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**‘The Labour Market Engagement of Women
Claiming Disability Benefits in the UK:
Qualitative Evidence’**

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ABSTRACT

There has been a steep rise in the number of women claiming disability benefits in the UK since the early 1990s, a number of years later than men. This paper assesses the extent to which women claiming disability benefits in the UK can be considered 'hidden unemployed' versus sick or disabled. A threefold typology of woman claimants is developed: 'discouraged workers', 'incapacitated' or 'dependent'. 'Discouraged workers' are those whose disability or ill-health is relatively minor or likely to be short-lived but who are discouraged from active job search because of a lack of suitable local job openings. Those falling into the 'incapacitated' category may see greater job opportunities open to them – for example because of a particular skill set they possess – but who currently see themselves as unfit for work on grounds of disability or ill-health. The final – and largest – group can be categorised as 'dependent' in that they see very little prospect of ever working again and perceive insurmountable risks to re-entering employment, for example that working would lead to a deterioration in health or that they would be unable to reclaim disability benefits in the event of a job not working out. Women in this final group, although in many respects 'dependent', have made a rational choice to remain on benefits in order to avoid risks to financial stability and their health associated with re-entering employment.

The likely effectiveness of recent and proposed policies aiming to reduce the stock of disability claimants in the UK are discussed, including issues of the availability of suitable jobs, claimants' lack of trust of public and pseudo-public sector agencies and difficulties engaging with hard-to-reach groups.

The paper draws on detailed evidence from 76 qualitative interviews with women claiming disability benefits and 44 interviews with state-run benefits and employment offices, employment and training brokers and family doctors in local areas with concentrations of claimants.

Keywords: dependency, discouraged workers, gender, health, unemployment, disability benefits, skills.

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This paper is work in progress and conclusions at this stage tentative. A fuller version with final conclusions, references and more detailed empirical material will be available by the end of July 2008 at www.geographyandgender.org

Introduction

There has been a marked increase in the number of people claiming disability benefits in a number of European and other developed countries over the last 25-30 years. Although international comparisons are problematic because of different entitlement rules, the sheer magnitude of the increase is apparent in a number of countries. Within Western Europe, the increase has been most severe in the Netherlands where in 1990 almost 12% of the working age population claimed disability benefits, although this has subsequently dropped to just under 10%. Sweden has the next highest rate at almost 9%, Denmark at over 7%, followed closely by the UK at 7% (Kemp 2006).

This trend is of social and economic concern. Long-term benefit dependency, poverty and ill-health have consequences for individual well-being and lead to disengagement from the labour market. Barriers to moving back into employment restrict labour supply, and the skills and experience of these men and women become unavailable to potential employers. The payment of state benefits to such a large number of people also represents a substantial expenditure. Reflecting these concerns, the UK government has set a target of a one million reduction in the number of claiming 'incapacity' benefits by 2016. This is to be achieved by labour market activation programmes and by a newly reformed incapacity benefit – Employment Support Allowance - that requires most new claimants to either search or prepare for work, for example by taking part in rehabilitation or retraining.

The rapid decline in manual employment in the UK throughout the 1980s and 1990s produced large numbers of men with ill health and limited alternative employment prospects who consequently claimed incapacity benefits. This was partly a consequence of a 'benefit-shift' from unemployment benefits to disability and sickness benefits because unemployment benefits are means tested whereas Incapacity Benefit is not, are less generous than incapacity benefits and carry increasingly onerous job search and retraining obligations. This benefit-shift has resulted in large numbers of people claiming incapacity benefits rather than unemployment benefits, who have been termed the 'hidden unemployed'. This interpretation is supported by the fact that in the 1990s many incapacity claimants indicated that they wanted a job, and that claimants are geographically concentrated in areas of industrial decline.

The number of women claiming incapacity benefits in the UK was initially lower, and the biggest increases occurred somewhat later, mainly in the 1990s, and carried on in the first part of the following decade after the male figures reached a plateau. In 2007, the headline total of just over 2.6 million incapacity claimants was made up of 1.5 million men and 1.1 million women, but women access state retirement pensions earlier than men, at 60 rather than 65. Stripping out the 60-64 year old male incapacity claimants, the ratio of male to female claimants is 52:48.

