HOUSE OF LORDS
Economic Affairs Committee

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The Rt Hon Liz Kendall MP
Secretary of State for Work and Pensions
Department for Work and Pensions
(By e-mail)

20 January 2025

Dear Secretary of State

1. Spending on incapacity and disability benefits has risen by more than 40 per cent in real terms since 2013 and now stands at £64.7 billion.[1] This is around 20 per cent higher than the UK defence budget and equal to 22 per cent of the total health budget.[2] Spending on incapacity and disability benefits is forecast to rise to £100.7 billion (or 3 per cent of GDP) by 2029–30, pushing the total welfare bill above £370 billion.[3] The latest figures show that around 3.7 million people of working age receive the health component of Universal Credit (or its predecessor, Employment and Support Allowance), 1.2 million more than in February 2020.[4] As the Office for Budget Responsibility note, since before the COVID pandemic this rise has been uniform across age groups.[5] This is in the context of there being 1.51 million people registered as unemployed.[6]

2. The House of Lords Economic Affairs Committee has conducted a short inquiry to understand what is driving this. We took evidence from the Minister for Employment; the Office for Budget Responsibility; the Bank of England; and several academics and policy analysts. This evidence can be found on the Committee's website.[7]

3. This letter sets out why urgent action is needed to address the rising social and financial cost of the health-related benefits system, and what needs to be done. Given we received

[1] Figures based on OBR, *Welfare Trends Report* (11 June 2015), Table 2.6 (carers/attendance allowances are added to incapacity and disability benefits to align with 2023/2024 figures) and OBR, *Economic and fiscal outlook* (30 October 2024), Table 5.10. Figures are adjusted using annual GDP deflators – see HMT, *GDP deflators at market prices, and money GDP December 2024 (Quarterly National Accounts)* (8 January 2025)
[2] Defence spending totalled £53.9 billion in 2023/24. See House of Commons Library, *UK defence spending*, Research Briefing Number 8175 (4 December 2024). Health spending totalled £221 billion; see House of Commons Library, *Public spending: a brief introduction*, Research Briefing Number 08046 (3 September 2024).
[3] OBR, *Economic and fiscal outlook* (30 October 2024), Table 5.10. When we refer to health-related benefits, we mean the Personal Independence Payment (and its predecessor, the Disability Living Allowance) and the two categories of health-related Universal Credit, LCW and LCWRA (as well as their predecessor, the Employment and Support Allowance). Where necessary, we refer explicitly to the specific benefit under discussion.
[4] DWP, Stat-Xplore
[5] OBR, *Welfare Trends Report* (10 October 2024), Box 3.1
[6] ONS, Labour Force Survey: Summary of labour market statistics (17 December 2024)
[7] House of Lords Economic Affairs Committee

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no convincing evidence that the main driver of the rise in these benefits is deteriorating health or high NHS waiting lists, the Government should instead focus on the benefit system itself; and whether the system is dealing effectively with protecting those with health problems while providing support in helping them back into employment. The danger is that people have incentives to claim health-related benefits; and, once in receipt of them, have neither the incentive nor support to find and accept a job. If the Government does not set out how it intends to address these weaknesses, this growing area of welfare spending will remain a challenge for the forthcoming Spending Review.

The need for action

4. Alison McGovern MP, the Minister for Employment told us that "it is obvious" that the current welfare system is not financially sustainable.[8] Given the state of the public finances and the low level of economic growth, the rising welfare budget increases the risk that the UK's debt becomes unsustainable in the medium term – highlighting the central conclusion of the Committee's last inquiry on the UK's national debt.[9] The benefits of tackling this challenge are clear: according to the Institute for Fiscal Studies (IFS), if 400,000 people who are out of work due to ill health were able to find work, this could save around £10 billion through higher tax revenue and lower benefit spending.[10]

5. Alongside the cost to the taxpayer is the heavy and growing social cost of more people being economically inactive and depending on welfare. Analysis based on data from February 2024 showed that only 5 per cent of people receiving incapacity benefits (i.e. the health-related component of Universal Credit (UC) or its predecessor, Employment Support Allowance (ESA)) were working; 83 per cent had been out of work for more than two years and were classified as having a limited capacity for preparing for work.[11]

