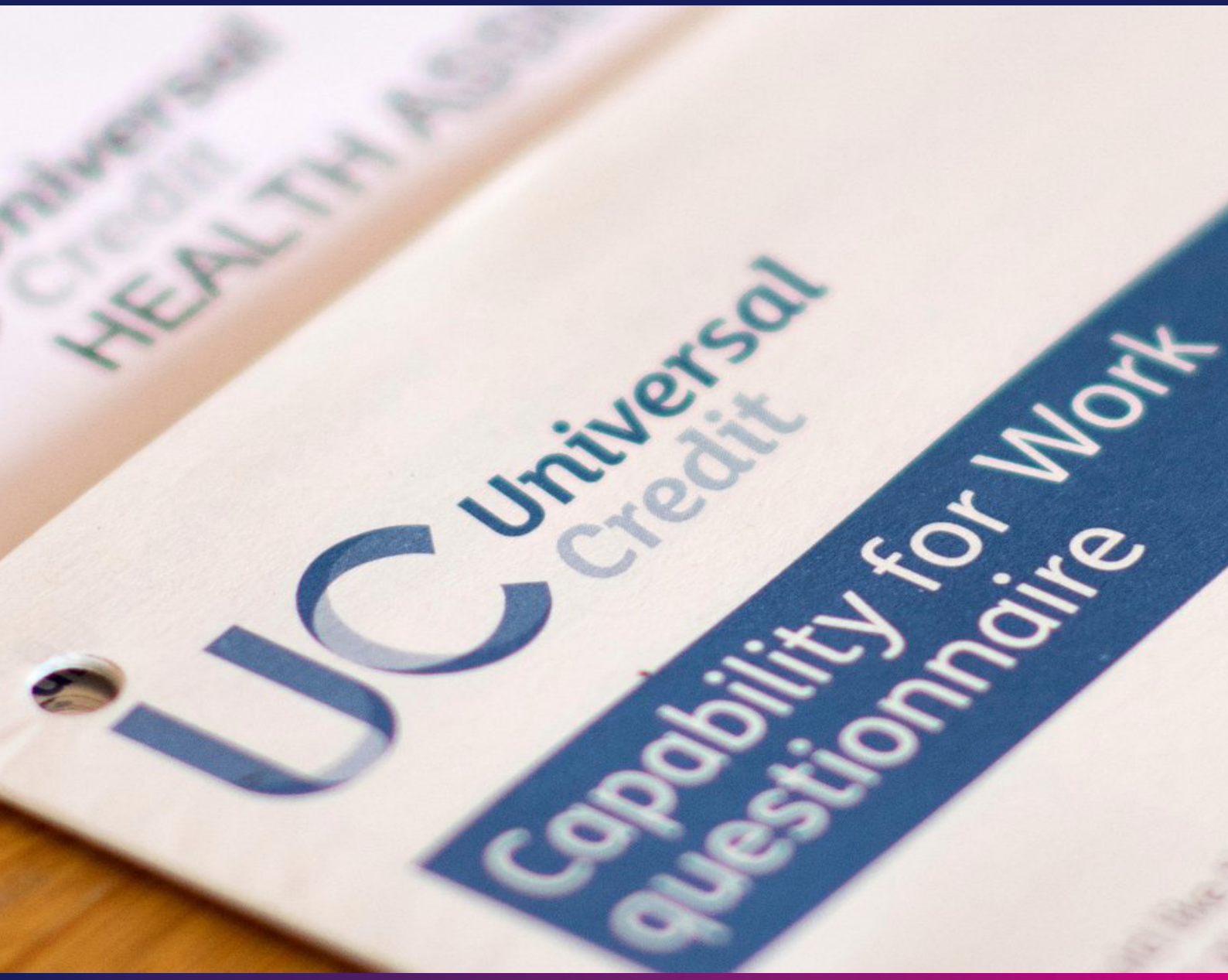
INSTITUTE FOR GOVERNMENT

Designing better incapacity benefits

How should government improve benefits policy making for people out of work due to ill health?



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About this report

This report forms part of a wider Institute for Government project on how government could make better policy for people out of work due to ill health or disability. Earlier this year, the Institute published a report looking at the role of employment support.[1] This report looks at how government could better design incapacity benefits to deliver on its objectives.

The report focuses on incapacity benefits specifically – that is, benefits for people whose health condition or disability limits their ability to work. Currently, this includes the health element of Universal Credit and New Style Employment and Support Allowance. The report also looks at the wider system of support available for people whose health may limit their ability to work – including other relevant benefits, such as Personal Independence Payment and standard Universal Credit, and other support available to help people who are out of work due to ill health or disability. The report covers five key areas of incapacity benefits policy making, exploring why they are inherently challenging and the problems with how government has approached them to date. It also sets out recommendations to improve policy making in the future.

The report is focused on the benefits system in England and Wales. Many of the findings will also be relevant to Scotland and Northern Ireland, but the devolution of disability benefits to Scotland and wider social security to Northern Ireland means some of the findings will be less directly applicable to these UK nations.

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List of abbreviations

ADHD – attention deficit hyperactivity disorder

AME – annually managed expenditure

DEL – departmental expenditure limit

DHSC – Department of Health and Social Care

DWP – Department for Work and Pensions

HMRC – HM Revenue and Customs

LCW – limited capability for work

LCWRA – limited capability for work and work-related activity

NEET – not in education, employment or training

OBR – Office for Budget Responsibility

OECD – Organisation for Economic Co-operation and Development

OPMC – Office for the Prime Minister and Cabinet

PIP – Personal Independence Payment

SEND – special educational needs and disabilities

UC – Universal Credit

WCA – Work Capability Assessment

WRAG – Work-Related Activity Group

Summary

The rising number of people out of work due to ill health or disability in the UK is a major challenge for government. It has damaging consequences for the economy, public finances and the people themselves. Spending on incapacity benefits – largely means-tested benefits for people whose health or disability limits their ability to work – has increased by almost 50% since the Covid pandemic as the number of claimants has risen dramatically. Drivers of this rise include worsening population health as well as problems with the wider health and disability benefits system.* The result is that people often do not receive support that is well matched to their needs.

Incapacity benefits are designed to provide income replacement for people whose health or disability limits their ability to work. The benefit level is higher than for people who are unemployed but do not have a work-limiting health condition. The health element of Universal Credit (UC health) is the main incapacity benefit, and is means-tested, but a minority receive New Style Employment and Support Allowance (NS ESA), which is a contributory and non-means-tested benefit. Around two thirds of people receiving incapacity benefits also receive non-means-tested disability benefits (primarily Personal Independence Payment, PIP). PIP aims to help cover the additional costs of being disabled and is not means-tested. Eligibility for PIP is based on the support someone needs to carry out daily living and mobility activities, rather than more work-specific activities.

Governments have long been interested in reforming incapacity benefits to control costs and encourage more people into work, but there are several challenges to doing so. The most recent attempt at reform, in spring 2025, saw substantial parliamentary opposition, with PIP reforms being largely abandoned and changes to UC health watered down despite some substantive reforms still being made.

The purpose of incapacity benefits has been unclear

The purpose of disability benefits is relatively clear, although eligibility for PIP is currently being considered in the Timms review. However, the purpose of incapacity benefits has become much less clear over time. The principle behind the introduction of incapacity benefits in 1971 was that it would support people whose ill health or disability meant they would be unable to work for a long period or indefinitely, and who therefore needed a higher level of income replacement through benefits than those who were unemployed for a short period.

This principle is less clearly applicable today. Greater flexibility in working patterns and remote working should have helped reduce barriers to work for at least some of this group, and medical treatments have improved. But, counterintuitively, the

* The incapacity benefits system is defined in this report as including incapacity benefits and support focused on helping people who have health- or disability-related barriers to employment into work. The health and disability benefits system is defined more broadly, and includes the incapacity benefits system alongside Personal Independence Payment (PIP) and other support aimed at supporting the independence and living standards of disabled people and people with a limiting health condition.

proportion of the working-age population out of work due to ill health is much higher than when incapacity benefits were introduced. The mix of claimants' health conditions has also changed – with mental health conditions now the leading cause of health-related inactivity. Together, it is likely that incapacity benefits are not optimally designed for the workforce and nature of work today.

There have been problems with policy making for incapacity benefits

Working-age benefits in general are a lightning rod for public debate. A simplified narrative whereby unemployment benefit recipients are considered 'undeserving' compared with 'deserving' taxpayers has been increasingly applied to incapacity benefits as spending has risen. While the public do not want benefits spending to rise in general, and recognise that the current health and disability benefits system is not working, they are often opposed to more specific measures that would limit spending, particularly when those measures would have an impact on disabled people. This has **made it difficult for those politicians who have tried to lead a nuanced public and political debate about reforming incapacity benefits**, including who should be eligible for what level of benefits and wider support. Politicians have struggled to gain public and parliamentary support for cost-saving reforms, even while being blamed for allowing the incapacity benefits bill to increase. Incapacity benefit claimants' lack of trust in government acts as a further barrier to communicating the rationale for reforms and implementing them effectively.

One big problem with the existing system is how similarly it treats very different types of people. **The approach to categorisation in the current system favours simplification over personalisation.** This has meant support is often not well matched to the complexity of people's needs. A rigid assessment process exacerbates this problem – it uses outdated criteria and has not been updated to reflect the changing nature of disability and work. In addition, the outsourced assessment process has been focused narrowly on eligibility for benefits, rather than the broader package of support from which people could benefit. Existing government plans for a new combined assessment for PIP and UC health present an opportunity to take a different approach.

People receiving incapacity benefits often interact with multiple parts of the public sector and may receive other benefits that are aiming to achieve the same or similar objectives. Changes in incapacity benefits can therefore affect other public services – and vice versa. This means that the join-up of incapacity benefits policy making with other health and labour market policy is vital. Despite some positive examples of joined-up working, including within the Department for Work and Pensions (DWP), **siloed structures and misaligned incentives can get in the way of effective collaboration across government to improve the incapacity benefits system**.

The Treasury has an important role in controlling costs, which is a necessary constraint in incapacity benefit design. However, the **pressure to tweak benefits for fiscal event announcements has made policy making more rushed, secretive and narrowly focused**. This focus has shrunk the scope of potential reforms and made it even harder to build broad-based support for a new system. Disconnected processes for reviewing

departmental spending and social security spending have made it more difficult for government to comprehensively review where it can get best value for money within the wider health and disability benefits system. Mechanisms for controlling costs, such as the welfare cap, have been largely ineffective.

A lack of good evidence on the impacts of potential changes to incapacity benefits holds back the effective design of incapacity benefits. Although experimenting with benefits policy has additional challenges compared with policy in other areas, gaps in the data and rushed policy making for fiscal events have limited evidence gathering.

Based on this analysis, this report makes recommendations for how the government can better approach incapacity benefits policy. We propose a shift in the system towards more personalised support that better matches people's needs. This would improve provision for people with health conditions or disabilities, ensure the system is delivering good value for money and make further reforms possible. Regardless of the government's specific objectives for the system, which politicians should specify much more clearly, we also propose other improvements to how benefits policy is made that will make achieving those objectives easier. These recommendations, elaborated on below, are in four main areas:

- a political narrative that leads public opinion
- an assessment that helps people access support that better meets their needs
- a fiscal and performance framework for policy making that enables collaboration and improves value for money
- better use of evidence to inform policy decisions.

Recommendations

This government has an opportunity to pursue transformational change of the health and disability benefits system, moving beyond the past approach of minor tweaks. With a new prime minister having entered No.10 since the ill-fated spring 2025 reforms, government has a fresh opportunity to define a vision of what the system should do, and the reforms needed to achieve this. To successfully deliver change, the way government makes policy on this tricky topic must also improve.

A shift towards providing more personalised support that better matches people's needs should underpin reforms to the health and disability benefits system. This means moving beyond crudely categorising people as having 'limited capability for work or work-related activity' and providing incapacity benefits but relatively little support to help them move into work. Personalisation should include more tailored support to help some people move into work but it could include different rates of incapacity benefits and conditionality requirements for different groups of people as well.

A political narrative that leads public opinion

1. Ministers should set out a political vision for what outcomes the health and disability benefits system is trying to achieve for different groups of people out of work due to ill health

Simplistic political narratives and their impact on public perceptions have limited politicians' room for manoeuvre on reforming health and disability benefits (see Chapter 2). To lead public opinion on reform, ministers must first more clearly articulate the purpose of different benefits and how they relate to the wider health and disability benefits system.

Ministers should also more clearly distinguish between different groups of people out of work due to ill health in terms of the outcomes the health and disability benefits system is aiming for them to achieve. For example, they could better distinguish between those who could work again in the future, and those whose health means they are very unlikely to. Or they could distinguish between people with different levels of independence in particular activities; or people of different ages.

Ministers should set out how these outcomes link to more personalised financial and non-financial support that will best help people achieve them* – and the evidence that is informing decisions about who should be eligible for different kinds of support. This would help to build trust with key stakeholders and consensus for reforms.

Building this consensus should be possible. The majority of the public see benefits as an important part of the state,[1] while two thirds of people think the current system is in need of reform.[2] And there is strong support for tackling the underlying causes of why people claim benefits as a means to reducing social security spending.[3] This suggests that a more personalised system could be popular.

Politicians therefore have a foundation for moving away from simplistic narratives that cement binary distinctions between 'deserving' and 'undeserving' claimants that cannot be applied to concrete reforms. Instead, they have an opportunity to put forward a more positive vision of what the system should achieve for people out of work due to ill health. Research shows that attitudes to social security and claimants can and do change[4] – and while this is attributable to many factors, the way that politicians frame narratives is a significant contributor.

2. Ministers must engage extensively with MPs to build the case for the reform of incapacity benefits

Parliamentary engagement was an apparent weakness of the Starmer government. Opposition from primarily Labour backbench MPs brought down the spring 2025 welfare reforms. Ministers must ensure MPs understand the political and policy choices made, are supportive of them and are able to explain them to their constituents. Getting this right should be a priority for DWP ministers. The way government built parliamentary support for reforms to special educational needs and disabilities (SEND) provision shows it can be done.**

* Examples of what this could mean in practice are set out on in Box 3, Chapter 3.
** Government's approach to building support for SEND reforms in 2025 and 2026 is discussed further in Chapter 2.

3. DWP should take concrete and visible steps to improve incapacity benefit claimants' experience of interactions with the department

Improving incapacity benefit claimants' experience of interactions with DWP would have several benefits. First, it could help reduce the distress for claimants related to some aspects of the benefits system.[5] It would also be valuable in showing to disabled people, the public and MPs some tangible steps that government is making to address concerns that claimants have raised. This may help to build trust and reduce opposition from disabled groups and MPs to a package of reforms – even if it does not negate potential more substantive disagreements about changing the level of benefits spending. Increasing trust with claimants may also support successful practical implementation of reforms, potentially increasing the level and quality of voluntary engagement with various forms of support. Some of the ways others have suggested would improve claimants' interactions with DWP include improving how the department communicates with claimants (for example, through the UC online journal) and improving the environment in which conversations with DWP staff take place.[6]

An assessment that helps people access support that better meets their needs

4. DWP should use the opportunity of a new combined assessment process to better personalise support to people's needs and circumstances

A more personalised system will only work if people's needs can be assessed effectively. The assessment process, which is already undergoing changes, is a crucial part of the system (see Chapter 3) and it should be central to any reform.