The large increase in the number of women claiming incapacity benefits in the UK is hard to explain in the same terms as for men. On the whole, the industrial job losses of the 1980s and 1990s were a male phenomenon, in sectors such as coal, steel and heavy engineering. That so many men in the areas affected by these job losses now claim incapacity benefits does not therefore seem difficult to understand. But in contrast, in the UK women have mostly seen an expansion in employment, underpinned by growth in the service sector, including in Britain's less prosperous areas where female incapacity claimants are overwhelmingly concentrated alongside their male counterparts. One possible explanation of this is that 'male' and 'female' sides of the labour market are much less segregated than in the past, with the consequence that the overall aggregate level of labour demand in a local labour market affects men and women equally. Another is that in these areas there is greater cultural acceptance of being 'on-the-sick' and that high levels of male claimants has increased awareness of incapacity benefits and how to access them.

A key question this paper addresses, therefore, is the extent to which women claiming incapacity benefits in the UK can be considered to be 'hidden unemployed' in the same way as men. As such, issues of job aspirations, dependency, work disincentives, perceived obstacles to work and levels of labour market engagement among women claiming incapacity benefits are explored. The paper also considers what policies may help reduce the number of women (and men) claiming incapacity benefits.

Benefit reforms, gender and disability

The 'workfarist' approach of New Labour which has been in power in the UK since 1997 emphasises the value of paid employment, both in terms of providing greater protection from poverty than state benefits and in providing wider 'socialisation' and health enhancements to individuals. Initially the 'welfare-to-work' policy targeted young long-term unemployed people through the New Deal, but has subsequently

been applied to groups further from the labour market, e.g. older workers. There are gendered aspects to labour market activation policies, for example the New Deal for Lone Parents and the New Deal for Partners of the Unemployed. Although neither of these schemes is mandatory for benefit recipients, they both disproportionately apply to women. Both schemes are symbolic of the value attached by the government to paid work, almost irrespective of child care, other caring responsibilities and domestic roles disproportionately carried out by women.

Welfare reform has now reached the sick and disabled as well as the long-term unemployed and lone parents. The 2006 welfare Green Paper *A New Deal for Welfare* and the subsequent Welfare Reform Bill later that year have paved the way for the replacement of Incapacity Benefit with the Employment Support Allowance in October 2008. For the first time, this introduces mandatory 'activation' to those on incapacity benefits, specifically work-focussed interviews. Furthermore, the Employment Support Allowance will be paid at a higher rate to those engaged in 'work-related activity' (for example, searching for work or retraining).

Although those with severe disabilities will be exempt from the mandatory aspect of the Employment Support Allowance, this policy development underlines the view from government of 'citizen as worker', an important example of 'conditional citizenship' in this case placing a strong responsibility on individuals to be engaged with the labour market in return for the right to state benefits. The 'work is best' mantra is applied irrespective of gender and sickness, albeit with some concessions to those with caring responsibilities or disabilities.

In some respects, 'workfarism' is about ensuring an adequate supply of labour – particularly low-skilled labour – to support advanced capitalism. In terms of labour market engagement, 'workfarism' is based on important assumptions about the causes of worklessness. These have long philosophical and moral predecessors dating back to the Poor Laws, but essentially 'blame the victim' by stressing failings in the workless individual themselves rather than emphasising systemic and structural forces and constraints acting around them (Grover and Piggott, 2008). For example, the local availability of jobs, pay and conditions, rights and obligations in the benefits system, gender relations in the home and workplace, and societal attitudes towards and perceptions of health and disability are all important structural factors influencing the likelihood of a particular individual being in employment.

Workfarism pathologises the workless, often using the term 'benefit dependency' to explain low levels of engagement with the labour market. From the point-of-view of the political right, dependency is seen as a cultural phenomenon, with people losing the work ethic and through time lacking the motivation to seek work. From the point-of-view of the political left, dependency is a less comfortable concept but is used to describe a loss of confidence (rather than motivation per se). Either way, the notion of dependency is embedded in New Labour's diagnosis of the causes of – and solutions to – worklessness.