6. However, our attempts to clarify the extent of labour market inactivity and its relationship with the growing welfare bill have been hampered by flaws in the Labour Force Survey (LFS), which is now being replaced. According to the latest LFS data, 9.3 million working-age people (21.7 per cent of the working-age population) are currently inactive, of whom 2.7 million (6.5 per cent of the working-age population) are self-reporting as long-term sick.[12] But it is unclear whether labour market inactivity has remained high or has fallen since the end of the COVID pandemic.[13] Analysis by the Resolution Foundation claimed

[8] Q 124 (Alison McGovern MP)
[9] Economic Affairs Committee, *National debt: it's time for tough decisions* (1st Report, Session 2024–25, HL Paper 5)
[10] IFS, 'The government's 80% employment rate target: lessons from history and abroad' (12 December 2024)
[11] IFS calculations based on DWP Stat-Xplore data from February 2024. IFS, 'Three challenges for getting people on incapacity benefits into work' (15 October 2024)
[12] ONS, Labour Force Survey: Economic Inactivity (17 December 2024); figures cited are the latest data available – August to October 2024.
[13] ONS, 'Impact of reweighting on Labour Force Survey key indicators: December 2024' (3 December 2024)

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that "the true rate of inactivity is considerably lower than in current estimates"; and modelling of the 16–64 inactivity rate shows "no rise since 2019".[14] The Resolution Foundation's analysis uses mainly HMRC payroll and self-employment data as well as more recent population estimates. We asked Huw Pill, the Bank of England's Chief Economist, whether the Resolution Foundation's analysis is broadly consistent with the Bank's analysis: he told us that "the short answer is yes."[15] If the rate of inactivity is lower than that derived from the LFS, this would mean that those in receipt of health-related benefits account for a larger proportion of the working-age inactive population.

The rise in the health-related benefits caseload

7. While it is difficult to unravel the data to provide a clear picture of the level of economic inactivity, administrative data show that spending on health-related benefits has risen. This has occurred in all parts of the country and in all age groups. As the OBR notes, "The proportion of the working-age population in receipt of an incapacity benefit reached a post-financial crisis high of 7.0 per cent in 2023–24 and is forecast to reach an all-time high of 7.9 per cent in 2028–29. This reverses the steady decline in caseload prevalence from the early 2000s to mid-2010s."[16]

8. Alongside legacy schemes, there are two main categories of health-related benefit within Universal Credit: Limited Capability for Work (LCW) and Limited Capability for Work-Related Activity (LCWRA), for which claimants must undertake a Work Capability Assessment – either face-to-face or remotely. Those placed in the LCW category are deemed to have a limited capability for work but are considered able to prepare for work in the future. Those placed in the LCWRA category – the more severe incapacity – are not required to look for work or engage in work-related activities due to their health condition or disability.[17] As the OBR notes, there has been a significant rise in the number of people classified as having "severe incapacity" over the last few years; indeed, "the increase in the approval rate [between 2018–19 and 2022–23] was nearly entirely in the more severe incapacity group".[18]

[14] Resolution Foundation, *Get Britain's Stats Working: Exploring alternatives to Labour Force Survey estimates* (November 2024), p. 12
[15] Q 94 (Huw Pill)
[16] OBR, *Welfare Trends Report* (10 October 2024), para 1.
[17] DWP, 'Universal Credit: Health conditions and disability guide'
[18] OBR, *Welfare Trends Report* (10 October 2024), para 10