The plans for a new combined assessment process for incapacity benefits and PIP are an opportunity to reform and improve the assessment process. In the future, the assessment should be used not just to determine entitlement and associated requirements. It should also direct people to the breadth of support that would help them live independently and better reflects their proximity to the labour market, so that those who may able to work again in the future are better supported to do so.

Doing this well would require assessors to be appropriately trained in functional assessment to ensure they can accurately assess what support would help people live independent lives. The organisation providing assessments should be integrated with local services well enough that assessors understand the support available locally.

One way this could be done is through the **creation of a personalised support plan** as the outcome for each assessment. This plan should set out:

- the broad range of support that would enable the independence of people living with a disability or long-term health condition (one of DWP's key objectives)
    - this should include health and disability benefits entitlement – any associated conditionality regime would be a key part of this
    - at a minimum, it should encompass employment and skills support for people where moving into work is a realistic goal

    - ideally, it should also cover other support – such as adult social care

- when reassessment will take place, taking into account factors such as proximity to the labour market and the degree to which the person's health condition fluctuates

    - given the contentious nature of reassessment, it should be linked to specific criteria and categories, rather than being left to the discretion of the assessor.

The non-benefit elements of a personalised support plan should not have a statutory basis, but should be used to help connect people to local services. This will require DWP to work with strategic and local authorities responsible for designing and delivering employment support, to understand the system of support available.[7] If government were to introduce greater conditionality for some groups of incapacity benefit claimants, the personalised support plan could act as a basis for discussion about what engagement is likely to best support the person's entry into work.

These changes would make assessments for incapacity benefits more similar to the assessment of needs under the Care Act 2014, which is more flexible and aims to better account for people's individual needs.[8] However, unlike Care Act assessments, the personalised support plan would not be a defined funding package for wider support, beyond benefit entitlement, at the end of the assessment process.

DWP should also consider whether new categories within health and disability benefits are needed to better personalise the level of benefits received and conditionality applied, rather than tailoring employment support (and associated conditionality) to different groups of people receiving the same financial award. Evidence on how different incentives, provision of support and conditionality regimes might affect different groups should drive this decision.

DWP has recently taken some steps in this direction through giving a higher rate of UC health to claimants in the 'severe' category. If government decides that more categories are needed to better allocate support to different groups of incapacity benefit claimants, then this could be done through changes to UC health and/or PIP categories. Having more categories may not just better match support to people's needs, but also help reduce incentives to claim incapacity benefits by reducing the cliff edge in rates and conditionality regime between UC health and the UC standard allowance.

5. DWP should insource the new combined assessment process

As part of setting up the new combined assessment process, government should formally review whether the current outsourced delivery model is fit for purpose. There are good reasons to think that a reformed and more personalised assessment process would be more effectively delivered in-house. Insourcing would provide DWP with greater flexibility to manage more complex outputs. It would also enable more flexibility in delivery, allowing DWP to more easily change how assessment is conducted in response to changing evidence or policy choices.

Insourcing would not be risk-free and would have practical and administrative implications – not least in terms of employing the assessor workforce. However, it is likely to be a necessary step to deliver a more holistic assessment as setting up a contract to do that well would be very difficult.

Whether or not DWP decides to insource combined assessments, it should use the combining of these assessments to conduct a review of the assessor workforce. This should include what training, competencies and professional background the department thinks assessors should have.

Given the abolition of the Work Capability Assessment (WCA) is pencilled in for 2029,[9] when current contracts are also due to expire, and insourcing the new assessments would pose practical challenges, government should aim to come to a decision on the delivery model as soon as possible to ensure insourcing is a feasible option for the new assessments. If DWP decides to continue with an outsourcing model for the combined assessment, then the department should set out clearly why it thinks outsourcing will deliver better value for money.

6. The assessment criteria and process should be regularly reviewed to ensure they continue to reflect the changing nature of work and disability, and are operating as intended

Better matching claimants' needs to support will require the assessment criteria and process to evolve to reflect the changing nature of work and disability. To ensure this happens, DWP should establish regular reviews of the new combined assessment process, and in particular the criteria used in it, with updates made as required.

Government could undertake these reviews itself, or could commission an independent reviewer to do so with a clear remit and set of objectives. The independent WCA reviews conducted between 2010 and 2014 after the introduction of the WCA offer a potentially useful model for the latter option. These reviewers generated some valuable recommendations that government subsequently adopted, such as the tribunal providing DWP with feedback on decisions that were overturned, to support continuous improvement.[10] Defining reviews in legislation, as was done for the independent WCA reviews, may also help ensure they take place but may risk restricting their remit and limiting political buy-in.

A fiscal and performance framework for policy making that enables collaboration and improves value for money

7. The Office for the Prime Minister and Cabinet (OPMC) and the Treasury should work with DWP and the Department of Health and Social Care (DHSC) to set joint outcomes for tackling health-related inactivity, and the political governance to enable accountability for delivering on them

Outcomes for tackling health-related activity should be outlined at a high level in autumn 2026, and developed in more detail at spending review 2027. DWP and DHSC, and other departments where appropriate, should be jointly accountable for delivering them through the government's outcomes framework.

The Treasury should require DWP and DHSC, and potentially other departments depending on scope, to submit a joint bid for spending review 2027 to incentivise collaboration.

The OPMC should ensure appropriate structures are in place to support collaboration, and ensure ministers in both DWP and DHSC are held to account for delivery. This should be through an inter-ministerial board; however, an alternative could be for the prime minister to appoint a joint DWP–DHSC minister. This political governance should be supported by senior officials in both departments. If the prime minister wants to make reducing health-related inactivity a top priority, then the OPMC should be actively involved in holding relevant departments accountable for delivering on these joint outcomes.

8. The Treasury should require social security spending to be reviewed at spending reviews alongside departmental spending

Government reviewing social security spending (annually managed expenditure; AME) alongside departmental spending (departmental expenditure limits; DELs) by DWP and other departments would allow the Treasury to more comprehensively assess where resources can be best spent to achieve the government's aims.* It would also allow ministers to make the case for rebalancing spending on and support for particular groups, from social security to DEL programmes, or vice versa.

In practice, this could work in the following way:

- The chancellor would explicitly put social security spending in scope, alongside departmental spending, on launching the spending review.

- The Treasury would define an indicative AME envelope based on the OBR's forecast level of spending in each year of the spending review. This should be combined with DWP's DEL to form the department's overall envelope, to enable more comprehensive spending review bids and negotiations.

- The Treasury would request joint bids between DWP and DHSC, with involvement of other departments where appropriate, that cover health and disability benefit spending. The Treasury should require joint bids and negotiations between the relevant departments, even though this would not result in formal joint budget allocations that include AME spend.

- The outcome of the spending review would be DEL allocations, alongside an updated OBR forecast for AME that reflects the impact of changes. A firm AME 'limit' would not be set, given the demand-led nature of spending.

* The different categories of government spending, and how they are allocated and managed, are discussed in Box 4, Chapter 5.

9. The Treasury should abolish or reform the welfare cap to support more proactive management of social security spending

The welfare cap is not serving any useful purpose (see Chapter 5). Removing it in its current form would be no great loss from a policy making perspective. However, abolishing it may be politically difficult. If abolishing the cap is not an option, then meaningfully reforming the cap to be a mechanism that provides an early warning system when social security costs increase, and helps the government to understand and proactively manage that spending, would be valuable.

One way the Treasury could do this, would be to reform the welfare cap along the following lines:

- The OBR should formally report at the budget each year on whether the forecast for social security spending within the cap has increased for (say) the third year of the forecast, compared with the OBR's forecast a year before. This would mean moving from a fixed point of assessment every five years to a rolling assessment on a three-year time horizon – bringing it in line with the fiscal rules.

- Where the OBR's previous forecast is materially exceeded – for example, by a given margin such as 2%* – the OBR should be required to produce a statement explaining the reasons for the higher-than-forecast spending. This should cover numbers moving on and off benefits within the welfare cap, benefit rates, wider economic and demographic factors, behavioural effects and forecast errors.

- The secretary of state for work and pensions should be required to respond to this statement in parliament, setting out the government's understanding of the drivers of changes that the OBR has set out – and the government's response to them.

- The government should be required to consult the Social Security Advisory Committee (SSAC) on this response before publishing it. The committee should assess:

    - the evidence used to inform the government's response

    - the trade-offs involved in the proposals

    - alternative options

    - particular gaps in the evidence base that create uncertainty.

- The committee should publish its advice alongside the work and pensions secretary's statement.

* We estimate this threshold would have been exceeded on four occasions since 2015. This is based on the OBR's autumn forecasts for spending within the welfare cap, adjusted for changes in CPI using annual CPI forecasts. The years when forecast spending increased by more than this threshold were 2016, 2021, 2022 and 2023.

The 'demand-led' nature of social security spending means a firm limit, as is in place for departmental spending, is not feasible or desirable. These reforms to the welfare cap should aim to highlight when social security spending is placing higher-than-expected pressure on the public finances, and focus the public debate on why this is the case. The rolling nature of the cap, and an independent assessment of the drivers of higher social security spend, would aim to help create the political space for ministers to address these drivers.

Better use of evidence to inform policy decisions

10. Ministers should make the case for building the evidence base on health and disability benefits

Testing new approaches to understand what works in health and disability benefit design has political and delivery risks. However, ministers must recognise the longer-term political opportunity of having a strong evidence base that can be drawn on to identify the right answers to the problem of health-related inactivity, and to build the case for pursuing them.

DWP ministers should make evidence generation and evaluation explicit priorities for the department. They should back officials both publicly and privately to test potential new approaches to assessment, conditionality and support. Ministers should provide support for both testing before changes are rolled out, and thorough evaluations of new policies that are introduced despite key uncertainties about their impacts. This should include both privately and publicly defending this approach in response to media criticism, to help counter risk aversion.

11. DWP should ensure future benefits legislation allows flexibility for testing and experimentation

DWP should incorporate flexibility into future benefits legislation to ensure government is able to experiment with different health and disability benefits regimes to better understand what works. MPs, including the Work and Pensions Select Committee, should work to ensure these powers are in place.

The 'pilot schemes' clause in the Welfare Reform Act 2012 shows this is possible. However, that this clause has only been used once, to our knowledge, shows the importance of legislation allowing enough flexibility for piloting to take place. Similarly, legislation should ensure temporary piloting powers do not become a back-door route for permanent changes.

12. DWP should more clearly set out the evidence needed to inform more accurate modelling and better future policy decisions

DWP should publicly identify a small number of priority policy areas where gaps in the evidence are holding back policy making. Officials should clearly articulate the evidence that is missing and how addressing this will inform future policy decisions. This should include DWP setting out more detail on how the 118 questions in its Areas of Research Interest will contribute to future policy decisions. Where appropriate, DWP should work with the OBR to identify specific evidence gaps that limit its ability to accurately model changes to social security policy. This would incentivise external researchers to prioritise working on the most important questions.

In cases where the Treasury and DWP disagree with the OBR's estimate for the impact of a policy decision, or the OBR does not feel it has enough evidence to score wider effects of the policy on labour market participation, the government should publish its own evidence. It should continue to accept the OBR's central estimate, but work with the OBR and external experts to build the evidence needed so that the OBR can revise its costing should the government's analysis prove to be correct.

1. Introduction

The substantial rise in the number of people out of work due to ill health since the Covid pandemic poses a major challenge for government. People in this group access a range of services to support their health, living standards and employment prospects – but an increasingly expensive component of this is incapacity benefits. Real-terms spending on these largely means-tested benefits for people with health-related barriers to work has increased by almost 50% since 2018/19 – and stood at £31bn in 2025/26.[1] This is more, for example, than the entire Home Office budget. Economic inactivity also has wider economic costs, as well as major adverse effects for the people whose health limits their ability to work.

Multiple, interconnected factors have likely contributed to higher incapacity benefits spending. These include worsening population health, challenging labour market conditions and, importantly, features of incapacity benefits design that have created perverse incentives and not effectively supported people into work. Yet reforms to incapacity benefits, and the wider system of support around them, to help control costs have proven difficult for government to deliver. Crucially, successive governments have not explicitly addressed the vital – but politically sensitive – questions of *who* should receive *what* support from the wider health and disability benefits system* and to *what end*. The result is that incapacity benefits have become increasingly expensive, but the system as a whole is not well set up to help those who can work into employment.

Incapacity benefits are a key part of a wider system of support for people out of work due to ill health or disability

Incapacity benefits are the main category of benefits for people who are out of work or on a low income due to a health condition or disability. The health element of Universal Credit (UC health) is the main incapacity benefit. UC health is paid at a higher rate than the UC standard allowance, which is for people out of work who do not have a work-limiting health condition. And, unlike UC standard allowance, there is no conditionality within UC health that requires claimants to look for work to receive it.

Many incapacity benefit recipients will also be eligible for other benefits, including other means-tested benefits, such as the housing element of UC, and non-means tested disability benefits, which aim to cover the extra costs of daily living associated with having a disability or long-term health condition.

Disability is defined in the Equality Act 2010 as "a physical or mental impairment [that] has a substantial and long-term adverse effect on [a person's] ability to do normal day-to-day activities". Official disability employment data uses a measure of self-reported disability. Therefore, both the underlying prevalence of disability, and how disability interacts with people's environment and social context to limit their ability to do daily activities, affect the data.[2]

* The incapacity benefits system is defined as including incapacity benefits and support focused on helping people with health-related barriers to employment into work. The health and disability benefits system is defined more broadly, and includes the incapacity benefits system alongside Personal Independence Payment (PIP) and other support aimed at supporting the independence and living standards of disabled people.

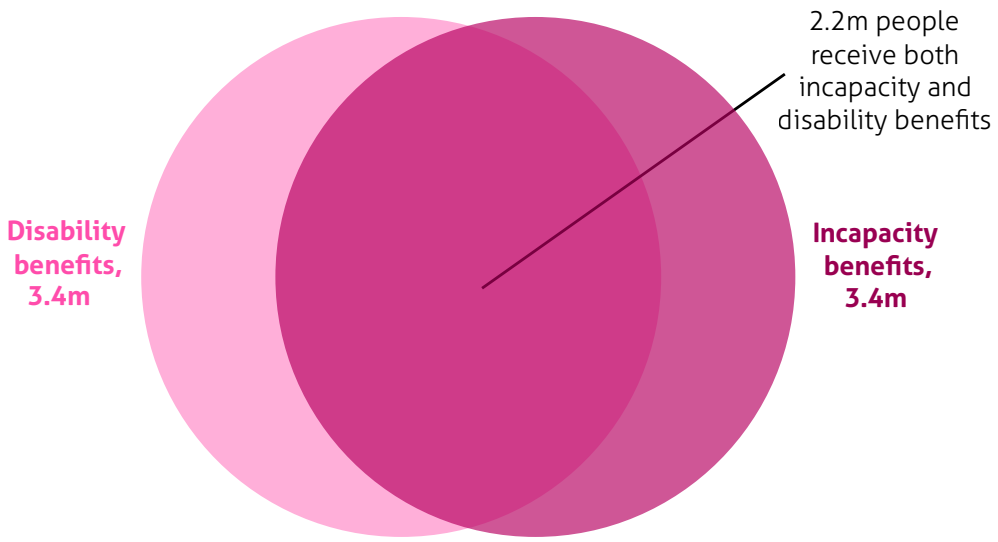
Within the social security system, eligibility for incapacity benefits versus disability benefits (such as Personal Independence Payment; PIP) is based on an assessment of the 'activities' a person's impairment makes it more difficult to do, as set out in government guidance (bold added for emphasis):

- PIP: "a long-term physical or mental health condition or disability" and **"difficulty doing certain everyday tasks or getting around" that is expected to last for at least 12 months**.[3]

- Incapacity benefits: level of income and having "a health condition or a disability which **limits how much work you can do**".[4]

In practice, someone's ability to work is closely linked to the difficulties they have doing everyday tasks. This is reflected in the many similarities in the criteria used to assess eligibility for incapacity benefits and PIP,* and that around two thirds of incapacity benefit recipients also receive PIP.[5]

Figure 1 **Working-age health and disability benefits claimants, March 2026**



Source: Institute for Government analysis of Department for Work and Pensions, Benefits combinations: Official Statistics to March 2026, 2026. Notes: Data is for England and Wales only. Circle area is in proportion to caseload. The area of circle overlap is a visual approximation for caseload overlap. Incapacity benefits includes people claiming Universal Credit (UC) health and New Style Employment and Support Allowance (NS ESA), or legacy equivalents. Incapacity benefits claimants data includes people who are waiting for an assessment or in the limited capability for work group. Disability benefits includes people claiming Personal Independent Payment (PIP) and Disability Living Allowance (DLA).

