much more on those who really need help. Does that sound like the sort of approach that one should be looking at here?

Edward Davies: Broadly, yes—I would take a lot of that.

The Chair: What are the pitfalls?

Edward Davies: I agree with further conditionality and encouraging people to get in touch. I am trying to think through the three. More face-to-face contact would be helpful, conditionality would be helpful and tailored support would be helpful. You mentioned troubled families; I think it is called strengthening families now. It was a great idea, but not a great name and not something that people necessarily want to be part of, but that sort of principle was in a lot of areas early in the Cameron Government.

Something that we have worked on a lot over the years is the concept of universal support. When universal credit was first designed, it was in essence supposed to be a quite boring mechanism by which benefits were administrated, but it was meant to go hand in hand with universal support and there was meant to be that human side of it. Over the years, that human side has been underestimated and lost. The last Government, in the last months of governing, put some money into something called universal support, which was a fairly small-scale, slightly watered-down version of it, but there is an acceptance now that that side of it is really important and that people respond to people.

Q59 **Baroness Wolf of Dulwich:** None of you has mentioned the way that we assess benefits. We have capability for work which, as colleagues have noted, is to a large extent a report on how you are experiencing life. This is not universal; other countries are much more directly health oriented. Do you feel that this is an appropriate approach and the right way to go?

Louise Murphy: It is a good question, and reasonable people can disagree, but, as you say, other countries have gone in a different direction. If we think about it from the philosophical sense, there is a merit to it in that, actually, plenty of people with a given health condition can work and want to work. They would say that it is not whether they have been diagnosed with a condition that is important, but how the condition affects them.

The rationale for this approach is coherent, but what we can do better at and what I think is more important than having more face-to-face assessments is making sure that we follow through with that functional assessment. At the moment, an assessor could say, "This person is going to really struggle with work"—because of whatever it is—"and their health condition means that using a computer would be very difficult, but, with a bit of assistance, maybe some technology on their computer, that might be easier".

That information goes absolutely nowhere. This is a point that Citizens Advice and others have made. There is so much information gathered in those assessments that, in an ideal world, would be used to help people find suitable work. It could get passed back to a job coach who would

say, "We've got someone here who might struggle with the job that they used to do but could do a different job with an understanding manager". That is the bit that really could be improved, making sure that all and any information that is gathered at those assessments is then used to help people find the work that is appropriate for them.

Q60 **Lord Londesborough:** Can we turn to the Government's targets, specifically their mission to increase the activity rate from 75% to 80%? This is not just the long-term sick; we are talking about getting 2 million people out of welfare and into work. It feels like a top-down number. Do we have a precedent for it in recent UK history? Can you point to any other country in the G7 or indeed the G20—you mentioned the Netherlands—that has achieved this sort of increase in activity in recent times? I am interested overall in whether you think that target is credible and what timeframe would be required to achieve it.

Edward Davies: It is definitely punchy. It is a big ask. When we heard 80%, we raised eyebrows: can you do it? But part of the reason that we focused on the Netherlands is that it has done it. Its participation rate, which is the employed and the unemployed but looking for work, is 85% and they are over 80% employed.

Lord Londesborough: Has it improved by five percentage points in the Netherlands?

Edward Davies: It has improved by a lot more than that. I will check the numbers. It was 80% in 2013 and is now over 85%, so it has improved by five percentage points over the last 11 years, by my maths. So there is precedent for it and it can be done. It is different and context is important. It is a different country; it is a smaller country. There is a difference of social contract there, so there are slightly tangible elements. But, at the very least—statistically—it is worth taking a good look at.

Louise Murphy: I agree that it is ambitious, but I do not think it is unrealistic when you look at other countries. There are a few caveats. Before we get there, we need to be confident in what our current employment rate is. At the moment, we can laugh and raise our eyebrows, but our employment rate could be quite a lot nearer 80% than we think it is now if the LFS's estimates are wrong. The department should focus energies on that, because it will be genuinely important in working out how big a change this will be.

The other thing to bear in mind is that, obviously, a portion of those people who are not working will be in receipt of benefits, as either unemployed or long-term sick. But as a country, we should be aware that a good chunk of those people will be economically inactive for reasons that we as a society tend to think of as good things: being in full-time education; people slightly under the state pension age taking retirement; and people looking after young children or sick and elderly relatives. We can have a discussion if we want to encourage more of those people to work rather than study, for example, but that is an open question. People

will disagree about it. There are certainly reasons why we would not want to totally disincentivise all those forms of economic inactivity.

Dr Sean Phillips: I do not have anything in particular to add, as I do not bring any particular expertise on the feasibility of reaching the target. Of all the levers the Government will look to pull to achieve that target, I hope that there is a sustained focus on the issues we are looking at, because there is an opportunity to shift the dial on trying to get people with disability into gainful employment—that is, employment that works for them. We should not miss that opportunity. We should really make sure that we grip this challenge of ill health too.