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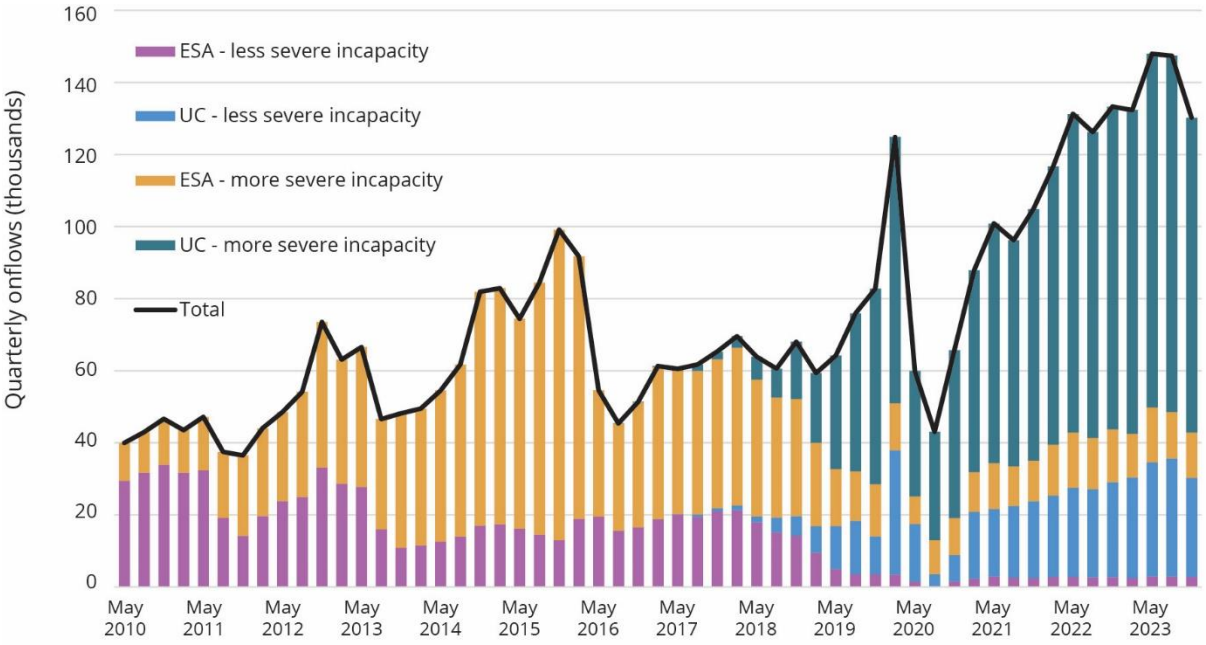

Note: Figures include the three months up to and including the month referenced. Onflows only captures initial WCA assessments. UC LCW and LCWRA initial onflows are estimated based on the split of initial and repeat assessments in third party assessment provider data, with a one-month lag. DWP intend to publish revised initial UC WCA outcomes in a future UC WCA statistical release.
Source: DWP, OBR

Figure 1: Incapacity benefits onflows

9. The OBR has analysed what is driving this rise in "onflows" (Figure 1). Onflows are additions to the caseload once a claimant has been assessed as eligible to receive incapacity benefits; onflows are determined by the number of initial claims submitted, the share of claims withdrawn before a WCA decision is reached, and the approval rate. It states that "only a minority (20 per cent) of the rise in incapacity benefits onflows between 2010–11 and 2022–23 reflects a higher number of people initiating claims."[19] Fewer people withdrawing their application for these benefits explained 30 per cent of the rise in onflows; and rising approval rates accounted for the remaining 50 per cent.[20] Tom Josephs, Member of the OBR's Budget Responsibility Committee, informed us that "fewer dropouts and higher approval rates … are the biggest drivers of the increase in on-flows [into the benefits system]."[21]

10. We note that the number of people coming off incapacity benefit (off-flows) due to reassessment fell dramatically in recent years (Figure 2). Again, as the OBR states, "most reassessments for ESA and UC were paused in response to the Covid pandemic, and the disallowal rate fell below 1 per cent. Reassessment volumes continued to fall over the rest of the period, and despite an increase in the disallowal rate as some Covid easements

[19] See OBR, *Welfare Trends Report* (10 October 2024), para 4.3 and Chart 3.4
[20] OBR, *Welfare Trends Report* (10 October 2024), para 4.3. See Charts 2 and 3.13
[21] Q 35 (Tom Josephs)