* The Work Capability Assessment (WCA) is used to assess people for incapacity benefits. The criteria for "reaching" in this assessment are closely linked to the PIP "dressing and undressing" criteria. For example, someone who "cannot raise either arm to top of head as if to put on a hat" (WCA criteria, 3b) will also likely need "assistance to be able to dress or undress their upper body" (PIP assessment criteria, 6b).

Box 1 **What are incapacity benefits?**

Incapacity benefits are part of the wider welfare state. Some form of support from the state to address the challenges associated with disease, poverty, demographic change and population change has been provided since the 1800s, with varying degrees of generosity and rules on eligibility.[6] But the modern conception of the welfare state is generally agreed to have developed from Sir William Beveridge's 1942 report, which set out an expansive vision for attacking the "five giants" of want, disease, ignorance, squalor and idleness.[7] He called for "a sense of national unity overriding the interests of any class or section" – a mission that created a 'welfare state' that has evolved in its definition over time,[8] but broadly encompassed social security, health, education, housing, social services and a policy of full employment.[9,10,11]

Health, education and social security are the most commonly identified pillars of the modern welfare state. Of these, access to health and education has remained largely universal. In contrast, social security, which consists of benefits to pensioners and people of working age, has taken two diverging paths. The state pension, the primary form of pension-age social security, is a near-universal benefit, whose main objective is to provide a foundation of retirement income for everyone, supplemented for many by private pensions and savings.[12,13] In contrast, working-age social security is more selective, providing means-tested income replacement for those on low incomes, alongside 'extra cost' benefits (such as those for health and disability, housing or children).[14]

The history of incapacity benefits

The first incapacity benefit, Invalidity Benefit, was introduced in 1971. It was split out from Sickness Benefit, a flat-rate, non-means-tested income benefit, and offered to those who had been on Sickness Benefit for more than 28 weeks. Invalidity Benefit was intended to provide additional income replacement for people with health conditions that prevented them from working for a long period or indefinitely. The logic was that this group were expected to require a higher level of income replacement than both (a) people out of work due to ill health for a short period of time and (b) people who were unemployed without work-limiting health conditions (who were assumed to be mostly out of work for only a short time). The reasoning for providing this higher income replacement was that being out of work long term was more likely to erode savings, and would have a bigger impact on overall lifetime earnings.[15]

Invalidity Benefit was replaced by Incapacity Benefit in 1995, which was then replaced by Employment and Support Allowance (ESA) in 2008. The current primary model of incapacity benefits, delivered through a health-related addition to Universal Credit (UC) (see below), is a result of reforms introduced by the Welfare Reform Act 2012. UC was a major change to the benefits system, rolling six benefits into one. However, the rollout was protracted and only began at a national level in 2016.

Current incapacity benefits

Since 2008, people who may be eligible for incapacity benefits are usually required to complete a Work Capability Assessment (WCA). This is a functional assessment carried out by private providers that assesses whether people have "limited capability for work and work-related activity" (LCWRA) and are therefore eligible for incapacity benefits.[16] Those assessed as being either 'fit for work' or having 'limited capability for work' (LCW) receive just the UC standard allowance (with fewer work-related requirements for the LCW group).

Depending on a person's history of national insurance contributions, the incapacity benefit they receive will be either the UC health and/or the New Style Employment and Support Allowance (NS ESA).* UC is means tested, whereas NS ESA is not. Most incapacity benefit claimants now receive UC health.

Since April 2026, the standard UC rate has been £98 a week while the health element is an additional £50 a week – apart from people who are nearing the end of life or have the most severe conditions, who continue to receive a higher rate.**

Incapacity benefits claimants are not required to engage in work-related activity, but some will be offered employment support on a voluntary basis to help them get into work. This support has been relatively small scale to date, with only one in 10 people out of work due to ill health engaging with support each year.[17] People with health conditions that limit their ability to work will often have multiple needs and interact with a range of other public services to access support, most obviously the NHS, but also local authorities, adult social care providers, housing associations, adult skills provision and many others.

Worsening population health and features of the benefits system have increased incapacity benefit caseloads in recent years

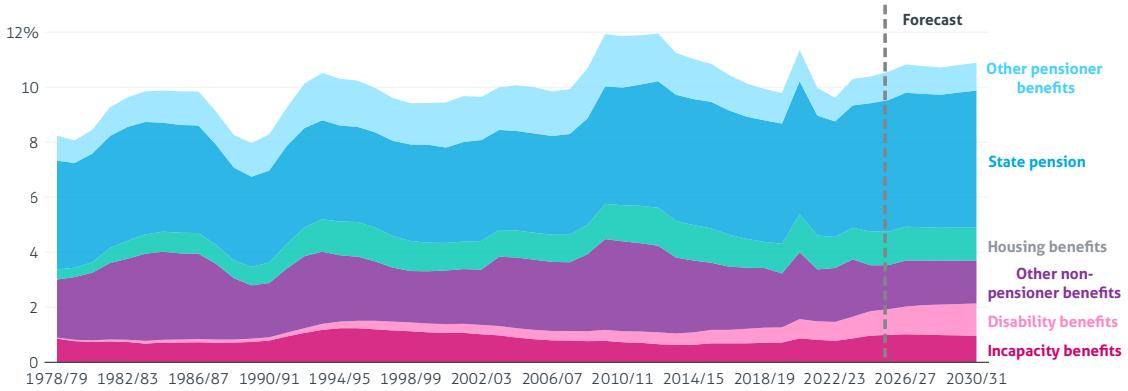
Total social security spending in Great Britain was £323bn in 2025/26, equivalent to 10.6% of GDP.***,[18] More than half of this went to pensioners, mostly through the state pension. Incapacity benefits spending was £31bn in the same year (1.0% of GDP). However, incapacity benefits spending has grown faster than spending on most other benefits in recent years – and now accounts for 9.4% of social security spending.

* New Style ESA is a contributory, non-means-tested incapacity benefit outside of UC. However, government is currently considering proposals to merge it into a new 'Unemployment Insurance'.

** These numbers are for a single person aged 25 or over in the LCWRA group from 6 April 2026 onwards. Changes announced in 2025 increased the standard UC amount from £92 to £98 a week for all claimants, while the UC health element was reduced from £97 to £50 a week for new claimants. For more information, see Department for Work and Pensions, 'Universal Credit', www.gov.uk/universal-credit/what-youll-get

*** Spending is for Great Britain only because most social security spending is devolved to Northern Ireland. However, the GDP figure used is for the whole of the UK.

Figure 2 **Spending on social security as a share of GDP, actual and forecast, 1978/79–2030/31**



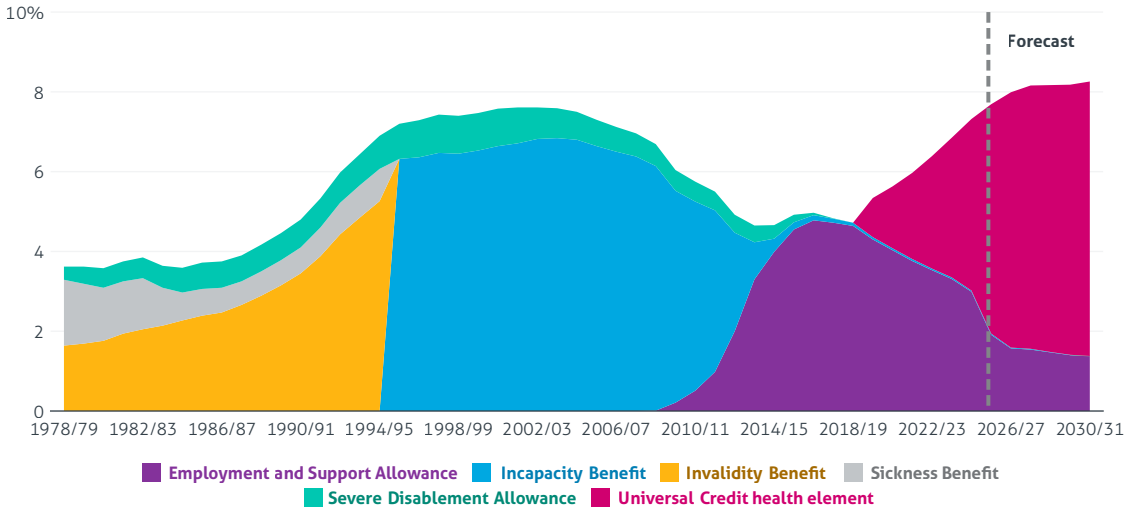
Source: Institute for Government analysis of Department for Work and Pensions, 'Benefit expenditure and caseload tables', 2026 and Scottish Fiscal Commission, 'Economic and Fiscal Forecast', various. Notes: GDP is for whole of UK, but working-age incapacity benefit spending excludes Northern Ireland. Housing benefits includes both pensioner and non-pensioner benefits. Disability benefits includes spending devolved to the Scottish government since 2020/21. Incapacity benefits spending excludes people waiting for an assessment.

An increase in the number of claimants for incapacity benefits has driven the rise in spending on these benefits. The number of claimants rose to more than 7.7% of the working-age population in 2025/26 (3.4 million people), almost equal to the last peak in the early 2000s.[*,19] In March 2026, the Office for Budget Responsibility (OBR) expected this to reach to 8.3% in 2030/31.[20]

The main reason for the rise between 2010/11 and 2022/23 was more people moving on to incapacity benefits, relative to the much smaller increase in the number of people moving off them.[21] However, just 20% of the increase came from a higher number of people making new claims. More important has been the success rate for claims made being higher and fewer people dropping out during the assessment process (responsible for 48% and 30% of the total increase respectively).[22]

* These numbers are for incapacity benefits claimants, excluding people waiting for a work capability assessment.

Figure 3 **Incapacity benefit caseloads as a share of the working-age population, actual and forecast, 1978/79–2030/31**



Source: Institute for Government analysis of Department for Work and Pensions, 'Benefit expenditure and caseload tables 2026'; Office for National Statistics, '2022-based national population projections: Migration category variant datasets for Great Britain (summary and machine-readable)'; Office for National Statistics, 'Population estimates for the UK and constituent countries by sex and age; Historical time series', 2024; Office for National Statistics, 'Summary of employment, unemployment and economic inactivity for people below state pension age', August 2026. Notes: Claimants waiting for assessment are excluded for both Employment and Support Allowance (ESA) and Universal Credit (UC). Universal Credit includes the limited capability for work (LCW) and limited capability for work and work-related activity (LCWRA) categories. Claimants of Income Support (incapacity/sick and disabled) are excluded because nearly all claimants also receive one of the other benefits shown. Dual claimants for ESA and UC are only counted as ESA. Data is for Great Britain; Northern Ireland is excluded.

Of the uptick in the incapacity benefits caseload of one million since 2018, DWP estimates that around a third can be explained by a combination of an ageing population, a higher state pension age and people transferring from old benefits to UC health.[23]

Another important contributor to higher onflows across all age groups in recent years is **worsening population health**.[24] Rates of self-reported disability rose from 17% in 2014/15 to 23% in 2024/25. The proportion of working-age adults reporting a mental health condition almost doubled between 2013/14 and 2024/25 (from 6% to 11%).[25] Mental health conditions have become the leading cause of health-related inactivity, while the prevalence of autism has also risen.[26] The interim report of the independent review into mental health conditions, attention deficit hyperactivity disorder (ADHD) and autism found that the rising prevalence of mental health conditions is not driven by a simple picture of either rising disorder or over-medicalisation.[27] Instead, it is caused by a mixture of:

- increasing underlying psychological distress
- health systems more intensively identifying and recording need
- social changes that shape who is identified as having a mental health condition.[28]

In addition, people out of work due to ill health are more likely to report multiple health conditions than in the past, with almost 40% reporting five or more conditions.[29] This suggests increasingly complex health needs among this group. The proportion of working-age adults requesting adult social care support has also increased, implying growing need for support with activities of daily living.[30] Improvements in medical treatments are, at least in part, driving this: people are living longer with conditions from which they would have likely died in the past.

This worsening of population health is reflected in rising numbers of people out of work due to ill health since the Covid pandemic,[31] many (but not all) of who claim incapacity benefits. However, some other countries where population health has deteriorated since the pandemic have not seen the same rise in health-related inactivity.[32] This suggests there may be other features of the wider incapacity benefits system that have contributed to the increase seen in the UK.[33] These are likely to include the following:

- **Incentives.** The large gap between incapacity benefits and unemployment-related benefits rates, and conditionality requirements, may incentivise people to start and complete an incapacity benefits claim. It may also have disincentivised people from taking steps to move off incapacity benefits. Cost-of-living pressures in recent years may have exacerbated this.[34]

- **The assessment process.** In 2025, 80% of completed assessments for incapacity benefits approved people as eligible for them (LCWRA), compared with 47% in 2011.[35,36] This increase in approval rate may reflect worsening population health. However, that the higher approval rate of applicants was a much larger contributor to rising inflows between 2010/11 and 2022/23 than the increase in people applying for incapacity benefits suggests the assessment process itself is likely to be a key contributing factor. Lower rates of reassessment in recent years may have reduced the number of people moving off incapacity benefits.[37]

- **Lack of support.** The small scale of, and low levels of engagement with, employment support for people out of work due to ill health may have contributed to the proportion of people moving off incapacity benefits and into work not keeping up with the numbers moving on to them.

However, there is not good evidence on the relative contribution of these features of the incapacity benefits system, and population health, to the rising caseload. This lack of evidence limits the effectiveness of policy making.