Q61 **Lord Londesborough:** Can I quickly throw in a supplementary question? We have not heard much about the employers, in particular those in the private sector. Taking the 2 million shift, if my maths are correct, the private sector will have to shoulder about 1.5 million new roles or take 1.5 million people off the inactive list into employment. For many regions, that will mean SMEs, which do not have a lot of experience. If you talk to employers there, they will point especially at the employment laws and say, "If we give people full-time employment rights from day one, it handicaps our ability to bring in, for a trial or on probation, people from difficult circumstances—those who have suffered from sickness or those from socioeconomically unprivileged areas".

I know that you at Policy Exchange have come up with *None of Our Business?*, which is a very interesting report. It strikes me that there is a huge amount of work to be done here at the micro level, in terms of getting SMEs in particular to engage with this challenge; in some cases, they may need to be incentivised to do so. Is that a fair comment?

Dr Sean Phillips: It absolutely is a fair comment. The previous Government established a task force on occupational health, which Dame Carol Black was chairing. There is a question mark over where we got to with that work—it was due to report around the time of the general election—but there was a clear recognition that, if you want to shift the dial on this question of occupational health provision, the rate-limiting factors were in raising understanding,andawareness and incentivising SMEs in particular to do this.

One of the observations that Policy Exchange made in the report you cited, *None of Our Business?*, is that we are making it very difficult for SMEs at the moment because we have initiative-itis. The Government do all kinds of well-meaning things: "Here are the things on mental health specifically; here's a pilot taking place in this local authority, which does these interesting things". We are not very good at bringing it together; we are certainly not very good at putting useful information in the places that make sense for SMEs: what "good" looks like and what good value for money is going to be.

Here are some of the things that we started to suggest in our report: can we start thinking about how to put high-quality information in a single place, such as a governmental "health in work" portal? Can we start

putting out information around what works for employers in this area through for example, local chambers of commerce? Can we think about the ways in which those employers already engage with the state and where the places that make the most sense are, rather than presuming that, just because we know this to be an important agenda they ought to grip, they can do it? That is the key thing.

Knowing what good-quality occupational health looks like too is a big challenge for that sector in terms of being able to scale it. On value for money, we see all kinds of workplace wellness schemes and things like that. Some of those things are clinically effective but some are not going to be appropriate.

Lord Davies of Brixton: I want to throw Sure Start into the mix, particularly as you have mentioned the issue of increasingly poor health among young adults. One of the knock-on effects of Sure Start was providing support for people in that age group.

Edward Davies: Yes. We recently did some work on this, looking at family hubs. I urge the new Government not to do what the previous Government did and scrap the thing that went before. What family hubs have largely done is build on the remnants of Sure Start. There is a real risk of the new Government coming in and saying, "We want Sure Start back", and getting rid of family hubs so that, five years later, there are one or two Sure Starts open. Family hubs are slightly different. They are geared more towards the long length of life but there is £300 million in them now, through Start for Life; that is absolutely something to build on. They are well focused on areas of deprivation, too.

Q62 **Baroness Liddell of Coatdyke:** I am interested in regional differences around how long-term sickness is dealt with and how you get to outcomes. I found the *Labour Market Outlook* report for Q1 2024 from the Resolution Foundation. What really caught my attention was the dramatic change in places such as Tees Valley and Glasgow. I know Glasgow very well. The real reason why there has been a change there is that we have moved from iron, steel and shipbuilding to a service environment, and a service environment is much more pleasant for people to work in. It might not be quite as exciting but, if you look at the skyline in Glasgow, you see every bank in the world represented there.

Looking at the regions, how do we analyse on a regional basis how to get people involved in the workplace? Coming from the west of Scotland, I am very conscious that lots of people have inherited lung conditions, for example. If you can manage to move people into employment at a more localised basis, it should build up the way, but it is about getting people there who are able to give this kind of advice. I note what you said about Scandinavia and some of the interesting things going on in Finland and Sweden. Are there any examples there of what we can do to get the long-term sick into employment?

Louise Murphy: Rates of economic inactivity due to sickness and of benefit receipt vary hugely across the UK. We should always have that

clear in our minds because, obviously, it is important when it comes to policy solutions. Related to what Edward just said, it is important because, if we are thinking about regional or local responses, we can think about what employers there are in that area and whether they are well equipped to take these people on board. Lots of businesses are not used to employing people with health conditions, which often fluctuate. Realistically, particularly for some mental health conditions, people might have better periods then periods of sickness. We need to think about whether employers are ready to take on those people. If we do that at a local level, it will be easier, I hope, because we will know who the big employers are, be it in the private sector or the public sector.