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subsided, there were only 3,000 reassessment off-flows in 2022–23." This compares with 28,000 reassessment off-flows in 2019–20. The previous Government decided not to reassess the vast majority of more severe incapacity cases, which the OBR states marked "a significant shift in their reassessment policy compared to the previous decade."[22]

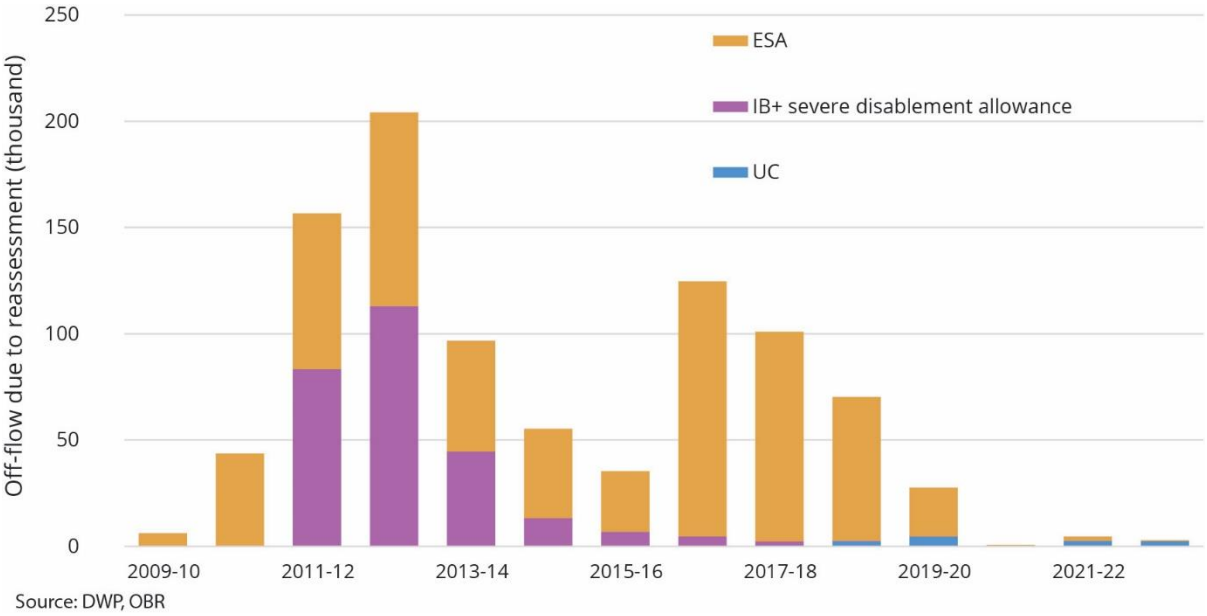

Figure 2: Incapacity benefits off-flows due to reassessments

The Government's plan to tackle inactivity

11. Central to the Government's strategy to 'Get Britain Working' is a pledge to reduce waiting lists in the 20 NHS trusts with the highest levels of inactivity. The Minister told us that "33% of those who are of working age and economically inactive are waiting for NHS treatment, compared to 19% of those in employment."[23] However, the Minister confirmed that it was not possible to say how many of the economically inactive in these communities are awaiting NHS treatment for a specific primary condition.[24] Fit notes issued by doctors, and claimants' assessments for benefits, fail to provide sufficient data to answer this question: according to analysis by Policy Exchange, 70% of fit notes do not record an individual's diagnosis.[25]

[22] OBR, *Welfare Trends Report* (10 October 2024), para 3.26
[23] Q 108 (Alison McGovern MP)
[24] Q 109 (Alison McGovern MP)
[25] Policy Exchange, *Not Fit for Purpose: An Appraisal of the 'Fit Note' and Assessments of Fitness for Work* (April 2024), p. 23

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12. As to Work Capability Assessments, the OBR states that "The inability to look at UC work capability assessment (WCA) decisions or caseload data by primary health condition – the predominant condition a claimant first presents with – severely limits our ability to analyse trends in conditions over time. This data would allow us to better assess whether changes in the incapacity benefits caseload track other health-related survey evidence, and the extent to which changes in approval rates can be explained by changes in claimants' health conditions."[26] Prof. Ben Geiger, Professor in Social Science and Health at King's College London, told us that those who are economically inactive are "not necessarily … on waiting lists, or that the thing they really need is more medical attention. They may need some other sort of employment support, a different benefit system, or a different world of work in which there is a space for them to make use of their talents."[27]