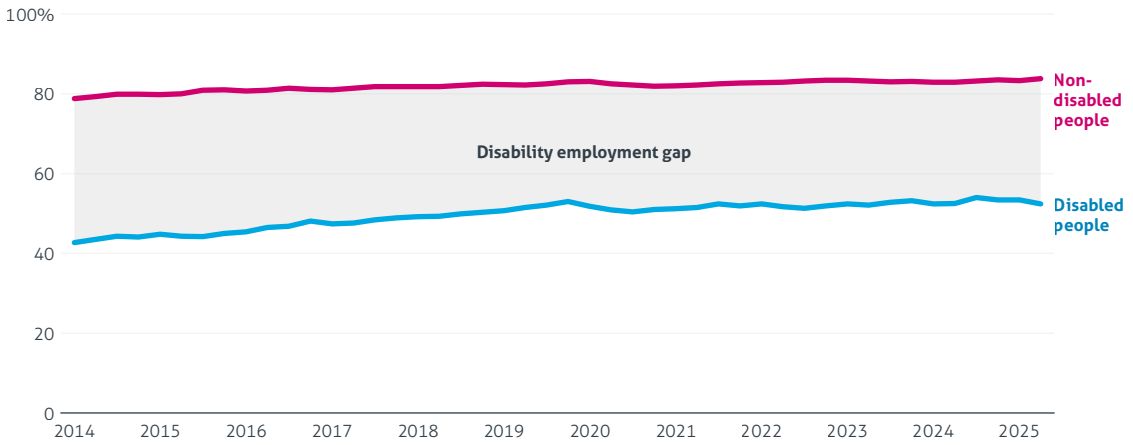
The rise in health-related inactivity has been particularly sharp for young people (aged 16–24), and has been a key driver of an overall rise in the number of young people not in education, employment or training (NEET). The number of young people on incapacity benefits rose from around 120,000 in August 2012 to 250,000 in August 2025.[38] While addressing rising health-related inactivity among this group is an important policy challenge, given the long-term scarring effects of being out of work while young, people aged 16–24 make up a relatively small proportion of incapacity benefit claimants (around 7%).

The government has been right to make tackling rising levels of health-related inactivity a priority

Health-related inactivity has huge costs for people out of work, the public finances and the wider economy. Being out of work is associated with a range of negative outcomes for people, including poor mental health and low levels of life satisfaction.[39,40]

The UK's disability employment gap – the gap between employment rates for disabled and non-disabled people – narrowed through the 2010s, before plateauing in the 2020s. This stasis may mask a more worrying trend, shown by a widening 'prevalence-adjusted disability employment gap'.[41] This metric adjusts for the fact that an increase in self-reported disability (as the UK has experienced) typically means more people with less severe physical or mental impairments, who are more likely to be in work, reporting they are disabled. However, the fact that the disability employment gap has stopped narrowing, and the prevalence-adjusted gap has widened to become one of the highest among Organisation for Economic Co-operation and Development (OECD) countries, suggests a problem in the UK with disabled people moving into and staying in work.[42] Increasing the disability employment rate, and hitting the overall 80% target that the Starmer government set, will likely depend on taking steps to increase the number of disabled people in work.[43,44]

Figure 4 **Employment rate, disabled and non-disabled people, 2014–25**

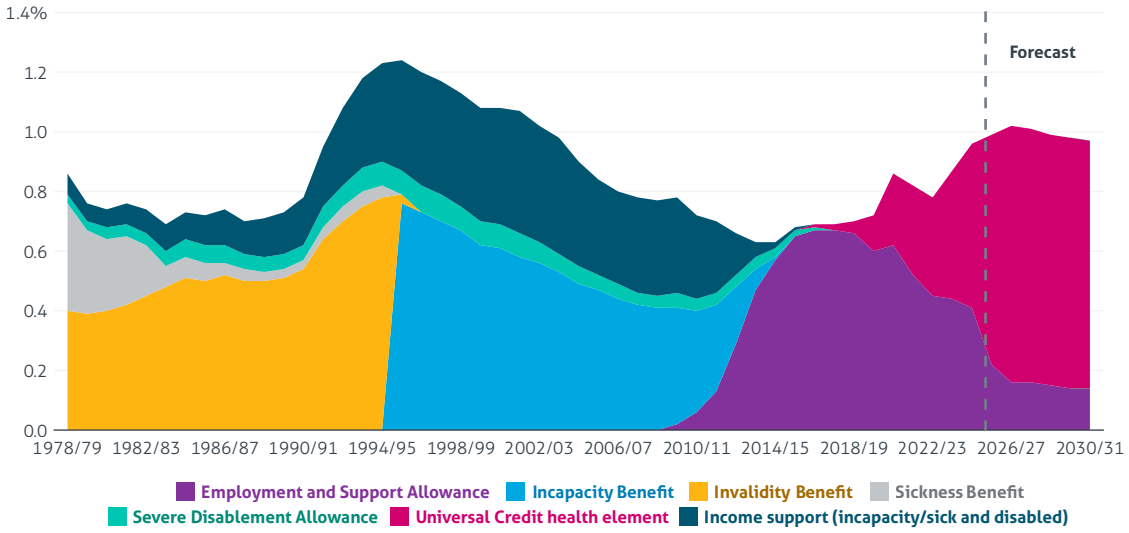


Source: Institute for Government analysis of Department for Work and Pensions, 'The Employment of Disabled People 2025', 2026. Notes: Data is for the whole of the UK. The definition of disabled people is the Government Statistical Service's Harmonised Standard definition of disability, which is in line with the Equality Act 2010 core definition.

The Keep Britain Working review, led by Sir Charlie Mayfield, estimated that health-related inactivity costs the UK £212bn a year: £132bn from lost economic output due to fewer people being available to work, and £45bn due to the fiscal costs of associated benefits.[45] The OBR has estimated that the government could save around £10bn a year if 400,000 people out of work due to ill health (14% of this group) moved into employment.[46]

Government spending on incapacity benefits specifically has risen markedly in recent years, driven by increases in caseload rather than higher spending per claimant. While incapacity benefits spending is expected to plateau in the coming years, helped in part by the spring 2025 reforms to UC health (see Box 2), spending on working-age health and disability benefits combined is expected to continue rising to more than £74bn a year by 2029/30 (2.1% of GDP), primarily due to large increases in PIP claimants.[47]

Figure 5 **Spending on working-age incapacity benefits as a share of GDP, actual and forecast, 1978/79–2030/2031**



Source: Institute for Government analysis of Department for Work and Pensions, 'Benefit expenditure and caseload tables 2026'. Notes: GDP is for whole of UK, but working-age incapacity benefit spending excludes Northern Ireland. Universal Credit includes the limited capability for work (LCW) and limited capability for work and work-related activity (LCWRA) categories. Spending on claimants waiting for assessment is excluded for both Employment and Support Allowance and Universal Credit. Universal Credit spend by category for 2014/15–2018/19 is estimated by assuming the proportion of spend in each category is the same as in 2019/20, the first year for which this data is available.

The Starmer government recognised the importance of rising spend on health and disability benefits, but its spring 2025 reforms showed how difficult reform in this area can be – and the damage caused by getting it wrong. If the Burnham administration is to have more success, it will need to learn the lessons from that and previous attempts at reform. The Starmer government U-turn showed the importance of any government that is serious about improving health and disability not only developing strong policy proposals, but also adeptly navigating the politics of this tricky topic.

Box 2 **The Starmer government's proposed welfare reforms, spring 2025**

In spring 2025, the Starmer government proposed a package of reforms to health and disability benefits. These would limit eligibility for PIP and reduce the rate of UC health while increasing the UC standard allowance. These changes were estimated to save £5.5bn in 2029/30 (compared with forecast working-age health and disability spending of over £70bn).[48]

These proposals to reduce or restrict benefits received intense criticism from disability groups and charities, as well as some criticism from the Conservatives that the changes did not go far enough.[49] Eventually, a rebellion by Labour MPs led to a government U-turn in June and July 2025. The original proposals, and whether they were carried forward, are set out in Table 1.

Table 1 **Planned welfare reforms, spring 2025**

Relevant benefit	Headline planned reform	Further details	Subsequent decision
Personal Independence Payment (PIP)	Changes to eligibility criteria	Introduction of additional requirement for claimants to score at least four points in a single daily living activity	Withdrawn, pending the Timms review
Universal Credit (UC)	Increasing standard allowance	UC standard allowance increased from £91 a week in 2024/25 to £98 a week in 2026/27, with plans to continue uprating it above inflation up to 2029/30	Carried forward in full
Universal Credit (UC)	Freezing health element for existing claimants	At £97 a week until 2029/30	Partially reversed, with the combined UC standard allowance and health element being protected in real-terms for existing claimants
Universal Credit (UC)	Reducing the UC health element for new claimants	From £97 to £50 a week, frozen until 2029/30 – but with a premium for people who are severely ill	Carried forward in full
Universal Credit and Personal Independent Payment	Merging the PIP assessment and Work Capability Assessment (WCA)		Carried forward (though not yet legislated for)

Source: Institute for Government analysis of Department for Work and Pensions, *Pathways to Work, 2025;* and *Hansard,* various. Notes: UC rates are for a single person aged 25 or over in the LCWRA group.

The new reforms that have been carried forward will mean very different incapacity benefit rates for people who begin receiving UC health before and after April 2026. However, the reforms will not help the government's ambitions to substantially reduce fiscal costs, ostensibly a key driver for the reforms in the first place. In the round, the new bill will deliver no savings after four years, compared with the £5.5bn initially targeted.[50]

Incapacity benefits policy contributes towards multiple government objectives, which can be in tension with each other

Rising levels of economic inactivity due to ill health have raised questions about whether the incapacity benefits system is working well. However, what the government is trying to achieve through the incapacity benefits system is not well defined or well understood. The broader benefits system is typically trying to achieve three core objectives at the same time:[51]

- supporting living standards
- helping people into work
- controlling costs for government.

These objectives often pull in different directions. Increasing benefits can improve living standards, but will also increase costs and reduce claimants' incentives to move into work. However, if benefits are too low, this can have a negative impact on claimants' health and living standards, which could contribute to shifting demand – and cost – to other parts of government spending.[52] Having a vision for incapacity benefits that balances these objectives, and is politically feasible, is therefore difficult.

How recent governments have seen the balance of these objectives for incapacity benefits has been unclear and contested, at least implicitly. When Invalidity Benefit was introduced in 1971, the explicit rationale was to provide a more generous out-of-work working-age benefit for those who could not work due to ill health.[53] Even now, incapacity benefits are only awarded to people who have 'limited capability for work and work-related activity' and have no work-related requirements. So, this could suggest that the objective of 'helping people into work' is less important.

In practice, however, policy changes and government rhetoric imply that supporting at least some of this group into work is an important aim – and changes under the Starmer government were focused on doing so. This government had an explicit objective to narrow the disability employment gap,[54] and had employment support programmes targeted at people out of work due to ill health. The reduction in the UC health rate for new claimants suggests that supporting living standards for this group, through the benefits themselves, was a lower priority objective. At the same time, the government acknowledged that some incapacity benefit claimants would never be able to work due to a severe disability or health condition – while 49% of claimants have said they never expect to work again.[55] This means the objective of 'helping people into work' only applies to some incapacity benefit claimants (unlike unemployment benefits where the expectation is that all claimants should be able to find work with support).

Various features of the incapacity benefits system have limited its use as a tool to help recipients into work. The scale of employment support available is limited, and no incapacity benefit claimants have any work-search requirement. The higher level of UC health compared with UC standard allowance reduces work incentives for this group – although government has begun to address this by reducing the UC health rate from April 2026. Other initiatives to support this group, such as (currently small-scale) employment support programmes and health initiatives, are not joined up with the administration and provision of incapacity benefits.

2. The politics of reforming incapacity benefits

Working-age benefits are a lightning rod for public debate

The existence of social security is premised on the fact that there are some shared risks that everyone is liable to experience at some point in their lives, from loss of salary due to short-term unemployment, to having inadequate income in retirement, which the state tries to mitigate or eliminate.[1,2] It is also there for people who might, for various reasons, have low lifetime earnings. What support government should or should not provide for people to help manage these risks goes to the heart of people's conception of what the state is for. But there are two important features of working-age social security that make it especially politically contentious.

First, most working-age benefits have become more selective, by means-testing, and so they are not something that most people expect to or want to claim.[3] There are reasons why selectivity makes sense:

- it helps control costs
- benefits can be more targeted towards people who are experiencing poverty
- it is perceived to be more fair.[4]

But it also means that most of the population do not see the social security system as being there for them, even if in practice a substantial share of people will be in receipt of benefits at some point in their working lives.[5,6] Other parts of the welfare state, namely health and education, which are universally provided, typically command significantly more support from wider society as people, and especially the "middle classes", are more likely to experience the benefits of free health care and childhood education.[7] They are seen as public services, which are distinct from 'welfare'.[8,9,10,11] The UK's social security system is relatively unusual among OECD countries, where both contributions and entitlement are more often earnings-related.[12]

Second, working-age benefits are cash transfers that act as a supplement or replacement for income from work. They create the perception of people receiving something desirable – 'free money' – that others have to work hard to receive.[13] In contrast, there is a strong political consensus that social security should be provided for pensioners, who are 'expected' to have stopped working. A perception that working-age social security costs are rising is exacerbating the salience of this. Almost two thirds (65%) of Britons think that spending on working-age social security is 'out of control' and that too many people are claiming benefits (64%).[14] However, although spending on working-age social security has risen since the Covid pandemic, it remains lower than the recent peak in the early 2010s as a proportion of GDP.[15,16]

These inherent features of social security policy create or imply conceptual divisions between parts of society, built on beliefs about 'earning' and 'deserving'. This turns them into a lightning rod for public debate.

Simplified narratives limit options for benefit reform

Some politicians have framed choices to reduce spending on working-age benefits as balancing the interests of 'taxpayers' against those of 'claimants' as part of making the case for policy decisions. Implicit within this narrative have been judgments about the extent to which people receiving working-age benefits, particularly unemployment benefits, are 'deserving' of support.[17,18,19,20]

The political narratives that both Labour and Conservative politicians have used at various points have highlighted paid employment as a marker of being included in society – and, implicitly, built up a picture portraying claimants of benefits as less deserving than 'taxpayers' unless they are working.[21] These framings came in tandem with a move towards a more 'active welfare state',[22] focused on interventions to move people into work – typified by 'welfare to work'. For example, Liam Byrne, then the Labour shadow work and pensions secretary, drew a contrast between out-of-work "shirkers" and hard-working "workers" in a 2011 speech.[23] In 2012, the then Conservative chancellor, George Osborne, spoke about the shift worker who looks up at the "closed blinds" of the house of their neighbour "sleeping off a life on benefits".[24] Although many politicians have moved away from this explicit framing in recent years, the implicit assumptions about who is 'deserving' or 'undeserving' of support and the shift to an 'active welfare state' have remained.

An implicit assumption in the design of incapacity benefits is that people living with disabilities and long-term health conditions that limit their ability to work again in the future are 'more deserving' of extra financial support compared with unemployed people. Data from the 2025 British Social Attitudes survey reflects this: only 3% of respondents thought that more spending on benefits for unemployed people should be prioritised, in contrast with 30% for people with disabilities.[25]

This division has led to a "cliff edge in support"[26] growing between claimants who are awarded health-related benefits and those who are not, exacerbated by cuts to unemployment benefits. The higher rate of, and lack of conditionality requirements for, incapacity benefits have created an incentive to apply for and claim health-related benefits, and may have been one of multiple factors that have driven increases in spending on health-related benefits in recent years.[27,28,29]

This increase in spending has contributed to a greater focus on who incapacity benefits are for. Language that implicitly or explicitly draws distinctions between 'deserving' and 'undeserving' groups in society has contributed to perceptions of different groups among incapacity benefit claimants – for example, the distinction between people with 'low-level mental health problems'[30] and 'serious illnesses and disabilities'.[31] However, the diversity and range of need among incapacity benefit claimants cannot be mapped on to a neat binary of 'deserving' and 'undeserving', and there is evidence that the public sees 'deservingness' as being on more of a spectrum.[32]

Broad reductions in spending on disability benefits – as the Starmer government attempted to do in 2025 – is difficult, since the majority of the public oppose cuts to benefits for disabled people. A 2025 survey found that 74% of Britons oppose cuts to the amount of money that disabled people who cannot work receive.[33] And according to a 2026 poll, just 11% of all adults believe that the benefits system offers too much support for people with a disability, in contrast with 41% who believe that it offers too little support.[34]

Governments are therefore stuck politically: the broader narrative justifying reform, broadly mirrored in public attitudes, is that working-age social security is not achieving its objectives well and generosity should be reduced. Yet specific cuts to incapacity benefits based on distinctions between 'deserving' and 'undeserving' claimants risk being unpopular when the reality of who is affected becomes apparent.[35] After the attempted spring 2025 reforms, polling showed that 63% of the public had little or no trust in the government to make fair decisions about who qualifies for disability benefits.[36]

Without a better story that captures this nuance, successful reform will be very difficult. Governments have been effectively chasing their own tails on reform, struggling to reconcile conflicting objectives and hamstrung by simplistic political narratives that have become established in the public mind. This has made it harder for governments to clearly set out more nuanced policy objectives, and build consensus on them.