A counterfactual to the notion of 'dependency' – at least in the cultural sense – is 'rational choice' theory. This acknowledges disincentives to move from benefits to low-paid employment introduced by the benefits system in the form of very high effective marginal tax rates due to the rate of benefit withdrawal as earnings rise. As such, it is a 'rational choice' to remain on benefits. Rational choice theory is influenced by neo-classical economics in two regards. First, individuals are deemed to make decisions purely on financial grounds. Second, there is a strong emphasis on 'marginality', implying that individuals can make decisions about precisely how many hours they might work at a given rate of pay in order to optimise their personal utility. Although an individual may claim a state benefit as a rational choice and not be culturally or psychologically 'dependent', it is entirely possible that someone may be dependent but also view their current position as 'rational'. In short, although the concepts offer different explanations of why people remain on benefits even when there may be jobs available locally, they are not mutually exclusive.

Aims

This paper reports the findings from qualitative interviews with women claiming incapacity benefits and professional stakeholders involved with the administration of state benefits, and the provision of retraining and rehabilitation schemes. The main focus is on addressing four key aims:

1. To assess the extent to which women claiming incapacity benefits can be considered to be 'hidden unemployed'
2. To assess to what extent cultural acceptance and learning of the benefits system might explain why women claiming incapacity benefits are so overwhelmingly found in the same locations as male claimants
3. To assess the extent and ways in which women claiming incapacity benefits can be considered to be either 'dependent' or 'rational' in remaining on benefit

4. To assess what policies might work in reducing the number of people claiming incapacity benefits, with a particular emphasis on women.

Methods

This paper reports the findings from 76 in-depth qualitative interviews with women claiming incapacity benefits and 44 interviews with professional stakeholders directly or indirectly involved with administering incapacity benefits or working with incapacity claimants. These included representatives of Jobcentre Plus (which administers benefit claims), staff working for providers of various employment support, retraining and rehabilitation services, family GPs and medical officers with the central government's Department of Work and Pensions (DWP). Claimant interviewees were contacted after taking part in a door-to-door survey of claimants, drawn from a sample of addresses provided by the DWP. In-depth interviews were conducted face-to-face in claimants' own homes. Interviews were tape recorded and partial transcripts and notes subsequently typed and thematically coded using XSIGHT textual analysis software. Interviews were in eight local authority areas all with high concentrations of incapacity claimants. Stakeholder interviews were conducted in the same eight locations.

The findings reported in the subsequent sections of this paper are based on a preliminary reading of the interview material and should be considered as work in progress. Although there is a conclusion section, this should be seen as tentative at this stage. A fuller version with final conclusions and more detailed empirical material will be available by the end of July 2008 at www.geographyandgender.org.

Are women claiming incapacity benefits 'hidden unemployed'?

Pointers towards women claiming incapacity as unemployment

Based on a survey of women claiming incapacity benefit, only four per cent of women claiming incapacity are regularly looking for work, although a further 17 per cent say they would like a job and 12 per cent might like a job in the future (Beatty et al, 2008). In total, this means one-third would like a job.

However, when interviewed in-depth almost all women talked about a latent desire to work, short circuited by what they perceive to be insurmountable obstacles in terms of health, low skills, inflexible employers and a lack of locally available jobs. This suggests that many more than one-third of women claiming incapacity can be considered – to some extent at least – to be involuntarily out of work. Whether this is

due to a lacking availability of jobs, their health or other factors is a crucial – but difficult – question to answer.

Some claimants reported often or at least periodically looking at job advertisements in the local newspaper, although few would apply for a job. Most indicated that the jobs were either not in their previous occupation, were asking for experience or qualifications they did not possess, were of insufficient pay or anti-social hours. A common perception was that employers would be unlikely to be able to accommodate their ill-health into work practices and requirements. Those who had applied for a job or jobs had mostly only applied for a small number and seemed to be easily put off further job search by rejection. So, although perceived low prospects of gaining employment based on their own characteristics and situation discouraged most from active job search, this judgement is shaped by low availability of suitable jobs in the local area and anticipation of employers being unable or unwilling to accommodate their disability or health needs.