13. Furthermore, in its 2023 analysis, the OBR estimated that "halving the NHS waiting list over five years – returning it to its mid-2015 level of around 3½ million – would only reduce working-age inactivity by around 25,000."[28] Richard Hughes, the OBR's Chair, told us "It is not the case that in general you have large numbers of people of working age on the waiting list. Most people on the waiting list are older and no longer part of the labour force, or children." He added: "if you get the waiting list down, you could very easily still have this problem [of inactivity] left at the end of it because that is not actually the barrier to most people getting back into the labour force."[29] Data provided by the Minister appears to support this. She wrote that "Each year between 2014 and 2023, there were on average 539,000 people in economic inactivity due to long-term sickness at the end of the year who were not there a year earlier. Of these, 27% were previously employed,14% unemployed and 59% were already inactive for another reason."[30]

14. There is also a wider question as to whether the nation has become sicker. Data from the UK's Household Longitudinal Study and the Health Survey for England suggest that the health of the nation has been fairly stable over the past decade (Figure 3).[31] The sharp rise in the number of incapacity benefit claimants does not therefore appear to reflect a deterioration in people's health.

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[26] OBR, *Welfare Trends Report* (10 October 2024), para 4.7.
[27] Q 73 (Prof. Ben Geiger)
[28] OBR, *Fiscal risks and sustainability* (13 July 2023), para 1.9 and pp. 61–62 Box 2.5
[29] Q 37 (Richard Hughes)
[30] Letter from Alison McGovern MP, Minister for Employment, to Lord Bridges of Headley (12 December 2024): https://committees.parliament.uk/publications/46156/documents/231025/default/
[31] *Financial Times*, 'What if the UK isn't actually the sick man of Europe?' (6 December 2024)

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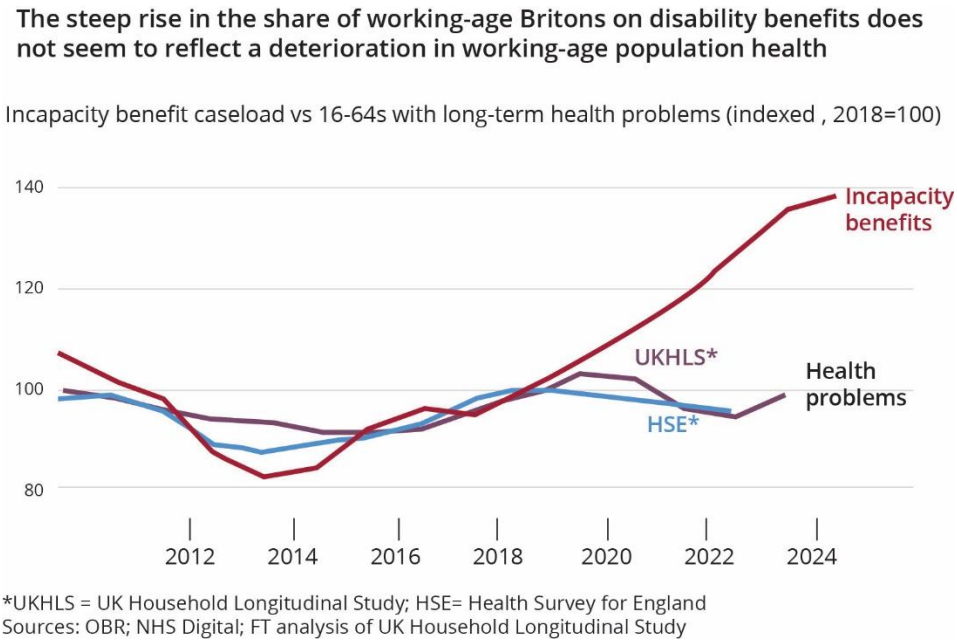

Figure 3: Incapacity benefit caseload and long-term health problems

15. It is notable that the rise in health-related benefits in the UK appears to be out of line with the stable or falling number of claimants in other comparator countries.[32] Whilst such comparisons are hampered by differences between countries' benefits systems, statutory sick pay, labour force markets and the availability of data, one analysis concluded that the official UK "worklessness data seems to be measuring something different to other countries".[33] None of our witnesses offered corroborating evidence that the rise in health-related claimants in the UK reflects a deterioration in the health of the working-age population.