Claimants' lack of trust in government makes it difficult to communicate and implement reforms effectively

There is a tension between the aim of controlling the cost of benefits, and the objective of supporting the living standards of people receiving them – the latter of which is the understandable priority for recipients. This can make it difficult to build and maintain claimants' trust in the government at any time, but particularly when it is pursuing reforms that seek to reduce spending on health and disability benefits. Distrust between claimants and government can be a significant factor impeding efforts to engage claimants in employment support that might help them into work.[37] It is also likely to contribute to significant opposition to passing and implementing future reforms that involve reducing health and disability benefits, regardless of their wider aims.[38] In addition to the inherent tension, features of how government has approached reform in recent years, and claimants' experiences of the social security system, have further damaged trust.

Most reforms that governments have tried to implement have been framed as trying to lift people out of poverty, giving everyone the chance to get a good job or providing a safety net when people genuinely need it.[39,40,41] Ministers often emphasise supporting people into work, because "work is the best route out of poverty".[42] This reflects the move towards an 'active welfare state', both in political framing and substantive policy, which has placed less emphasis on the additional costs of disabilities and more on work capability – alongside cost-saving reforms. As focus groups for this report showed, this has contributed to a suspicion among some incapacity benefit claimants that the government's emphasis on work capability is,

in effect, cover for cuts. The Social Security Advisory Committee has also noted that the way that previous reforms to health and disability benefits have been handled has damaged trust between claimants.[43]

A High Court case brought against the government by a disability activist illustrates the problems that this suspicion of government's intentions causes. The 2022–24 Conservative government attempted to implement changes to the Work Capability Assessment (WCA) – the way eligibility for incapacity benefits is assessed – setting out the aim in its health and disability white paper to "encourage and support people into work and focus on what people can do".[44] The activist said that she was motivated by the lack of trust in the fairness of the consultation process.[45] The High Court ruled that the 2023 consultation into changes to the WCA was unlawful for several reasons, including because the government did not make clear that one of the main reasons for the reform was not to support disabled people into work, but to make cost savings.[46,47]

Focus groups and interviews with disabled people for this report also highlighted how the Starmer government's attempted reforms to Universal Credit (UC) and Personal Independence Payment (PIP) in spring 2025 may have exacerbated this lack of trust in a few ways:

- The reforms aimed to cut health and disability benefits, which many disabled people disagreed with.

- Some felt that the government was hiding this objective behind others, such as supporting disabled people into work.

- People felt the changes had been announced without much warning or consultation with the people who were likely to be affected by them.

Claimants' negative experience of features of the social security system have also contributed to an adversarial relationship between the government and health and disability claimants.[48] In a recent survey, 64% of claimants felt as if the benefits system was trying to catch them out, and just under half (49%) agreed that the system made them feel as if they were not deserving of any money.[49] Some claimants have described the process of claiming benefits as "dehumanising",[50] noting in particular the lack of privacy in jobcentres, the short duration of work-coach appointments, perceived judgmental treatment from work coaches because of their status as claimants[51,52] and a lack of respect from the system as a whole.[53,54] Many claimants have said they also experience a feeling of 'implicit' conditionality – they feel their benefits are insecure and contingent due to the presence of conditionality and sanctions in the wider system, even if they are not subject to work-related requirements themselves.[55,56] Research has shown that the Department for Work and Pensions (DWP) is a common topic of discussion in online support spaces for people experiencing poverty, highlighting the prominent and often negative role of the department in claimants' minds.[57,58]

It is also important to note that this lack of trust frequently translates to an adversarial relationship at a collective level through campaign and representative organisations for groups of benefit claimants. For example, disability campaign organisations were prominent in the public discussion of Labour's spring 2025 reforms, and likely helped build both public and parliamentary opposition to the policy changes. Disability Rights UK, the UK's leading disabled people's organisation, has argued that the Starmer government's consultation for the Pathways to Work green paper was "bogus" and "dishonest" because it was "refusing to consult on almost everything that matters most to claimants".[59]

The lack of effective engagement with key stakeholders and the public for the reforms reduced the government's ability to control the narrative about its aims. A view that cost control was the overriding objective, at the expense of people with disabilities and health conditions, was allowed to dominate – and ultimately became politically unfeasible.[60] But potentially more damaging to the government's ability to pass these reforms was that 56% of people believed the government either was not trying to limit the impact on or had actively chosen to target certain vulnerable groups through spending cuts and tax rises.[61] Just under half (44%) also thought that the government's reforms were too harsh.[62] The eventual U-turns on tightening PIP eligibility and freezing the UC health rate for existing claimants meant that the reforms that have been carried through are now forecast to deliver no net savings.[63]

Governments need not – and will not – get every stakeholder onside to deliver a major policy change, but a failure to bring along influential stakeholders can make it much harder to navigate the politics of reform. Opposition from important stakeholders can help to turn public sentiment against the government. Importantly, MPs listen to stakeholders, particularly when they are constituents, who will include thousands of people in receipt of benefits, many of whom, in this case, were due to be affected by the proposed changes to health and disability benefits. With governments dependent on MPs to support legislation, losing their support, as happened in spring 2025, can be fatal for reform. For the Labour government specifically, disabled people and associated campaign groups have traditionally been an important electoral group, making their opposition particularly powerful. For this government, the particularly chilling impact of the spring 2025 reforms on trust between disability campaign groups and the government will make future reform harder than it otherwise would have been.

The way government navigated reforms to the special educational needs and disabilities (SEND) system holds lessons for the reform of incapacity benefits. Reporting suggests ministers engaged extensively with MPs, local authorities, campaign groups and directly with parents ahead of the reforms being announced.[64] Publication of the white paper on SEND reform was delayed from autumn 2025 to late February 2026[65] to further refine the proposals, and garner political support for them.[66] That these controversial reforms were announced without major backbench rebellion – despite Starmer being in a weaker position than at the time of the welfare reforms a year earlier – shows the benefits of not rushing policy development, and making efforts to convince stakeholders, and MPs in particular, of the case for change.

Building public support for reform should be possible

Beveridge argued that "social security must be achieved by co-operation between the State and the individual".[67] Although he envisaged this co-operation as coming from a primarily contributory system – security in exchange for contribution, rather than a means-tested system – the idea of mutual benefit was at the core of his proposals.[68] However, achieving this co-operation and building the new consensus needed to undertake reforms should be possible for this government, for a few reasons.

The public see benefits as an important part of the state, with the majority of adults believing that the ability to claim benefits is an important right.[69] In a 2025 survey, seven in 10 (71%) adults agreed that people should not feel ashamed to claim benefits that they are entitled to.[70] This may be related to the fact that people's circumstances change over their lifetime, and many people will claim out-of-work benefits at some point in their working life.[71]

There is strong support for long-term investment in tackling the underlying causes of why people claim benefits, as a way to reduce spending on social security.[72] Research by More in Common shows that 59% of Britons think that the government should reduce spending by prioritising this investment over restricting eligibility or cutting benefit rates.[73] Whether or not this investment would lead to cashable savings, it represents a foundation on which consensus on a system that better matches support to people's needs can be built.

Politicians in the past have successfully managed to lead public opinion to implement changes in a particularly contentious policy area. When Cameron's Conservative-led government decided to legalise same-sex marriage, it stuck to its decision, but made sure to take the time to understand the views of those people who disagreed, and to either "address their concerns or explain why it couldn't".[74] Ministers and officials consulted stakeholders throughout, from consultation design to implementation, accommodating concerns without diverging from their purpose of legislating for same-sex marriage.[75] The credit for the long-term consensus that has been built has been put down to this ongoing engagement and consultation.[76] Although it required taking a political risk to implement, this example highlights that it is possible to have a sensitive conversation about contentious policy areas, which can create long-term consensus.

3. Assessment and categorisation

The government uses assessment and categorisation to determine who is eligible for social security. This means the process and criteria used to decide who gets what support are vital to whether the government's social security system delivers on its objectives. The current assessment process for incapacity benefits – including its relatively simplistic categories for eligibility – do not reflect the complexity of need among people whose health or disability limits their ability to work.

Assessing eligibility for health and disability benefits is more complex than for many other forms of social security

For some parts of social security, eligibility is determined by age – the state pension, for example. For others, a means test is applied – for example, Universal Credit (UC) standard allowance. Eligibility for health and disability benefits is determined by an assessment of the person's health or disability, and whether that limits their ability to work or imposes additional costs on their lives. Assessing this is necessarily much more complicated and multifactorial than age or income. Different conditions affect how someone functions in different ways, the severity of many conditions fluctuates and a range of other factors affect people's ability to manage their condition(s). Different jobs also require different capabilities.

The Work Capability Assessment

The Work Capability Assessment (WCA) has been used since 2008 to determine eligibility for incapacity benefits. The WCA assesses the impact of claimants' conditions on their ability to work rather than being a purely medical assessment. Applicants must first fill in a questionnaire, then typically have an appointment with an assessor in person or virtually, unless the questionnaire provides enough information to make a decision on entitlement without one. The assessor is a health professional (such as a doctor, nurse or physiotherapist) employed by an outsourced private provider. The assessment reviews how easily someone can perform certain activities to determine whether their health limits their ability to work. For example, for Activity 5, 'using your hands', specific descriptors and the points attached to them include: "cannot press a button or turn the pages of a book with either hand" (15 points) and "cannot use a suitable keyboard or mouse"(9 points).

Table 2 **Stylised journey through the Work Capability Assessment (WCA)**

	Action	Details
1	Reporting of health condition	The individual reports their health condition when applying for Universal Credit (UC) or while already receiving it if their health changes
2	Questionnaire and medical evidence	DWP sends a WCA50 form – also called the 'Capability for Work Questionnaire' – for the claimant to complete. The claimant may provide supporting medical evidence as part of this, such as a GP letters
3	Work Capability Assessment (WCA)	An assessor from a private provider conducts a WCA, unless the questionnaire provides sufficient information for a decision to be made without
4	Decision	DWP makes a decision based on the assessor's report and other evidence. The claimant receives a decision letter explaining which work group they are in (see Table 3)
5	Claimant's recourse	If the claimant disagrees with the decision, they can ask for a mandatory reconsideration by DWP. Following which, claimants can appeal to tribunal

Source: Institute for Government analysis.

The conclusion of this assessment then forms the basis of DWP's final decision about which 'work group' the applicant is in (set out in Table 3). In practice, the work group determines:

- the level of benefits someone receives
- the conditionality regime around this
- the employment support they will be offered.

Table 3 **Work Capability Assessment outcomes**

Work Capability Assessment (WCA) outcome	% of WCA decisions (April 2019 to February 2026)[1]	Eligibility for incapacity benefits	UC rate per month, 2026/27	Employment support offered	Conditionality	Further information
Fit for work	12%	No	£424.90 (UC standard allowance)	Mostly through Jobcentre Plus; more extensive than for people with LCW	Intensive work-search requirements for most, unless extenuating circumstances apply, such as caring responsibilities	
Limited capability for work (LCW)	16%			Through Jobcentre Plus	Required to prepare for work but not full conditionality	Received an intermediate rate of incapacity benefits until 2017 The Pathways to Work green paper[2] proposed abolishing this category
Limited capability for work and work-related activity (LCWRA)	72%	Yes	£642.16 (UC standard allowance + health element)	Limited, through voluntary programmes	None	Rate reduced for new claimants from April 2026
LCWRA (severe)			£854.70 (UC standard allowance + higher health rate)			Introduced from April 2026

Source: Institute for Government analysis. Notes: UC rates are for a single person aged 25 or over.

The WCA process is rigid in its format, and the support resulting from it is relatively simplistic: provision of additional financial support with no work-search activity requirements (for example, UC health), or no additional financial support with either strict or less-strict work-related requirements (for the fit for work and LCW groups respectively). Since April 2026, there has been slightly more nuance with the introduction of the second UC health rate for people who meet the 'severe, lifelong health condition or disability' criteria.

This relatively simplistic approach to categorisation and the support provided for people in each category mean support is unlikely to match the complexity of need among those applying for incapacity benefits.

There is an inherent tension between simplification and personalisation in categorisation

Categorisation of some form is necessary to determine what benefits someone should be able to access, but the approach to categorisation in social security is much more simplistic than that in other parts of the welfare state. Access to the NHS, for example, is universal and free at the point of use, but the treatment offered is personalised based on a clinician's judgment of the nature or severity of need. Education is similarly free at the point of use, but access to additional provision is determined through tailored Education, Health and Care Plans to match support to individual children's needs.

The incapacity benefits assessment system prioritises simplification over personalisation by placing people in one of a small number of categories that determine the level of benefits provided and the conditionality regime. Among those in the broad category of being eligible for incapacity benefits, there is no guarantee of access to tailored employment support or other interventions to help them move closer to entering work.

Simplification arguably makes the system more streamlined – which was a key objective of social security with the introduction of UC in the 2010s. Having a small number of simple and broad categories also promotes fairness through people being treated equally. However, this relatively crude categorisation arguably means less equitable provision, with less efficient matching of financial and non-financial support to people's needs.

The Starmer government said it would abolish the WCA, merging it with the assessment for Personal Independence Payment (PIP), which represents a further simplification of the system.[3] DWP has said that eligibility for incapacity benefits will be determined based on the "impact of disability on daily living, not on capacity to work", partly so that "people can be confident that the act of taking steps towards and into employment will not put their benefit entitlement at risk".[4] This will also reduce duplication of processes that require similar information and involve similar judgments about the functional impact of an impairment. However, given that the PIP assessment and the WCA each assess different things – daily activities/mobility and work-related capability respectively – and 35% of incapacity benefit claimants (1.2 million) currently do not receive PIP, it is unclear how the combined assessment will work in practice.[5]

Table 4 **Key differences between the WCA and a PIP assessment**

	WCA	PIP assessment
Primary focus	To assess how a person's health or disability affects their ability to work	To assess how a person's health or disability affects their everyday life
Relevant benefit	Incapacity benefits (UC health / New Style Employment and Support Allowance (NS ESA))	PIP
Employment/income status	Means-tested (UC) Contributory (NS ESA)	Not means-tested
Use of supporting evidence	Not required (but recommended)	Not required (but recommended)
Assessment criteria	17 activities to assess limited capability for work (LCW), divided into 'physical function' and 'mental, cognitive and intellectual function'. Assessment of limited capability for work-related activity uses 16 activities, and alternative non-functional criteria – including those relating to terminal illness and the 'substantial risk' criteria	12 activities, split into 'daily living' and 'mobility'

Source: Institute for Government analysis.