Many more claimants interviewed had engaged in skills retraining or health rehabilitation programmes than with sustained active job search. IT courses are popular, fuelled by a perception that this would be vocationally useful. However, a number of interviewees abandoned these courses due to health problems. Those completing these courses never seemed to have gone on to search for jobs that may require working with computers. In short, these courses seem to have usually acted as a 'hobby' – something to get people out the house rather than stimulating active labour market reengagement. Nevertheless, successfully completing a course can boost a claimant's confidence.

Pointers towards women claiming incapacity as sick

Survey evidence reveals that 70 per cent of women claiming incapacity indicated that their last job came to an end because of ill health or injury, compared to only 11 per cent citing some form of severance. Nevertheless, only a quarter say they cannot do any work in any circumstances.

During in-depth qualitative interviews, the majority of women reported substantial ill-health or disability that they thought would make holding down a job difficult. However, their assessment of their capabilities may have been diluted by assigning themselves to a 'sick role'. Once signed off work by their doctor and subsequently assessed as qualifying for incapacity benefits, their self-image, even identity, can

alter. Rather than seeing themselves as physically active and economically independent, claimants seem to come to think of themselves as poorly and incapacitated. A fuller typology of women incapacity claimants in terms of self-perception and sick versus worker roles is set out later.

With more time on their hands once no longer working – mostly spent in their home, often alone – claimants can become despondent about their health and employment prospects. Indeed, a number of interviewees reported experiencing depression some time after initially becoming physically ill. Some interviewees with chronic pain conditions such as back problems and arthritis reported a heightened awareness of their pain when they were not busy. In addition, a new, more passive lifestyle often results in poorer diet and less physical activity with further real and perceived impacts on health and wellbeing. It is remarkable how many interviewees reported multiple health problems, many having been developed since moving onto incapacity.

Of those who had taken part in health rehabilitation programmes, pain management and acupuncture were usually reported on very favourably. However, claimants seem to need to continue these treatments continuously, with the benefits receding soon after treatment stops. Most women interviewed had undertaken these programmes to improve their day-to-day quality of life rather than with a view to re-entering employment. Nevertheless, for claimants with significant health problems, medical interventions will often be required – possibly on an ongoing basis for chronic conditions – before labour market reengagement would be a realistic proposition.

Although many people genuinely experience ill health, physical and economic activity would in many cases go a long way to improving their general wellbeing. Counter to this, however, a great many claimants do face very real and insurmountable health obstacles to employment and it would be wrong to suggest that changes to their psychology or self-image could on its own re-engage them with the labour market.

Conclusion

Claimants report high levels of incapacitating ill health and disability, which they perceive in most cases to be insurmountable obstacles to employment. This is consistent with the majority indicating that ill health was the primary reason for their last job coming to an end (Beatty et al, 2008). So, to what extent can women claiming incapacity be characterised as 'hidden unemployed'? On the one hand,

labour market engagement is low and ill health predominates in many claimants' self-image, suggesting that these women are 'sick' rather than 'unemployed'. On the other hand and more indicative of hidden unemployment among female incapacity claimants, most retain a latent desire to work and at the time their last job came to an end many were less incapacitated than they are now but did not re-enter employment when their health was less of an obstacle, possibly because of a lack of locally available jobs.

As time goes by, being ill seems to make people more ill. If they were able to retain their job or re-enter employment soon after leaving a job on grounds of ill health, their health may not deteriorate further and their self-image may remain one of active worker rather than passive dependent. Although ill health may be the trigger to leaving employment, low labour demand is often the obstacle to re-engagement in some parts of Britain. These considerations point towards many incapacity claimants being *both* (to varying extents) unemployed *and* sick/disabled.