16. We therefore looked at how the structure and process of our welfare system might be driving individuals' behaviour or decision-making, as they apply for, are assessed for, and then receive benefits.

Incentives to claim health-related benefits

17. A number of witnesses highlighted the stark financial disparity between the health-related component of UC and unemployment benefits and the differences in the conditions attached to them. Witnesses said that together these create an incentive for those who are unemployed (and in receipt of income support) to seek this component of UC.[34]

[32] IFS, *Health-related benefit claims post-pandemic: UK trends and global context* (19 December 2024), p. 9 Figure 3
[33] *Financial Times*, 'What if the UK isn't actually the sick man of Europe?' (6 December 2024)
[34] Q 38 (Richard Hughes), Q 35 (Tom Josephs), Q 49 (Louise Murphy), Q 49 (Edward Davies), Q 19 (Tom Waters)

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18. With respect to the financial disparity, Eduin Latimer, Research Economist at the IFS, told us that "if you move out of work, getting on to health-related benefits … would almost double your income. You would also have some of your housing costs covered … On top of that, how much you get in personal independence payments can be quite varied, but it can be up to an additional £9,000 a year".[35] Louise Murphy, Senior Economist at the Resolution Foundation, noted that for someone in receipt of UC, "their income can double if they are deemed to have limited capability for work-related activity … So there is an incentive to [pursue] that."[36] As the OBR stated in their October 2024 *Welfare Trends Report*, "The 2017 policy to reduce generosity for the less severe incapacity group is likely to have contributed to the rising share of approvals for more severe incapacity."[37]

19. There is also a disparity in the conditions attached to various benefits. With respect to conditionality, Mr Josephs told us that "higher relative conditionality on unemployment benefits has contributed to more people moving onto incapacity benefits".[38] As Tom Waters, Associate Director at the IFS, told us: "You used to be able to be out of work and get housing benefit and child tax credit, but as long as you did not claim jobseeker's allowance you would not be subject to conditionality. UC bundles all these benefits together, so if you are out of work and claiming it, you are typically subject to conditionality."[39]

The process of claiming benefits

20. Qualifying for health-related benefits should be based on a rigorous assessment. However, we heard evidence that the process of scrutinising and monitoring claimants and their needs is inadequate.

21. The basis upon which an individual can access health-related benefits is the Statement of Fitness for Work, or the 'fit note'. This can be issued after the first seven days of sickness absence if a healthcare professional (currently almost always a GP) assesses that a patient's health affects their fitness to work.

22. Although the fit note is undergoing some changes, witnesses said that it lacks sophistication by producing only binary outcomes rather than any assessment of an individual's specific needs so as to help them return to work. Dr Sean Phillips, Head of Health and Social Care Policy at Policy Exchange, declared it "unfit for purpose" and added: "general practice is trying to funnel a lot into a 10-minute appointment … often

[35] Q 10 (Eduin Latimer)
[36] Q 49 (Louise Murphy)
[37] OBR, *Welfare Trends Report* (10 October 2024), para 4.3.
[38] Q 35 (Tom Josephs)
[39] Q 19 (Tom Waters)

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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." [40]

23. Witnesses told us how the second stage in many individuals' engagement with the welfare system, the Work Capability Assessment (WCA), is inadequate as a means of gauging a benefit claimant's needs (and underlying medical condition).[41] This may be partly due to it being conducted largely online (a legacy of a switch to this mode of assessment during the COVID pandemic). The Minister told us she was "not comfortable" with assessments being conducted remotely, but declined to say whether such assessments would be scrapped.[42]

24. Furthermore, one significant trend in the increase in long-term sickness claimants is the growth in the numbers and proportion of awards based on mental health conditions rather than physical disabilities. It appears particularly challenging to assess accurately these claimants' condition and capability to work in a short WCA interview conducted remotely via telephone or video assessment.