A simplistic approach to the categorisation of incapacity benefit claimants does not capture the range and complexity of need

The focus on simplification in the way people are assessed and categorised as eligible for incapacity benefits has created problems with both the way categories are defined and the assessment process itself. As discussed above, underpinning these problems is a lack of clarity about the purpose of incapacity benefits (see Chapter 2)

Currently, the WCA places people in one of four categories, depending on the severity of their health-related barriers to work. The rate of benefits provided, the support offered and the conditionality regime vary depending on the category people are placed in.

Once someone is assessed as eligible for incapacity benefits (that is, they are categorised as having limited capability for work and work-related activity; LCWRA), they have no conditionality requirements and are not necessarily offered employment support. Only one in 10 people in this group engage with employment support each year.[6] And until April 2026, more than 2.4 million people in this group received the same rate of benefits.*

Incapacity benefits eligibility and conditionality also do not differ by age, as is the case in some other countries, where younger people may have lower rates and/or need to meet more conditions.[7] Even within the UK, other parts of labour market policy treat different age groups differently. UC standard allowance is set at a lower rate for people under the age of 25, and this group currently have a lower minimum wage to encourage employers to hire them.

* When the main UC health rate was approximately halved for new claimants in April 2026, the old higher rate was maintained for those with the most severe conditions or terminal illnesses – effectively creating an additional category of incapacity benefits.

Having more categories for benefit entitlement makes sense in theory, but would have practical difficulties

DWP's relatively binary approach to categorisation in relation to incapacity benefits reflects the department's revealed preference for simplification rather than personalisation. UC exemplifies this – a benefit designed to replace and combine six working-age benefits – aiming to simplify the system for both government and claimants. Its rollout makes clear that simplification does not necessarily make delivery easier: UC has taken more than 10 years to fully roll out, with its full implementation beset by delays due to information technology issues and changes in senior policy makers.[8] The removal in 2017 of the third intermediate rate of incapacity benefits for the 'work-related activity group' (WRAG, now 'limited capability for work' or LCW) is a further example of simplification, where the intention was finding savings.

There are good reasons to have rules that determine the level of benefits provided. Rules help claimants to receive the support they are entitled to by ensuring consistency across the country, predictability for applicants and legal protection against discrimination. Having a wider range of possible categories could mean support better reflects the range of need among claimants. The premise of incapacity benefits is that people who are expected to be out of work for a long period or indefinitely require a higher level of income replacement than unemployed people. It therefore follows that the level of benefits should be different depending on how long someone is expected to be out of work for. A similar principle applies to PIP, which aims to provide higher rates to people who experience higher additional costs from their health condition or disability. Within incapacity benefits, this has not been the case in recent years, until the introduction of the 'severe' higher rate from April 2026.

Having more categories could help remove the 'cliff edge' effect, which incentivises claimants to get over a particular threshold to qualify for the substantially higher rate. The relatively binary nature of eligibility raises the stakes for claimants and assessors in the assessment process, potentially making it feel adversarial and more risky,[9] which may have contributed to the formulaic assessment process.

While having a more nuanced system of categorisation to reflect need makes sense in theory, putting this into practice would be more difficult. Translating the range and complexity of functional impairment due to ill health or disability into specific categories inevitably involves making arbitrary distinctions. Defining multiple categories is, at least superficially, more difficult than making a single distinction between whether a person is eligible for incapacity benefits or not – particularly given how contentious the criteria that define these categories are. Having more categories would also increase the risk that claimants move between them more frequently, which could reduce the consistency of support provided – both financial and non-financial. However, introducing more categories could help deliver a system in which the level of benefits, conditionality and wider support provided for people is better "tailored to their needs and capabilities", as the Pathways to Work green paper envisages.[10]

Creating more categories would have an uncertain impact on cost. If creating more intermediate categories led to fewer people claiming the highest rate, this could lead to savings. However, it could also mean that those on unemployment benefits who might not qualify for incapacity benefits currently would then qualify for *some* incapacity benefits, which would have additional costs.

Categories for conditionality are not personalised

Categorisation with respect to conditionality regimes is also relatively simplistic. Those in the LCWRA group have no requirements to look for work or engage in employment-related activities, while those in the intensive work search (IWS) group must engage in substantive work-search activities and attend regular work-coach appointments. The intermediate, smaller LCW group are also required to engage in employment-related activities, but these requirements are not as intensive.

The typical reasoning behind making benefits conditional on engaging with specific activities is threefold:

- Engagement with mandatory activities will help claimants enter work.
- Conditionality contributes to the social contract on benefits, countering a perception that claimants receive 'something for nothing'.
- The inconvenience of conditional activities will act as a disincentive to claiming benefits.

In the Pathways to Work green paper published in March 2025, the Starmer government said it was exploring the possibility that claimants would be expected to "engage in conversations from time to time about their aspirations to work and to hear about the support available to them".[11] The aim of reforms, the green paper said, would be for "all disabled people and people with health conditions to have conditionality expectations tailored to their needs and capabilities". While some of the reforms in the green paper were explicitly abandoned, these expectations appear to have been retained.

Moving towards a more personalised conditionality system – in which conditionality is tailored towards a person's circumstances and the support that would help them move closer to work – could help better match support to need, and encourage engagement with this support. However, expanding conditionality to some of those currently on incapacity benefits would have risks. The greater complexity of barriers to employment that those who are out of work due to ill health face, and the weaker evidence base for support that helps them into work, could make conditionality more difficult to apply in a way that is fair and effective for this group than those who are unemployed.

A 2017 review of the available evidence for conditionality among those out of work due to ill health was mixed.[12] Two studies (including one UK-based study) found it had negative effects on employment outcomes or increased rates of disability benefits

receipt, four studies found mixed results and one study showed positive effects. Interestingly, the studies with negative effects were looking at social security systems with more demanding conditionality requirements and the study that found positive effects was for a less demanding regime. In addition to the lack of strong evidence for the positive effects of conditionality on employment, there is evidence that it has negative impacts on the wellbeing of people in this group, including in the UK context.[13]

A strict conditionality regime for people with long-term conditions and disabilities could also potentially make support less effective at getting incapacity benefit recipients into work. Government's understanding of what would help most people on incapacity benefits into work is limited, in part because most studies to date have been based on the small, selective subgroup that has engaged in support voluntarily.[14] The introduction of conditionality would risk increasing distrust among claimants and so could damage the quality of relationships between claimants and those supporting them, which are important for effective engagement.[15,16] This could risk making the support provided less effective, even if more people are compelled to engage with it at some level.

The introduction of conditionality for some disabled people may have benefits, but by itself is unlikely to substantially shift the dial on helping this group into work – and would carry risks. Any introduction of conditionality should be done in a way that seeks to manage and mitigate these risks, and build the evidence base for what works.

Crucial to any conditionality regime would be having an offer of support that can help people move closer to entering work. Even within a broad category for benefits entitlement or conditionality regime, it is important that support is tailored to people's individual needs.

The 'all-or-nothing' Work Capability Assessment is a missed opportunity to identify the wider support that could help people

The primary function of the WCA is to be the gateway to incapacity benefits. At the end of a process involving a health care professional's assessment of how a person's health affects what they can and cannot do, the outcome is relatively binary: claimants either receive financial support or they do not. No recommendation is made about wider support to help them into work. This can create an adversarial relationship between assessor and claimant,[17] and some health care professionals completing these assessments say they find the process emotionally difficult.[18]

With only one in 10 incapacity benefit claimants engaging in employment support,[19] the WCA is one of the final substantive points of contact with DWP-related non-financial support for many claimants. An alternative model would enable government to identify how a wider system of support could help applicants into work, or better enable them to live independently. This could draw on the information gathered in the assessment about the health-related barriers to work that people are experiencing. That an assessment process would always be expected to help people access some support, even if they are not assessed as eligible for additional benefits, may help make the process less adversarial.

The Timms review is actively exploring broadening the support that PIP claimants receive. The emerging recommendations, published by the review's co-chairs in September 2026, proposed: "Cash will remain the foundation of the award; some awards will also include services, and offer other non-cash support."[20] The combining of the WCA and PIP assessments would also be an opportunity to introduce greater flexibility in the support incapacity benefits claimants receive following assessment.

One potential challenge is that a more local service may be better placed to help people access tailored support than a DWP-commissioned assessment process, particularly as the devolution of employment support progresses. One option could be to have local areas carrying out assessments using centrally determined criteria. Central government could still provide the benefits, avoiding the incentive for local areas to ration provision – as has happened for locally funded adult social care.[21] Local assessors may also be better placed to join up applicants with support available locally. Whatever model of assessment is in place, a more personalised assessment is likely to be more effective if assessors understand the local provision of relevant support.

The assessment process is not set up to accurately assess the impact of ill health and disability on people's ability to work

The Work Capability Assessment (WCA) has not evolved to reflect the changing nature of disability and work

While the WCA is, in theory, a functional, real-world assessment, it has been criticised for not accurately reflecting what work a person may or may not be able to do at any given time.[22] One common criticism is that it does not reflect the impact of mental health and neurodivergent diagnoses on people's ability to work, instead focusing on physical health conditions.[23] One example of the WCA not being used as intended is the growing use of the 'substantial risk' criteria. This is used when there is a "substantial risk to the health of the claimant or others were the claimant found not to have LCWRA" – for example, due to self-harm or suicide. Its original intention was as a safety net for a small group of claimants, but by 2023 was being used in 15% of cases assessed as being eligible for incapacity benefits due to limited capability for work and work-related activity (LCWRA).[24] And that 42% of initial WCA decisions for Employment and Support Allowance (ESA) that go to tribunal were overturned in the fourth quarter of 2025 (albeit a decrease from the same period in 2024)[25] suggests flaws in the way the WCA is being used to make decisions.

One reason the WCA does not accurately reflect the current state of work and health is that activities and descriptors – the criteria claimants are assessed against – were last comprehensively reviewed in 2011.[26] Minor changes followed at two points in 2013, but there have been no changes to the functional descriptors since then.[27] The Conservative government launched a consultation on reforms to activities and descriptors in 2023. This included plans to remove the 'mobilising' activity descriptor, which judges claimants' ability to walk unaided, and to reduce points awarded for the 'getting about' descriptors, to reflect "new flexibilities in the labour market" including hybrid and remote working.[28] According to the Chartered Institute of Personnel and Development (CIPD), 74% of organisations now offer hybrid or remote working to

some degree (with 27% of workers working in hybrid roles and 14% working fully remotely).[29,30] In 2025, however, the High Court ruled that this consultation was unlawful as it failed to highlight the "substantial loss of benefit" that claimants would face, and the reforms did not go ahead.[31] Nevertheless, there are strong arguments to review activities and descriptors on a regular basis to ensure they remain relevant and are operating in the way the government intends them to.[32]

A reduction in the number of WCA reassessments taking place since the Covid pandemic may also limit government's understanding of the health-related barriers to work that current incapacity benefit claimants are facing, particularly those whose health conditions fluctuate in their severity and their impact on function. While, initially, reassessments were paused as part of pandemic measures, continued low levels of reassessments are due to capacity constraints. Rising incapacity benefit caseloads and assessment providers having difficulty recruiting and retaining staff after the pandemic created large backlogs.[33] This has led DWP to prioritise new claimants over reassessments. DWP has said it plans to reduce the frequency of PIP reassessments to free up capacity for overdue WCA reassessments.[34]

Confusion about the role of incapacity benefits creates inconsistencies in the use of medical evidence

Eligibility for incapacity benefits is determined by a functional assessment of whether a person's health limits their ability to do sets of work-related activities, rather than the presence of specific medical diagnoses. The WCA is carried out by approved health care professionals, including doctors, nurses, physiotherapists and occupational therapists. However, the flexibility for these qualified health professionals to exercise their independent judgment is relatively limited. Assessors must stick to a specific set of criteria and a defined process for assessing potential claimants against them.

The rationale for having specific health care professionals conducting these functional assessments is not entirely clear. While health care professionals may be trained in integrating a range of clinical and social information, they will often not have occupational health expertise that is most relevant to conducting functional assessment. The British Medical Association has previously said that most GPs have done "very minimal training in occupational health medicine" and are therefore "not in the best position to advise people about whether [people] are fit or not to work".[35]

Applicants for incapacity benefits may provide medical evidence, such as from their GP, and assessors request medical information. However, guidance on the use of medical evidence is unclear, and its use varies in practice. Some have called for the assessment process to place greater focus on medical evidence.[36] The reasoning for this is typically that health assessment outcomes should be more closely linked to more objective medical evidence of particular diagnoses and their severity. However, similar health conditions will affect different people, and their ability to work, in very different ways.[37] Moving towards eligibility based on diagnosis rather than function would imply a different purpose for incapacity benefits – making them a benefit to compensate for having a health condition, rather than income replacement because a health condition functionally stops someone from working.

If the medical evidence provided was focused on the severity of a health condition, rather than diagnoses, then it is unclear how this would be substantially different from what happens now. A health care professional's assessment of severity is often based on a subjective judgment of function – and may be more subjective than an assessment based on clear criteria. And regardless, it is unclear that generalist health care professionals are well qualified to complete these functional assessments, as outlined above.

The muddled approach to the use of medical evidence and expertise in assessments stems, at least in part, from a tension between a desire for the assessment to be fair, objective and evidence-based, and the inevitable degree of subjective judgment involved in a functional assessment. A lack of clarity about who and what incapacity benefits should be for exacerbates this. The role that medical evidence should play in assessment will need to be clarified as government designs the new combined assessment for PIP and incapacity benefits.

The current model of outsourcing reduces flexibility

The WCA is outsourced to large private providers, which DWP commissions directly on a regional basis. A key reason for this is that private providers are seen as better placed to recruit and manage the workforce of health care professionals needed to conduct the assessment.

The data on this workforce is very limited. Private providers employed 5,300 WCA and PIP assessors in July 2023,[38] but no breakdown by professional background is available. However, providers have faced major recruitment and retention issues in recent years, which have contributed to a backlog of assessments.[39]

Outsourcing of the assessment reduces government's flexibility and control over the process. The impact of outsourcing on controlling costs, both delivery costs and costs related to incapacity benefit onflows, is unclear, despite the lower cost of delivery being one reason for outsourcing in the first place.[40]

Another potential downside of outsourcing is that providers may not be incentivised to manage flows on to incapacity benefits, and may be incentivised to increase onflows and therefore costs. There have been reports of assessors being given bonuses for completing additional assessments beyond their target,[41] which incentivises assessors to work quickly rather than thoroughly. This may indirectly incentivise assessors to give an LCWRA outcome, since they may want to take more time and be thorough in assessing someone as not eligible for incapacity benefits, given this outcome is more likely to be challenged. DWP has been criticised for not being transparent enough about the key performance indicators used in assessment contracts,[42] which may have helped create space for these perverse incentives to arise.