The only other thing to add is that it is quite interesting that, when you look at trends among young people who are out of work due to ill health, you see that the geographical picture is quite different. The historical picture is that there is a clear trend, with more deprived areas—historically, the west of Scotland, Merseyside and parts of the north of England—having high rates of economic inactivity, going back to the post-industrial period. Actually, among young people, there is little difference between more deprived areas and less deprived ones.

In fact, the biggest difference is between large cities and smaller settlement types—that is, small towns and villages. This largely reflects the different make-ups of those places: young people with high levels of education, who are graduates in high-paying jobs, tend to be concentrated in cities, while the most vulnerable young people are those in small towns and villages, who often have low levels of education and do not really have access to graduate jobs. They are often disadvantaged by poor health and poor education. So, again, it is useful to look at geography, but look at geography and age as well.

Lord Davies of Brixton: We got a brief from the NHS Confederation earlier today. A particular sentence leapt out at me; I would be grateful for your comments. It said, "Social and environmental determinants are often more important to health outcomes than clinical or behavioural factors, such as diet and exercise". Is this reflected in your work? Is it about where you live?

Edward Davies: Absolutely—100%. Let me point you towards two world-leading, landmark publications from the last few years. You may have come across *Deaths of Despair* by Angus Deaton, who won a Nobel prize in economics in 2015. It looks at the collapse of social relationships as a massive factor in the declining health of America.

You may also know about the Harvard Study of Adult Development. Last year, Robert Waldinger wrote his book, *The Good Life*. After 80 years of longitudinal research, the fundamental finding from the study is that your happiness and health in life fundamentally depend on the quality of your close relationships. That is very underestimated in all this. It is why, when we look at employment support—certainly at the CSJ—we always look to that relational factor. If you do not have relationships, everything

else goes wrong. In what we see, that determinant of health, as a social/environmental factor, is all about relationships.

Even when we talk to small charities working in areas such as addiction or working with ex-offenders, first and foremost in every single one is a trusted relationship. It is the first thing you see. It will be the same working to get people into employment.

Q63 **The Chair:** Can I ask you about statistics, picking up on Baroness Liddell's point? Do you think we should redefine how we think about the unemployed? Do you think that the figures that came out today are not helping address the problem we face here? The Centre for Cities' work says that there is a hidden unemployment rate of 12.7%, not 3.7%, for example. Should we be thinking about the unemployed differently? Obviously, from some perspectives, the unemployed will be those who choose not to work, for perfectly understandable reasons, while others cannot work because they have been thrown out of a job, but, within this group, there are people who say that they cannot work—obviously, many of them cannot—because they have become disabled or they suffer from mental ill-health. Should we just redefine the definition of unemployment here?

Edward Davies: There is a strong leaning towards a deficit-focused assessment—that is, looking at what a person cannot do then ruling things out. There absolutely could be a better focus on what a person can do, with a push into that. I do not know whether that would lead to a completely different definition; it is a slightly intangible but really important difference.

The Chair: It may just be a case of moving deckchairs around on the "Titanic", but would this help us in terms of policy-making?

Louise Murphy: The measure of unemployment is useful because it tells us how many people are out of work and actively looking for work; I do not think we should do away with that core economic concept. You are right that, for policy-making, it is useful to think a bit more widely about people who are out of work. At the moment, we have this "economically inactive" group, but that is perhaps not the most helpful term because it includes students, for example.

The Chair: Should we redefine "economically inactive"?

Louise Murphy: The overall grouping does not need to be redefined—perhaps just for policy measures or for policymakers, they need to have a clear sense of the groups they are interested in. To me, being careful about language seems more important than creating new definitions. The definitions that we have are good and fine; it is just that we often use them interchangeably or a bit misleadingly.

Lord Turnbull: I have a quick question. On a statistical note, are we still defining the workforce as those aged between 19 and 64? More realistically, the workforce is 22 to 67. So, for all these figures, such as the activity rate—

Lord Razzall: Ignoring all the people sitting round this table.

Lord Turnbull: Are we still using this old definition of working life?

Louise Murphy: Often, the core ONS statistics look at either 16 to 64 year-olds or people aged 16 and above. It is a good question. The 16-to-64 cut-off is useful sometimes because the rising state pension age means that trends can be a bit hard to interpret because the impact of the policy change is showing up.

Q64 **Lord Layard:** Could we come on to international comparisons? We know that the inactivity we have experienced since Covid has been different from that in almost any other country, in the sense that there has not been here the recovery that there was elsewhere. What is your take on why that is the case?

I know that some people think it is to do with the health service. John Burn-Murdoch had an interesting graph answering the question, "Do you have access to the medical healthcare you need?" The answer "no" has shot up in Britain; it has gone up much less in other countries. What is your take on our different experience since Covid?