There are likely to be important interactions between health and labour market conditions. In more buoyant labour market conditions, employers may be more active in retaining employees who become ill and more willing to recruit people with health or disability issues. At the moment this remains conjecture and needs to be examined through on- and off- flow rates to/from incapacity in different parts of the country, as well as through in-depth interviews with employers.

Is there cultural acceptance of being 'on the sick' and/or learning of the incapacity system in areas of geographic concentrations of claimants?

The fact that women claiming incapacity benefits are concentrated in the same locations as men requires explanation. An alternative, although not mutually exclusive, explanation to the role of overall aggregate demand for labour in relation to supply, is that there is cultural acceptance and learning of being 'on the sick'. There are two distinct elements to this. First, areas which have had high levels of men claiming incapacity for a generation or more may develop a cultural acceptance of being 'on the sick', making people more inclined to claim incapacity benefits. Second, there may be more awareness of the benefits system in general and in particular the eligibility rules for incapacity benefits and the process of moving onto incapacity from Statutory Sick Pay, other benefits or economic inactivity. To test these notions, interviewees (all resident in areas of high incapacity claims) were asked a series of questions relating to how they felt about claiming incapacity,

whether people treated them differently since claiming, whether they knew other people claiming, whether anyone suggested that they claimed and, finally, whether they received help or advice in making their claim.

A striking feature of claimants' responses was how few people other than immediate family knew they received incapacity benefit. Many interviewees indicated that benefit receipt and financial issues were things that were not talked about. Interviewees talked about feeling humbled by claiming, although most claimants relatively easily reconciled this with the fact they feel unable to work and had paid tax and National Insurance while working before claiming. More problematic for claimants is 'raised eyebrows' from neighbours and acquaintances about their source of income, particularly if they ever buy a car or go on holiday. These responses are not consistent with a widespread 'sickness' culture.

Turning to the question of 'learning the system', we again found little evidence of this, certainly among claimants. Most indicated that they did not know anybody claiming incapacity before they claimed and that no-one other than a benefits officer helped them make their claim. Indeed, some had not even heard of incapacity benefit before they claimed. Most talked of the process of moving onto incapacity in vague terms. Common responses were 'it just happened automatically' or 'I was told this was what I should do', apparently with remarkably little understanding of the details, or implications, of moving onto incapacity. These responses from claimants suggest there is little if any 'learning the system' in areas of high incapacity claims.

Although there appears to be little learning of the system among the general population, the same may be less true among professionals and institutions who deal – directly and indirectly – with the incapacity system. Many claimants interviewed indicated that the trigger to their claim was a suggestion from a medical practitioner, often a nurse rather than their GP, that they might be eligible to claim. Without replicating the interviews in areas of low incapacity receipt, it is difficult to be certain that this effect is greater in parts of the country with a high level of claims, but it seems plausible that medical staff will develop a greater awareness of incapacity benefits in areas with a higher proportion of the population claiming. GPs interviewed were mostly of the view that employment is good for most patients' health (assuming it is at all possible for a particular individual to work) so would not be inclined to encourage an incapacity claim per se. Some GPs thought that many of their patients who end up on incapacity are capable of at least some jobs, but that as

their primary health care provider it is not their place to question a patient's own view of themselves as incapable of work. The value attached to paid employment on health grounds by GPs is in contrast to their view in the 1980s and 1990s. A number of professional stakeholders interviewed (including some GPs themselves) were of the opinion that until 10 years ago or so, GPs saw incapacity benefits as an important source of financial security to people being made redundant. But seeing the health consequences of long-term benefits receipt among some of their caseload, most GPs appear to have now changed their view.

There is a similar change through time in the practices of benefits staff. Until benefit reforms that restricted eligibility for a number of benefits in the mid 1990s, the official policy (and unofficial practice) in the then Department for Social Security was to maximise uptake of benefits in order to guard against the impacts of redundancy. In areas of declining heavy industry with high levels of ill-health, Invalidity Benefit (now Incapacity Benefit) was a major part of this strategy. However, today there is a different emphasis, reflecting central government policy and targets, that benefit claimants, if capable of work, should be redirected towards employment as quickly as possible. In the words of one Jobcentre Plus officer, *'we spent the last twenty years putting people onto incapacity benefit, now we're going to spend the next twenty getting them off again'*.