However, bringing assessments back in-house could be politically contentious and practically difficult. It could potentially lead to accusations that the independence of the process is being compromised, with the aim of reducing awards. One barrier to insourcing might be the administrative complexity of government directly employing a large number of health professionals to conduct assessments. In particular, DWP has said the civil service pay and career structure is a barrier to insourcing, and that it lacks the "recruitment, retention and management skillset" to employ health care professionals.[43] However, DWP is used to employing more than 90,000 people, most of whom are based in jobcentres across Great Britain, and it already directly employs around 200 health care professionals in other roles.[44] While there may be additional challenges to employing the 5,300 health care professionals currently working for private providers as assessors, they are unlikely to be insurmountable. The challenges of employing this workforce should be weighed against the benefits of insourcing. The question of who should make up the assessor workforce should also be reviewed.

DWP will be required to complete a delivery model assessment as part of merging the WCA and PIP assessments, to review whether outsourcing is the right model. If government wants to move towards a more flexible, personalised assessment process that better helps people access more tailored support, then there is a strong case for bringing the assessment in-house.

Box 3 **Examples of potential incapacity benefit system reforms**

This report does not make recommendations about what support government should provide for different groups of people. But below are two illustrative examples of potential reforms, which extrapolate from recent reforms or independent reports. They explore what it might mean in practice for outcomes to be set and support provided for specific groups:

- Government could decide that because young people often face different barriers to employment, and being not in education, employment or training (NEET) has particularly damaging long-term consequences, a different approach is needed for this group than for other working-age adults. The interim report of the Milburn review into young people and work talked about a "participation-first" welfare system.[45] Government could decide that implementing this means participation – in the form of employment support, skills training or other related activity – should be a key outcome for the system. Government could decide that to achieve this it will expand the Youth Guarantee and introduce stronger incentives for NEETs to engage with support, including conditionality requirements for health and disability benefits receipt for some groups.

- Government could decide that its priority outcomes for the health and disability benefits system are supporting disabled people to live independently, by helping to cover the additional costs of disability and supporting those who could work in the future to enter employment. As part of this, government could decide that having a higher rate for incapacity benefits is less important and that it should equalise the rate of UC health with UC standard allowance, going beyond the reduction from April 2026. Resource might then be reallocated to PIP and employment support, or other services such as adult social care or health interventions – targeted at newly defined groups – to better achieve the government's aims. Government could set measurable outcomes relevant to the ability of disabled people to live independently, drawing on stakeholder consultation to help ensure consensus on them. It could also improve the assessment process so government better understands who may be able to work in the future.

4. Join-up across government

Incapacity benefits policy interacts with various other parts of state support. Someone claiming incapacity benefits may receive other benefits and access support from multiple NHS services, local or DWP-led employment support, adult social care, skills providers, a local authority, a housing association and many more arms of government. Together, these may all support someone to have 'independence and control' – part of DWP's objective for disabled people.[1] This means that good incapacity benefits policy making must be joined up and view the health and disability benefits system as a whole – including policies held across DWP, other central government departments and different levels of government.

Changes to incapacity benefits affect other policies, and vice versa

Around two thirds of incapacity benefit claimants are also receiving disability benefits: PIP or Disability Living Allowance (DLA).[2] Many will also be in receipt of other benefits, such as the housing element of UC or Carer's Allowance. From the perspective of government, these benefits are designed to cover specific costs (for example, UC health is formally income replacement while PIP is designed to cover the additional costs of disability). But for the benefit recipient this is all money that supports their living costs. This means that a change in one benefit may affect how the recipient behaves in relation to others.

There is evidence of interactions between different benefits from past policy changes. Between 2008 and 2012, the government introduced the Lone Parent Obligation, which aimed to improve employment rates for single, out-of-work parents by making receipt of unemployment benefits dependent on work-search activities once their youngest child turned five (rather than the previous age threshold of 16). This policy increased employment rates, although this was almost entirely due this group moving into low-paid part-time jobs, and was associated with a decrease in unemployment benefit claims.[3] However, the savings from this were offset by an increase in the take-up of incapacity or disability benefits among this group, as people moved onto other benefits to support their incomes and avoid additional conditionality requirements. Whether the policy led to any fiscal savings is unclear.[4]

When making changes to one benefit, government must therefore consider interactions with others. For example, in spring 2025 the Starmer government announced it was going to reduce the UC health rate, while increasing the UC standard allowance. A key aim was to narrow the gap between unemployment and incapacity benefit rates to "reduce perverse incentives" to claim the much higher health rate, thereby promoting "labour market engagement over inactivity".[5] However, the OBR estimated that reducing the UC health rate would lead to 50,000 more people claiming PIP by 2029/30 as a means to increase their income, which reduced the savings from this policy by £300m.[6] In this case, considering how reducing UC health would affect PIP and UC standard allowance was vital to designing this aspect of the policy (which was implemented) effectively.

The wider system of support for incapacity benefits claimants includes many other non-benefits policies. The most direct example of this is employment support – where DWP employment support to help people into work can directly reduce the benefits bill.[7] But the number of people moving on and off health and disability benefits is shaped by wider factors, including labour market conditions, poverty rates and population health. For example, healthy life expectancy for women in the UK has declined, from 63.7 years in 2012–14 to 60.9 years in 2022–24,[8] with the largest falls in the most deprived areas.[9] The causes of this are complex and multiple,[10] but it means more working-age people are living with health conditions, which has likely driven up demand for incapacity benefits. Policy areas that affect population health, such changes to NHS primary care access or social housing provision, could, at least in theory, affect the incapacity benefit caseload. And this relationship likely also operates in the other direction. Higher levels of poverty are also associated with higher demand for expensive acute services,[11] and incapacity benefits provision may help limit demand for these services. For a government aiming to best support people out of work due to ill health – with their living standards and/or into work, while controlling costs – benefits cannot be considered in isolation from other policies.

Internal join-up in DWP is relatively strong, despite its large size

DWP has a broad policy remit and more civil servants in its 'core department' than any other department, primarily due to running Jobcentre Plus internally. This includes several teams with responsibilities for various policies focused on supporting people out of work due to ill health – including those leading on employment support to the DWP directorate focused on health and disability benefit policy. The formation of DWP in 2001 brought social security and employment policy together, and the addition of post-19 skills in 2025 has meant another relevant policy area is now within its remit.

Interviewees for this report said that, broadly, these structures work well, with responsibilities sensibly distributed across teams and constructive join-up across them common. A strength of the department is the ability to join up between policy and front-line delivery because of DWP's large operational delivery profession responsible for, among many other things, managing health assessments and running jobcentres. However, the sheer size of the department in terms of headcount – and the breadth of its policy remit – can be a barrier to effective internal join-up in some cases.

The incentives facing departments tend to reinforce departmental silos

The incentives that departments – and the ministers and senior officials at the top of them – face, strongly shape cross-government collaboration. However, budgets are typically allocated along departmental lines in the spending review, and parliamentary accountability for how money gets spent is through individual departmental accounting officers. This minimises the financial incentives for cross-departmental collaboration. A lack of clearly defined, measurable outcomes for the system that multiple departments are explicitly responsible for delivering exacerbates this, so departments are not incentivised to work together.

This operates at both a political level with ministers and through the civil service. Senior officials are focused on serving their ministers and are more likely to be responsive to their priorities over those of the government as a whole. In relation to incapacity benefits, DWP has explicit goals relating to employment opportunity and disability, but these are not shared with other relevant departments, such as the Department of Health and Social Care (DHSC) and the Department for Education. The result, as identified by the Milburn review into young people and employment, is: "different Whitehall departments pursue their own strategies and develop their own plans".[12]

Siloed structures can get in the way of collaboration

Key to effective, co-ordinated support for people out of work due to ill health is join-up between health and social security – meaning, in England, DWP and DHSC (and NHS England, while it still exists) working closely together at a central government departmental level. The Joint Work and Health Directorate (formerly 'Unit') was formed in 2015 and aims to "join up the health and employment systems".[13] The directorate is a positive example of cross-government working, with officials in DHSC and DWP working together to oversee health and employment programmes such as Work Well.

However, a few factors have limited the directorate's ability to facilitate join-up across DHSC and DWP. Its focus has primarily been on a small number of programmes, such as Work Well, and building evidence, such as through the trial of employment advisers in talking therapies. Its involvement in health and disability benefits policy appears to have been less significant. Its funding has typically been limited – tied to these specific programmes and/or dependent on DWP and DHSC allocating funding towards it after a spending review, rather than explicitly receiving a specific settlement itself (apart from at the 2015 spending review, when it was set up).[14] This leaves its ability to facilitate cross-departmental join-up vulnerable to fluctuating ministerial interest from DHSC, DWP and the centre of government. Having a specific directorate responsible for cross-departmental collaboration can also mean other parts of DWP and DHSC do not see join-up as a priority – meaning this collaboration is not seen as core to how the department works.

DWP has also historically been a very centralised department, which has limited join-up of initiatives at a local level. For example, it has taken a centralised and programmatic approach to employment support for people out of work due to ill health in the past, which has made it more difficult for services to work together at a local level.[15] Particularly striking is the running of jobcentres through the core department, which is an unusual model for service delivery across government (compared with, for example, the NHS where commissioning happens at a regional integrated care board level). This has shifted somewhat in recent years, with more local approaches to employment support being rolled out – such as locally delivered Connect to Work. The new prime minister, Andy Burnham, announced plans for further devolution in July 2026.[16]

The limited evidence on interactions between policies affecting people out of work due to ill health makes join-up more difficult

There are often good theoretical reasons for policy makers thinking that a change in one policy area will affect another – such as providing employment advice through mental health services. But the empirical evidence for these effects is often much more limited.

This is, at least in part, because understanding the nature and degree of interactions between incapacity benefits spending and other non-benefits intervention is inherently difficult due to the complexity of the relationships and the time delay that often exists between cause and potential effect.[17] For example, if someone does not have access to youth services as a 12-year-old, it may make them more likely to be NEET (not in employment, education or training) at age 18. But the six-year delay and a multitude of other factors affecting this person's journey make identifying this relationship difficult. This temporal delay and the interconnectedness of factors affecting flows on and off incapacity benefits make it hard to build evidence about the underlying, upstream drivers of benefits caseloads.

However, there are examples where government has built and drawn on an evidence base to develop a strong system of support for people out of work due to ill health. Individual Placement and Support for people with severe mental health conditions has a strong evidence base,[18] while a recent trial of employment advisers in talking therapies helped show which groups this intervention is effective for (and which groups it is not).[19] More recently, the Health and Growth Accelerators have been trialled using targeted health interventions to tackle health-related inactivity, aiming to help build the evidence for the join-up of support.

Part of the reason that evidence is patchy is that departments are not incentivised to evaluate the impacts that fall outside the purview of their own department. But this barrier can feed a negative cycle that gets in the way of join-up: without a strong evidence base, policy makers are less able to make the case for joining up policy – meaning more siloed departmental instincts and incentives prevail.

Planned reforms to incapacity benefits will require particularly strong join up

The government's plans for incapacity benefits in the coming years will require strong join-up within DWP, and across departments and levels of government. Abolishing the WCA and instead assessing eligibility for incapacity benefits through the PIP assessment is a substantial organisational change and will create different incentives in the system. This will require careful management and co-ordination across DWP. The effectiveness of an expanded local employment support offer or potential conditionality regime for incapacity benefit claimants will be dependent on it encouraging people to take part in activity that helps them get into work.

This will require DWP to work closely with other departments, particularly DHSC, and crucially with regional and local government to understand what works, implement changes in a joined-up way and monitor their impact. Doing this will require government to create the right incentives and structures at a political and official level. Plans to align strategic authority and NHS integrated care board boundaries[20] should support local co-ordination. DWP should also consider how changes to adult social care – a key plank of support that working-age disabled people receive and a priority of Andy Burnham – after the Casey Commission could affect incapacity benefits.

5. The Treasury and fiscal control

Cost control is an important and necessary constraint in incapacity benefit design

Social security spending is managed differently from departmental spending – with much greater Treasury involvement – due to both the sheer scale of social security spending (£323bn in 2025/26)[1] and its unpredictability. Social security spending is 'demand-led' and therefore not subject to fixed limits like departmental spending (see Box 4). This means seemingly small changes in the economy or policy on individual benefits (for example, tweaks to eligibility criteria) can lead to substantial changes in spending, with the department under no obligation to try to find offsetting savings to stay within a cash limit.

The Treasury's role ensuring sustainable public finances and responsibility for economic growth means it has a significant interest in the overall cost and labour market impacts of benefits policy. With government spending on incapacity benefits more than £30bn a year[2] – more than the entire Home Office budget – the Treasury has a legitimate interest in ensuring incapacity benefits are delivering good value for money.

However, the Treasury's focus on cost control can undermine good policy making – and it does not always successfully control spending in the round. In spring 2025, Treasury pressure meant significant cuts to health and disability were announced at short notice in the week before the spring statement, with little advance warning for those inside or outside government, cutting across a long-running reform process that was focusing on system improvement. By insisting on immediate cuts, in a way that proved politically unsaleable to Labour backbenchers and the public (as well as disabled people themselves), the Treasury both set back the cause of reform and ended up failing to deliver significant savings.

Box 4 **Categories of government spending**

The government's accounting framework splits spending into two main categories:[3]

- departmental expenditure limits (DEL) – planned spending such as staff salaries (day-to-day or resource spending) and spending on the construction and maintenance of public buildings (capital spending)
- annually managed expenditure (AME) – demand-led spending, which includes social security spending such as benefits and the state pension.

This binary distinction is, to some extent, arbitrary. Demand affects some DEL spending lines more than others, and the same is true for AME.* However, it would not be viable or sensible to set cash limits on most AME spending: allowing social security spending to rise in response to demand when there is an economic downturn can help rising numbers of people who are unemployed and act as an automatic stabiliser to support the economy.

Government manages DEL and AME in different ways, as set out in Table 5.

Table 5 **Management of DEL and social security AME spending**

Feature	DEL	Social security AME
Method for setting level of spending	Spending reviews, with some updates in between (for example, at fiscal events)	Fiscal events
Limits on spending	Multi-year departmental settlements	No limits are set, but there is a welfare cap for a subset of social security AME
Formal accountability	Departmental basis, via the accounting officer framework	DWP accountability via the accounting officer framework, combined with joint DWP / HM Treasury management
Process for agreeing policy	Business case process	Internal DWP and HM Treasury decisions

Source: Institute for Government analysis.

Different processes for reviewing DEL and AME spending have meant government does not look at the system of support for incapacity benefit claimants as a whole

While there are good reasons to set and manage departmental spending (DEL) and demand-led spending (AME) on benefits differently, it can mean government does not always comprehensively assess where it can get best value for money in achieving its objectives. For example, in deciding how to better help people out of work due to ill health, government should simultaneously consider changes to incapacity benefits alongside improved employment support or targeted health interventions to decide which would be more effective.

DEL and AME are set and reviewed at different points in the fiscal cycle

Multi-year DEL settlements for departments are set at spending reviews, unlike AME benefits spend, which is assessed at fiscal events. Spending reviews often take place at a different time to fiscal events, although not always. This does not mean that the Treasury and DWP ignore the impact of DEL changes on AME. At fiscal events that assess AME spend, there can be substantial pressure for DWP to prioritise DEL policies that the OBR would score as reducing AME.

* DEL spending on the Access to Work programme, for example, has increased significantly in recent years in response to rising demand, leading to some calling for it to be treated as AME (see, for example, Prager JA, Phillips S and Tait A, *For Whose Benefit?*, Policy Exchange, 2025, https://policyexchange.org.uk/wp-content/uploads/For-Whose-Benefit-Proposals-to-Reform-Health-and-Disability-Benefits-and-To-Create-a-New-Social-Contract.pdf).