Edward Davies: Clearly, there are pressures on the NHS model that have come about as a result of Covid; we see ourselves experiencing them worse than some other countries. I do not know that that necessarily translates into what we are seeing in economic inactivity, because it tends to be for older people—beyond that 16-to-64 group—looking for elective surgery. It is definitely a differentiator between other countries, but it is not necessarily the root of the problems we are seeing.

More broadly, this is one of those debates where it is easy to say, "How do we reform the NHS? Do we look at X country or Y country? Everyone talks about America. Can we do it like France? We need a social insurance system". I must say, I have not seen anything compelling that says that the system is the problem. It is about making the system work. Different countries have different outcomes and different ways of doing it. I am yet to see anything that shows absolutely categorically that, if we just did it like America or the Netherlands, it would be that much better.

Dr Sean Phillips: The evidence that the OBR gave last week showed that it is difficult to know exactly what the weighting of these factors is, but the burden of ill health in society—in terms of its changing nature, with more multiple conditions and comorbidities, and how it will change over time—is significant. Of course, it also impacts the way in which we deliver services. It is not necessarily a reflection of the way we fund the National Health Service; it is about the way in which we provide services. How that differs in other comparator countries is interesting.

We have focused on the dynamics and function of the benefits system. Some of the comparators that we have looked at have not seen the same gradient in the rise in health-related benefits—notwithstanding all the complexities of directly comparing them. Then there are the wider structural changes in the economy which colleagues at the OBR, for

instance, were far better at weighing up [the significance of]. It is in the blend of those factors—but the weighting is the difficult thing for us. I am unhelpfully not providing you with a clear answer.

Louise Murphy: I do not have much to add other than that I do not think anyone has a definitive answer to this. I just think that we should all be trying harder. The Government should be trying to do this. We should be trying as hard as we can to fund academic research on this because it feels like such an important question that we do not fully understand.

The other thing is that comparisons of employment rates and economic inactivity rates are difficult with our statistics, but it is clear that what is happening in our welfare system is not showing up in other welfare systems. We do not really know why.

Q65 **Lord Layard:** I want to throw out a question. The witnesses could send us the information. Do we have any information on what fraction of the people who are long-term sick are being treated for their condition? This is a very understudied question. If you could send us any information, that would be extremely valuable, but one of the most obvious ways to reduce inactivity is to reduce long-term sickness.

The Chair: I was struck by the table in your report, Sean, on the 20 local authorities with the highest proportion of WCA caseloads. It lists Hartlepool, Blackpool, Inverclyde and so on. Picking up on Lord Layard's point, let me pose his question to you. Given what those WCA caseloads must be showing in terms of, say, mental or musculoskeletal sickness, one would expect to see a large explosion of demand for NHS support in those trusts, but is the data backing that up? Has it been seen that this is all feeding through into the NHS?

Dr Sean Phillips: One thing that is critical and that we have not really touched on it today—is the join-up between the various relevant datasets. For instance, if you go to your GP, the likelihood is that, if there is any detailed occupational information on your GP record about what you do for work and how that might impact your overall health, it is going to be down to what has been recorded previously. That line of sight—the link between employment and the NHS—is often quite weak. Here, in terms of the commissioning of health services, we would look to the role of integrated care systems; over that wider geographic footprint, they will have a clearer line of sight in providing key services.

The Chair: What my brain is struggling with is why, when it looked into inactivity two reports ago, the OBR came to the conclusion that reducing NHS waiting lists would not have an enormous impact on inactivity. It makes me wonder who is treating all these people who say that they have musculoskeletal problems. Where are they?

Dr Sean Phillips: A lot of people will be in pain and trying to work through it. They will be falling in and out.

The Chair: How come they are not on the waiting list?

Dr Sean Phillips: For instance, they may be managing back pain rather than requiring a knee replacement. Part of that is down to what we record on the waiting list.[4] Often, we refer there for elective treatment—that is, planned treatment; the traditional things are cataract surgery, knee and hip replacements, and so on—but what people need is potentially provided much more locally. MSK solutions are part of this.

The Chair: I am sorry for being slow here. What I am saying is, if they are not on the waiting list, they are not electing for treatment. They are just sitting at home—that is what you are saying—taking medication, such as painkillers, to try to overcome the problem. As Lord Layard said, the question is: is that what is happening?

Dr Sean Phillips: That will be one of the factors. It would be helpful to provide more quantification of that for you but, yes, there will be people who do not have a clear diagnosis and a clear treatment pathway. They will instead need to manage pain effectively. That is where the conversation is, in terms of thinking about different types of service provision. What is the role of the leisure sector? How do we rethink these services in primary care in a different way? Those things are quite an important part of the conversation here.

The Chair: We have no further questions. We have taken up a lot of your time. Thank you very much for all your comprehensive answers. I know that I speak on behalf of the entire committee when I say that we are very grateful. That was a great session.

[4] https://www.gov.uk/government/publications/health-assessment-channels-research