There is certainly a lot of knowledge of the incapacity system accumulated in the 'third sector' shadow state, which is well represented in areas of high incapacity claims. However, these organisations are mostly tasked with rehabilitation, mentoring and training to help people already on benefits back into work. It is therefore difficult to see a role here for 'institutional learning' that has contributed to the level of incapacity claims.

In conclusion, we have found very little if any evidence of cultural acceptance of being 'on the sick'. Nor have we found much to support the view that there is heightened awareness among the general population of incapacity benefits in areas of high claims. GPs and benefit officers reportedly encouraged invalidity/incapacity claims until the mid to late 1990s but that both these sets of professionals now encourage people to remain in or move towards employment whenever possible. However, GPs are constrained by their duty as primary health care provider to actively challenge a patient's own view of themselves as incapable of work.

Can women claiming incapacity be considered 'dependent' or 'rational'?

The notion of 'dependency' implies a psychological barrier to moving off benefits into employment. This is thought to be due to a lack of confidence or, more pejoratively, a lack of motivation. An alternative perspective is that remaining on benefits is a rational choice because moving into low-paid or part time work may not result in an individual being much better off due to the loss of benefits. The benefits system certainly produced high effective marginal tax rates for low earnings before the UK government introduced a series of Tax Credits from the late 1990s to reward low-paid work, particularly for those with children. Now, even low-paid and part time work plus Tax Credits will usually reward people substantially more than benefits.

Nevertheless, stakeholders interviewed indicated that there is a widespread misperception among benefit recipients that loss of benefit will mean moving into low-paid employment is barely worthwhile. In contrast, claimants interviewed rarely talked about the benefits/work 'choice' in purely immediate 'better off' financial terms. Rather, they expressed concerns around a wider set of risks associated with a return to work, mainly that if the job did not work out that they might not be able to reclaim benefits to the value they are currently receiving. Reasons for fearing they may not remain in employment included a deterioration in their health, an employer not accommodating their health needs, e.g. avoiding certain tasks or providing time-off for medical appointments, and the variability of some chronic health conditions meaning they would have a poor attendance record.

These fears, although understandable, reveal an assumption that they would find it difficult to go on a secure alternative employment if a particular job did not work out. As such, this risk aversion may be related to a lack of confidence. Indeed, professional stakeholders interviewed, particularly those providing employment placement, job search and retraining services, put a strong emphasis on claimants' lack of confidence as an obstacle to moving into employment.

There is, however, variation between claimants in how they perceive themselves in relation to the labour market and how confident they are about the prospect of returning to work. Broadly, claimants can be characterised as falling into one of three groups. Firstly, there are those whose disability or ill-health is relatively minor or likely to be short-lived but who are discouraged from active job search because of a lack of suitable local job openings (real or perceived). This first group can be characterised as 'discouraged workers' – those who are still relatively close to the

labour market in terms of aspirations but who are currently discouraged from looking for work due to a combination of ill-health and poor job prospects in the local labour market. As such, these workers can in many respects be considered to be unemployed. In a fully employed local economy, these are people that might return to work after a short spell on incapacity. However, in less economically buoyant parts of the country, progressive disengagement from the labour market and despondency often sets in. Indeed, many of the claimants interviewed indicated that they were initially optimistic about returning to work soon after they first became sick but now were resigned to life on benefits.

Secondly, there are those claimants who see themselves as 'incapacitated'. Members of this group may see greater job opportunities open to them – for example because they are relatively young or they possess a particular skill set – but who currently see themselves as unfit for work on grounds of disability or ill-health. Although not actively engaged with the labour market at present, this is not due to perceived low job prospects but due to their ill-health which they hope will improve putting them in a position in the future to re-enter employment. Their identity remains that of 'worker', albeit temporarily incapacitated for work. As such, this group can be thought of as temporarily sick rather than unemployed.