25. Moreover, as stated above, we were told that a lot of information derived from the WCA "goes absolutely nowhere … 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."[43]

Incentives to return to work

26. As noted earlier, the IFS highlight that 83 per cent of incapacity benefit recipients had been out of work for more than two years. Likewise, Mr Pill told us that the Bank of England did not see a substantial number of economically inactive people who were "marginally attached" to the labour market, i.e. those who "are no longer actively seeking a job but, if a job were to become available, they would take it."[44]

27. Witnesses told us there are a number of reasons for this. The IFS has stated that if an individual loses their LCWRA status, their income falls for two reasons: first, they lose the UC health element; second, "they lose their work allowance so now the universal credit taper applies to all of their earnings rather than to their earnings net of the work allowance."[45]

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[40] Q 53 (Dr Sean Phillips)
[41] Q 44 (Dr Sean Phillips)
[42] Q 118 (Alison McGovern MP)
[43] Q 59 (Louise Murphy)
[44] Q 94 (Huw Pill)
[45] IFS, 'Three challenges for getting people on incapacity benefits into work' (15 October 2024)

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28. Prof. Portes, Professor of Economics and Public Policy at King's College London, told us: "if the expected value of moving from benefits to work is an increase in your income of £20 but you have some risk aversion and there is a 30% risk that you will be kicked back on to unemployment benefit and get £50 a week … that will lead to people who would be better off, from their point of view and from the point of view of the economy and the DWP, not taking that chance because they are rationally risk-averse."[46]

29. This is despite the fact that, as Mr Waters told us, the risk of an individual being reassessed once back at work "is probably quite low".[47] Dr Phillips told us of the approach taken in Finland, where recipients of health-related benefits looking to accept employment receive a "rehabilitation supplement" that provides "an uplift for a set period of time that takes you above the incentive to remain on welfare."[48]

Reassessment of, and support for, those on health-related benefits

30. Off-flows are those cases where a claimant becomes ineligible for incapacity benefits. This can be for a number of reasons: reaching a certain age; entering employment (and exceeding the allowed number of hours or earning above a certain threshold); or being reassessed as no longer eligible to receive the benefit. Reassessments for ESA and UC have driven a third of all incapacity off-flows since 2009–10, but the level of off-flows has varied significantly across this period. As the OBR observes, and as noted earlier, most reassessments were paused during the COVID pandemic: reassessment off-flows fell to 3,000 in 2022–23, compared with 28,000 in 2019–20. In 2023 the previous Government decided not to reassess the vast majority of more severe incapacity cases, "marking a significant shift in their policy compared to the previous decade."[49] Therefore, once an individual is in receipt of longer-term health-related benefits, many claimants cease to have contact with assessors.

31. We heard how this means there is limited contact with the inactive and long-term sick, which risks individuals becoming even more remote from the world of work. Witnesses told us how we do not have a joined-up system in which those managing the benefits system, offering support via job centres and care via the NHS, might work together to help an individual back to work. There is no single point of contact (as exists in countries such as the Netherlands) to help a benefit claimant overcome obstacles, both in terms of health and employment, so they might return to work.[50] Consequently, claimants can find themselves lost in a maze of government initiatives and processes. This is particularly concerning given the high number of people qualifying for health-related benefits due to

[46] Q 76 (Prof. Jonathan Portes)
[47] Q 25 (Tom Waters)
[48] Q 57 (Dr Sean Phillips)
[49] OBR, *Welfare Trends Report* (October 2024) para 3.26
[50] Q 78 (Prof. Ben Geiger)

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mental illness, where appropriate support might be most effective. As Prof. Geiger told us: "Good caseworkers [taking] effective approaches for supporting people with health problems, including mental health problems, can be effective."[51]

32. We were told by the OBR that although reducing face-to-face contact may reduce costs in the short term, it may be adding to economic and social costs in the long term. As Prof. Miles told us, "The rate of return, just in pure economic terms, for getting a young person who might be in their mid-20s or early 30s back into the labour force is potentially extremely high. If there were policies that looked like they were making some progress on that front, it seems to be the kind of thing that the OBR would naturally want to start scoring, and it would become potentially more than self-financing."[52]

33. We note that the Government plans to publish a Green Paper to address many of these issues. Following the evidence we received, we make the following recommendations.