However, the separation in when AME and DEL are formally reviewed makes it harder for DWP and the Treasury to make these comprehensive trade-offs. When DWP is bidding to the Treasury for its DEL budget to deliver on its objectives, it is not as strongly incentivised to simultaneously consider how social security changes might help support those same objectives. Similarly, it means the Treasury is less easily able to weigh up DWP social security spending against DEL spending in another department – such as mental health support covered by DHSC spending, which may help people into work and off incapacity benefits. And if a government wants to do fiscal tightening at a budget while avoiding raising taxes, the fact that DEL has been set at the previous spending review, and the state pension is typically not up for consideration, drives a focus on cuts to working-age benefits.

Different mechanisms for accountability may have reduced the focus on getting value for money on AME spending

The Treasury gives departments responsibility for managing the fixed DEL budgets they are allocated, within which they have 'delegated authority limits' that can be allocated without seeking Treasury approval. This gives departments some flexibility, while ensuring they are strongly incentivised to control and make the best use of their DEL budget, reducing wasteful spend and making investments that will deliver savings in the future.*

However, DWP's AME spend is subject neither to these fixed limits nor to this flexibility. This means DWP is less incentivised to change benefits or DEL spending in a way that will deliver lasting AME savings. These different incentives are reflected in the formal accountability structures: the DWP permanent secretary is formally accountable to parliament for both AME and DEL spend, but DWP "jointly manages" its AME budget with the Treasury.[4]

AME benefits policy is not subject to scrutiny through the business-case process

Government uses different processes to approve policy covered by DEL and AME spending. DEL policies must undergo a business-case process, as per the Green Book, with evidence provided for the estimated costs and benefits. Changes to benefits, on the other hand, go through a less formal, internal process between DWP and the Treasury, followed by a formal OBR assessment of their fiscal and economic impact. These different processes may further prevent DEL and AME policies being reviewed together, while the lack of a formalised business-case process for AME may mean DWP is less incentivised to draw on evidence in making changes to benefits policy.

The pressure of fiscal events has made policy making rushed, secretive and more narrowly focused

Fiscal events are an important opportunity for government to review economic and fiscal policy in the round, and announce new measures to drive forward its agenda. However, successive chancellors' decision to hold two fiscal events a year has driven short-term and announcement-chasing fiscal policy making, including in response to

* The three-year settlements for day-to-day budgets agreed at the spending review limit the incentives for departments to take a long-term approach to this.

forecast changes when chancellors have left little headroom.[5] In contrast, the current Charter for Budget Responsibility sets out plans for spending reviews to set DEL spending only every two years, in recognition of the benefits of stability.[6]

The current timetable for and approach to benefits policy making at fiscal events has two main problems. First, the rapid nature of the policy-making process, often accompanied by the desire to show quick savings, biases government towards tweaking the current system rather than looking at fundamental reform. This was true in spring 2025 but is also true more broadly. As previous chapters have shown, it is difficult to manage the complicated objectives and trade-offs involved in incapacity benefits by making tweaks to the existing system. Second, budget policy making tends to be secretive, meaning stakeholders (including backbench MPs) are often not consulted. This makes it harder to build the case for reform publicly.

Mechanisms for controlling social security costs have been ineffective

The government uses the fiscal rules and welfare cap to help control costs from incapacity benefits. However, their effectiveness is limited – and, combined, the result has been rising costs in recent years, rather than fiscal control.

The fiscal rules

The government publicly commits itself to meeting the fiscal rules, and asks the OBR to independently assess whether they are being met, to signal to the markets that it is fiscally responsible. This also creates political pressure to achieve fiscal control, which helps the Treasury impose spending constraints on departments.

The size of health and disability benefits spending creates a strong top-down pressure to control benefits spending at fiscal events to help meet the rules, which policy makers in DWP and the Treasury feel keenly. However, the relatively narrow headroom against the fiscal rules in recent years has, in practice, meant increased focus on more micro and less effective cost control, delivering savings within the three-year fiscal rule window, rather than thinking about how more transformational system redesign could deliver savings over the longer term.

The welfare cap

George Osborne as chancellor introduced the welfare cap in 2014, which is intended to be a limit, which the government sets, on future spending on a set of benefits that are generally less affected by the economic cycle (including disability and incapacity benefits). If the welfare cap is breached, the secretary of state for work and pensions must respond to the breach in parliament, with MPs given a vote on "the suitability" of the response.[7] Initially, the welfare cap was set for each year in a rolling five-year period, and the OBR assessed it each year. In 2016, then-chancellor Philip Hammond changed the cap so it only applied to a single fixed year in the future and the OBR formally assesses it once every five years at the start of a new parliament.

Although the welfare cap was ostensibly introduced to limit benefits spending, it was as much a political device to show Osborne was being tough in controlling it. However, it has been largely ineffective on both counts. In practice, the government has been in breach of the rule for much of its existence, including in autumn 2024 at the start of this parliament. This is in contrast to other fiscal rules, which have not generally been formally breached.[8] Yet this has not garnered much media attention, and the requirement for the secretary of state to report to parliament has also not yielded pressure for policy change. This may be because demand drives spending within the cap (which includes housing, disability and incapacity benefits) and the secretary of state for work and pensions may not feel they have the policy options to stem that demand. Or it may be that the way the cap is set up does not explicitly surface the key drivers of higher spend nor effectively stimulate a public debate about what can be done in response.

One factor limiting the efficacy of the current design is that the cap is set for a fixed year, five years in advance. This means those setting the cap are rarely around to be held accountable for whether it has been met. For example, between the setting of the last welfare cap in 2020 and its final assessment in 2024, there were five different chancellors and four work and pensions secretaries. After the breach of the most recent cap in autumn 2024, the work and pensions secretary not unexpectedly placed the blame on the previous government.[9]

In 2019, the OBR said that "it is not clear that the welfare cap has any meaningful impact on spending plans and outcomes".[10] Seven years on, it remains unclear that the welfare cap makes any contribution to fiscal sustainability. Getting rid of it would make for a more streamlined fiscal framework from a policy making perspective. However, doing so would be politically difficult – opening up the government that did it to accusations of being uninterested in controlling social security spending. If the welfare cap is to be kept, then it should be reformed to more meaningfully contribute to improving benefits policy making.

A lack of clear responsibility for managing social security spending may constrain policy design in DWP

Although DWP is "responsible" for AME spending, it has no delegated authority to make AME changes: "HM Treasury is involved in all decisions involving DWP AME spend."[11] Even operational changes that could affect benefits, such as temporarily changing the frequency of work-coach appointments to meet capacity constraints, requires Treasury approval.[12] While the Treasury's focus on cost control can feel constraining to many departments, this is particularly pervasive in DWP – in part due to a lack of clarity about who is responsible for the control of spending.

Formally, joint management of AME spend operates through a DWP–Treasury 'Senior Welfare AME Group'. Within DWP, the director general for finance "holds executive level accountability" for AME controls while the director general for policy "holds executive level accountability around the welfare cap, monitoring longer term risks toAMEspend and overseeing fiscal event processes".[13] There is minimal public

information on how these boards work to shape benefits policy. In practice, more informal discussions between DWP and Treasury ministers and officials lead to the policy decisions that might have an impact on social security spending.

Interviews for this report showed that there was no uniform view of how this 'joint management' of social security spending works, or should work, in practice. The relationship between the chancellor and the secretary of state for work and pensions is crucial, and can help enable effective collaboration. But the influence of formal structures is unclear.

The feeling, by some, that the Treasury's cost control focus constrains DWP's policy design may be exacerbated by a lack of clarity about the extent of DWP's responsibility for designing policy that helps control social security spending. This confusion may mean DWP is less likely to be creative about substantive changes to the system that could save money overall. Greater clarity about the roles of DWP and Treasury ministers and senior officials, and structures around them, in helping to manage social security spending could help set a clearer direction for DWP officials.

6. Evidence and evaluation

Gaps in the evidence base have held back reforms to incapacity benefits

The lack of evidence on key policy parameters for health and disability benefits makes it more difficult for government to pursue changes. The estimated impact of policy changes is often based on theoretical assumptions, which means policy is made on less reliable forecasts. These estimates may be contested – such as the reported disagreement between the government and the Office for Budget Responsibility (OBR) in spring 2025 regarding behavioural responses to changes to the Personal Independence Payment (PIP) criteria.[1] A lack of strong evidence also makes it more difficult for government to decide on the right course of action, and then for ministers to justify it publicly. And when a decision is taken in the absence of strong evidence, it may be less likely to deliver the desired impact. For example, the removal of the intermediate Work-Related Activity Group (WRAG) rate of incapacity benefits in 2017 led to a lower level of savings than expected.[2]

Policy makers cannot always wait for definitive evidence to inform changes – often political judgments are more important. It is vital for government to make some changes where there is significant uncertainty, while setting up evaluations to monitor implementation, and being deliberate about where evidence is most important to inform better policy choices. Particular evidence gaps that may have held back policy making include:

- the behavioural responses to changes in rates of benefits (including movement between the receipt of different benefits)
- the impact of conditionality regimes for different groups of claimants
- the impact of different models for assessment.

There have been gaps in key data due to systems not being set up to collect it, but this has improved in recent years

Poor-quality and limited availability of data has made it harder to build evidence. In some cases, this is due to the difficulty of surveying the relevant people, as in the case of the Labour Force Survey and the Family Resources Survey.[3,4] In other cases, it is because systems have not been set up to gather – and share – the data in a useable form. For example, a medical condition was recorded for only 77% of Work Capability Assessments (WCAs) between January 2022 and February 2025, and there is no publicly available data on how those medical conditions that are recorded have changed over time.[5] Data on claimant vulnerability is patchy[6] and government does not always have a clear picture of which benefits people have previously claimed when they undergo a WCA. Much of the data comes from systems used for day-to-day delivery of the benefits system, which may not have been set up with as strong a focus on gathering information that can be used to improve the system. They might also be particularly old systems, which are difficult to extract data from.

In recent years, however, there have been important improvements in data availability, and its accessibility for external researchers. For example, data that links key DWP and HMRC information has been in place for 20 years and is important to the operation of Universal Credit (UC). This is being made available to academics through Administrative Data Research UK.

Collecting evidence to inform incapacity benefit design is inherently more difficult than some other policy areas

There are problems with the use of evidence in policy making across government, particularly where there are no comparable past policy interventions that can be evaluated. However, there are some features of benefits – and incapacity benefits in particular – that have made it more difficult to test what works to help build an evidence base.

The operational complexity of the benefits system can be a barrier to trialling different approaches. Testing different regimes within the large, complex and sometimes outdated online systems that DWP uses to distribute billions of pounds each month to millions of people is practically difficult. As many people are dependent on this income for basic necessities, this means experimentation creates risks of hardship for vulnerable groups. The legislative basis for benefit entitlement also makes experimentation harder, with fear of legal challenge a real concern for policy makers in cases where conditionality is increased or benefit levels are reduced. Experimentation also carries the political risk of the trial being criticised as being too harsh or lenient for recipients.[7,8]

Some of these challenges are heightened for incapacity benefit claimants. The potential added vulnerability of those whose ill health or disability limits their ability to work heightens the operational and political risk of trialling different approaches. That incapacity benefit claimants are, currently, not subject to any conditionality requirements and so are not required to engage with DWP support, can make it more difficult to access a representative sample of claimants (for example, for assessing employment support initiatives).[9] In addition, significant and relevant variation in broader health and labour market policy between countries limits the ability of policy makers to use international evidence on incapacity benefits.

Flexibility in legislation that could enable more experimentation has had limited use

The legislative basis for much of the eligibility and conditionality regime around incapacity benefits is a barrier to innovation. Trialling different approaches for different groups can open up the risk of legal challenge. The lack of wiggle room within legislation for testing is the flipside of a regime that aims to provide defined rules and safeguards on expected requirements for benefits claimants. However, a lack of flexibility for government to experiment and understand what works can lead to changes that are less well evidenced, which may be damaging for both government and claimants.

Government has attempted to incorporate legislative flexibility in the past. Section 41 of the Welfare Reform Act 2012 allows DWP to introduce regulations to set up "pilot schemes" that test changes that could help people "obtain work" and "affect the conduct of claimants or other people in any other way". On the face of it, these relatively broad terms seemingly provide substantial wriggle room for the testing of UC within the legislative boundaries. However, this provision appears to have only been used once – for the Universal Credit (Work-Related Requirements) In Work Pilot Scheme,[10] which tested imposing work-related requirements for some people who are in work but on low incomes.[11] DWP's ability to use the regulation-making power to set up pilots depends on there being primary legislation that enables the amending of regulation. This significant restriction may have limited the productive use of pilots, including for incapacity benefits.

Rushed policy making for fiscal events limits the opportunity to improve the evidence base

The pressure to design benefits policy as part of the cycle of twice-yearly fiscal events – to provide the chancellor with announcements – does not help with creating the room to generate and use better evidence. Designing policy in a secretive way on rushed timelines can also make it more difficult to engage with external experts in the detail of policy design or set changes up in a way that enables strong evaluation. This can also be true of tax changes, and is a key reason why having one fiscal event a year should improve policy making.

Another way in which government has attempted to generate policy proposals that draw on expertise and evidence outside the heat of fiscal event timetables is through setting up policy reviews, such as the Timms review of PIP and the Milburn review of young people and work. Both reviews published interim reports that drew on new and existing evidence to set out a diagnosis of the problems, in the hope of laying the groundwork for change in the future.[12,13]

DWP's ambitions to use specific experimental evidence can mean other forms of evidence are not drawn on enough

A strength of DWP is its analytical capability. With 400 staff in the central analysis and science directorate and a further 600 members of the 'analytical community' based elsewhere in the department,[14] DWP has more capacity to conduct high-quality evaluations than some other departments. However, experimentation – in particular randomised controlled trials (RCTs) – is more difficult for benefits than for other policy areas. This means that other forms of evidence may need to be drawn on (for example, observational studies and qualitative evidence).

Some interviewees suggested that a strong preference in DWP, and the Treasury, to use specific types of evidence in benefits design, such as RCTs or quasi-experimental approaches – and a risk aversion to making policy without this evidence – can be counterproductive. It can lead to a reluctance to draw on more observational or qualitative evidence in decision making where it already exists, or a reluctance to commission it where it does not. And it can lead to a preference for small changes, which are more amendable to robust evaluation, over attempts at more transformational redesign of systems.

At the same time, DWP's 'Areas of Research Interest 2026' contains 118 questions, including 16 under the following objective: "Support disabled people to get into work where possible, providing a safety net to those who cannot." While the breadth of research interest in DWP is welcome, the lack of prioritisation within these many questions – and a lack of clarity about how they will help inform policy design – may be a barrier to external researchers engaging with them.

7. Conclusion

The economic, fiscal and individual impacts of high levels of health-related inactivity make this an important problem for the government to address. Problems with how government has gone about designing benefits for people out of work due to ill health in the past have held back attempts at reform. A different approach is needed.

- Politicians should aim to lead public opinion with a narrative about the role of the health and disability benefits system, rather than reverting to simplistic narratives that end up limiting options for reform.

- The assessment process should better match people's needs with the right support.

- The fiscal and performance framework should be changed to incentivise more joined-up policy development and drive better value for money.

- Evidence and evaluation should be used to inform better policy design, and ensure government learns what works when changes are rolled out.

These changes to the way incapacity benefits policy is made should enable more transformational change of the wider health and disability benefits system.

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