The final – and largest – group can be categorised as 'dependent' in that they see very little prospect of ever working again and perceive insurmountable barriers and risks to re-entering employment. As well as the risks outlined previously, this group see a number of barriers to re-entering employment, in particular their health, low skills and qualifications, disability/health discrimination by employers and low awareness of what type of work is available locally.

In conclusion, the majority – but by no means most – of claimants interviewed can be characterised as 'dependent'. But this does not imply their long-term benefit receipt is 'irrational'. Although they may be capable of some types of work and would in most cases be financially better off in work than on benefits, their disengagement from the labour market is quite rational in terms of avoiding the financial risks of not being able to sustain employment and of avoiding risking their health by taking on a job that is too demanding for them.

What policies will reduce the number of incapacity claimants, particularly among women?

Notwithstanding the fundamental question of whether there are enough suitable jobs available locally to absorb large numbers of incapacity claimants, there is much to commend some aspects of current policy towards incapacity claimants. Given that initially many claimants can be characterised as 'discouraged' or 'incapacitated' before through time becoming 'dependent', there is merit in attempting to maintain labour market engagement through Work Focussed Interviews and encouraging people to engage in 'work-related activity' such as retraining while claiming incapacity.

However, such labour market 'activation' policies need to be applied with great care and precision to sick and disabled people. Many claimants we interviewed expressed concern at engaging with job search or retraining for fear of these activities implying that they are capable of work therefore no longer entitled to incapacity benefits. While those with severe disabilities will be exempt from the mandatory aspect of the Employment Support Allowance to be introduced in October 2008, many claimants with substantial health limitations will not. The Personal Capacity Assessment, whereby in most cases the claimant needs to be assessed face-to-face by a government-appointed doctor, resulted in claimants interviewed reporting feeling as if they had to justify their sickness or disability in order to continue to receive incapacity benefits. Many reported feeling 'like a criminal' or 'guilty until proven innocent'. Some found the PCA upsetting, particularly recounting personal medical problems to someone who they felt, unlike their own GP, may not have their best interests at heart. Mandatory activation measures in the Employment Support Allowance will only amplify these negative feelings.

While the emphasis in employment intermediaries and voluntary sector service providers on raising confidence and awareness of the types of jobs available among claimants is entirely appropriate, to make substantial inroads to the stock of people on incapacity, this will need to be resourced much more intensively. Few incapacity claimants can be given a short programme of confidence building and job search skills and be expected to secure and retain employment. Most will require sustained one-to-one mentoring to gradually alter their perception of themselves as dependent, build confidence, attain new skills, find creative solutions to overcome health problems, raise awareness of jobs available locally and, in some cases, retrain.

Many of the women claiming incapacity interviewed had not just specific health problems, but often multiple health issues including depression, low skills, lacking confidence, caring responsibilities and poor access to transport. As well as these factors giving rise to a generally difficult home life, experiences of managing their ill-health in their previous job often resulted in a difficult work life, sometimes including bullying from managers. This underlines the scale of support and intervention that is required to move a woman (or a man) from incapacity into employment.

Although some service providers interviewed reported women being more open-minded than men about alternative occupations, this may be countered by some women being discouraged by partners at home from re-entering employment. This finding was reported by claimants and some professional stakeholders, both through a husband's concern for his wife's health and traditional gender-employment relations in the home.

Professional stakeholders interviewed tended to talk in terms of low labour market engagement, low motivation and low confidence. Although these issues were apparent in a lot of what most claimants said, a wider – and possibly deeper – set of issues relate to risk associated with re-entering employment – risks to household financial stability and risks to a woman's health. Perhaps a discourse providing reassurances of risk (as well as confidence building and motivation/activation) could be developed by Jobcentre Plus and employment support providers.

Summary and Conclusions

The findings reported in this paper are based on a preliminary reading of the interview material and should be considered as work in progress. The conclusions presented in this section should therefore be seen as tentative at this stage. A fuller version of this paper with final conclusions and more detailed empirical material will be available by the end of July 2008 at www.geographyandgender.org.