Recommendations

34. ***We agree with the Minister that the current benefit system "does not work for anybody" and "it is obvious that it is not" financially sustainable.[53] For this reason, the Government must reform both the unemployment and health-related benefits systems and how they interact. There should be more support to help those who are able to find and accept work and to ensure that those who cannot work for a period are not abandoned to a life on benefits.***

35. ***Policy makers are having to operate in a fog of data. The ONS must accelerate the completion of the Transformed Labour Force Survey.***

36. ***We received no convincing evidence to support the claim that the Government's targeting NHS waiting lists will have a material impact on the number of sickness-related benefit claims. This is not to deny that improving the health of the population will increase employment. But the DWP and the NHS must share and analyse health and benefits data in order to establish whether and how targeted intervention to cut NHS waiting lists could have a material impact in reducing labour market inactivity.***

37. ***A GP consultation is usually the first point of contact for those who are unwell and the first step along a path to receiving health-related benefits. However, we believe that GPs are unable to offer a sick individual the degree of support they may need.***

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[51] Q 74 (Prof. Ben Geiger)
[52] Q 41 (Prof. David Miles)
[53] Q 107 and Q 124 (Alison McGovern MP)

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The fit note should be overhauled; GPs should be encouraged or enabled to refer an individual to an occupational health professional, while individuals who are signed off work for more than a month should undergo additional or ongoing assessments.

38. ***The lower level of conditionality attached to health-related benefits creates an incentive to apply for these benefits. The Work Capability Assessment is insufficiently rigorous and susceptible to error. The Government is right to plan to reform the WCA; the WCA should be conducted face-to-face and seek to establish what work an individual can do rather than looking to corroborate what they cannot do.***

39. ***Once in receipt of these benefits there is a disincentive for claimants to apply for and accept work. The Government needs to review the conditions for those in receipt of health-related benefits so that, if people return to work, they are not at risk of immediately losing those benefits; or, if the job proves unsuitable, they are not immediately faced with having to reapply for these benefits.***

40. ***We should have a system in which those who receive health-related benefits are proactively helped to overcome obstacles rather than remain on benefits and out of work indefinitely. We urge the Government to consider providing enhanced support, prioritising those claimants where the returns and rewards for getting back into the labour force are high – for example, young people. We recommend that, just as unemployed people have a work coach, so should those on incapacity benefit for the first two years of their period on benefits. Each caseworker's aim would be to help the claimant overcome obstacles, both in terms of health and employment, and get back to work.***

41. ***Overall, we welcome the Government's intention to "take a whole new approach with fresh thinking" to welfare: reform is needed both to curb the increasing fiscal burden and to address the ever-growing social cost of hundreds of thousands of people dependent on benefits. We see no reason to delay action. A wealth of analysis already exists on the issues we have raised and which offers credible solutions to the problems we have highlighted. We urge the Government to accelerate its plans to reform health-related benefits. If the Government does not set out how it intends to address these weaknesses, this growing area of welfare spending will remain a challenge for the forthcoming Spending Review.***

42. We look forward to your response to the recommendations set out in this letter by March 20. This letter is copied to the Chancellor of the Exchequer and the Secretary of State for Health and Social Care.

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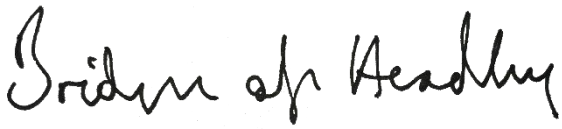
Yours sincerely,



Lord Bridges of Headley MBE
Chair of the Economic Affairs Committee