Whether women (and men) claiming incapacity benefits can be considered unemployed or sick influences whether demand-side or supply-side policy interventions are likely to be more effective in reducing the number of women claiming incapacity. A lack of suitable local jobs requires a boost on the demand side of the labour market, whereas issues of low skills and ill-health require retraining and rehabilitation on the supply side. These factors are not, however, independent. Employers in a slack labour market with little difficulty in recruiting may be less

flexible in accommodating employees with health or disability issues compared to their counterparts in more buoyant labour markets who may face greater pressures to attract and retain staff. In other words, ill health or disability may be a greater disadvantage in a slack local labour market than a tight one.

Geographically concentrated ill-health in combination with a slack labour market gives rise to a situation where many people are likely to claim incapacity. Both these factors can be thought of as necessary but not sufficient conditions to produce a large number of people on incapacity benefits. Although health rather than redundancy is often the trigger for job loss among incapacity claimants, most of these people could reasonably be expected to be employed in a fully employed local labour market. We say this on two grounds. First, they may be more likely to be either retained by their existing employer when they became sick or recruited by a subsequent employer before or soon after claiming incapacity benefit. Second, their health would in all likelihood not have been as bad in the first instance if they lived in a more prosperous part of the country. Although ill health may be the trigger to leaving employment, low labour demand is often the obstacle to re-engagement in some parts of Britain.

These interactions between health and labour market conditions make it difficult to neatly categorise incapacity claimants as either 'unemployed' or 'sick'. Probably the most accurate representation is that many disability claimants are *both*, but to varying degrees depending on local labour market conditions and a specific individual's skills, confidence, household position and, of course, their health/disability.

There appears to be little if any evidence of cultural acceptance of being 'on the sick', even in areas with a high level of incapacity claims. Nor does there appear to be a heightened awareness among the general population of incapacity benefits in these areas. GPs and benefit officers reportedly encouraged invalidity/incapacity claims until the mid 1990s but that both these sets of professionals now encourage people to remain in or move towards employment whenever possible. However, GPs are constrained by their duty as primary health care provider to actively challenge a patient's own view of themselves as incapable of work.

We have developed a threefold typology of women claiming incapacity: 'discouraged', 'incapacitated' and 'dependent'. 'Discouraged workers' are those whose disability or ill-health is relatively minor or likely to be short-lived but who are

discouraged from active job search because of a lack of suitable local job openings. Those falling into the 'incapacitated' category may see greater job opportunities open to them – for example because they are young or possess a particular skill set – but who currently see themselves as unfit for work on grounds of disability or ill-health. The final – and largest – group can be categorised as 'dependent' in that they see very little prospect of ever working again and perceive insurmountable obstacles and risks to re-entering employment. Through time, discouraged and incapacitated workers will tend to move towards the dependent category.

There is a relationship between the classification of claimants as 'unemployed' or 'sick' and the typology of 'discouraged', 'incapacitated' or 'dependent'. Discouraged workers are all unemployed in that they would like a job but their job prospects are low due to a combination of low skills, ill-health and availability of suitable jobs. No incapacitated workers can be characterised as unemployed on the basis that – at least currently – they do not want a job due to ill health or injury which they anticipate or hope to improve – they see themselves as a temporarily sick worker. Dependent claimants are a combination of those who are only sick (do not want a job due to insurmountable health obstacles) and those who are a combination of both sick and unemployed (retaining a latent desire to work but face a range of health and other obstacles to employment such as low skills and low confidence).

Claimants interviewed did not talk at great length about making a 'rational choice' to remain on incapacity benefits, although some thought they would only be able to command a low wage. Rather, most of the women interviewed could be better described as 'risk averse'. To a woman who is risk-averse, 'dependency' is a rational choice because entering employment risks their health and their financial stability should a job not work out. A lot of women incapacity claimants have partners in employment, often reasonably well paid, and perhaps more so than the wives of their male counterparts. This, along with enduring cultural notions of the male breadwinner and men as risk-takers, may encourage women claiming incapacity benefits to perceive of themselves as 'dependent' rather than 'incapacitated'.