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# From Impairment to Incapacity:

# Educational inequalities in disabled people’s ability to work

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**Abstract**: Significant numbers of working-age people in high-income countries claim benefits due to incapacity. This is conventionally explained as the result of people rationally ‘choosing’ to claim benefits, or as ‘hidden unemployment’ due to a lack of jobs, with claim rates much higher among the low-qualified. However, neither account considers whether low-qualified people find it harder to deal with an impairment in the workplace, and are therefore *genuinely* more incapacitated. This study explores these issues using 32 depth interviews in England in 2009/10. It finds that there are considerable differences in people’s ability to respond to impairments, with some – but only some –able to avoid incapacity through workplace flexibility, adjustments, or changing jobs. Better-educated people had more of these choices, partly because education is associated with job flexibility (which allows people to work around their impairments). Education also played a direct role; it is not just the case that less employable people found it harder to get work (‘hidden unemployment’), but that they found it harder to get *suitable* work, and were therefore genuinely incapacitated. It was therefore only some lower-qualified people who were left in a ‘Catch-22’ situation where they were not fit enough to do jobs they could get, and not employable enough to get jobs they were fit to do. Moreover, there were further inequalities among those with partial fitness-for-work limitations, with wealthier people having more choices around ‘struggling on’. The paper concludes by drawing together the implications for research and policy.

**Keywords**: Disability; Incapacity; Working conditions; Education; Employability; Hidden unemployment

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# Introduction

Prior to the financial crisis, 6% of the working-age population in OECD countries were claiming disability-related benefits ([OECD 2010:59](#_ENREF_33)). While more recent figures on benefits claims are hard to come by, in 2013 there were still more working-age (15-64) people inactive due to illness, disability or retirement across the EU than the number who were unemployed.1 The distinction between unemployment and disability-related benefits is important because incapacitated people – i.e. those who unable to work due to sickness or disability – are widely felt to deserve special treatment ([van Oorschot 2006](#_ENREF_40)). As a result incapacity benefits predate unemployment benefits ([Kangas 2010](#_ENREF_20)), and while there has been an increasing activation of incapacity claimants, they still generally receive higher benefit levels with fewer attached conditions.

The most common interpretation is that these high incapacity claim levels do *not* reflect genuinely high levels of an inability to work. Instead, bodies such as the OECD ([2003:169](#_ENREF_32)) argue that there has been a ‘policy failure’ that encourages people to *choose* to claim incapacity benefits. Partly this reflects an economic model of rational decision-making, given evidence that claimant rates are influenced by incentives ([McVicar 2006](#_ENREF_30)) – sometimes with the implication that claimants are ‘malingering’. But more influential has been the biopsychosocial model ([Wade and Halligan 2004](#_ENREF_41)), according to which the policy failure has been allowing people to believe that they are incapable of work and to become ‘dependent’ on benefits.

This view has been contested by those who focus on how weak labour demand constrains choice. Beatty and Fothergill have influentially described incapacity claimants as the ‘hidden unemployed’ ([Beatty et al. 2000](#_ENREF_7)), amid extensive evidence that plant closures lead to rises in incapacity receipt, and that incapacity claimants are primarily low-skilled people in areas with few jobs ([Houston and Lindsay 2010](#_ENREF_16), [Beatty et al. 2009](#_ENREF_6)). This is not to suggest that claimants are non-disabled; Beatty & Fothergill recognize that disability may be a factor in losing work and being left at the back of the ‘queue for jobs’ ([Beatty et al. 2009](#_ENREF_6)). Fundamentally, though, disability is a criteria for sorting the unemployed, and the ‘hidden unemployed’ are not seen as incapacitated.

This account is in many ways compelling ([Houston and Lindsay 2010](#_ENREF_16)), yet it does not consider whether inequalities in benefit receipt may partly be due to *genuine* incapacity; indeed, it is striking that neither the biopsychosocial or hidden unemployment models consider incapacity in any depth. Beatty & Fothergill ([2005](#_ENREF_5)) ignore health inequalities, despite evidence that mortality explains at least as much of the spatial variation in incapacity claims as labour demand ([McVicar 2009](#_ENREF_31)). Moreover, ‘incapacity’ means that work risks the health of the worker; or risks the health of others; or – crucially – that the person is unable to work to the expected level ([Palmer and Cox 2007](#_ENREF_35)). It is therefore possible that incapacity – beyond ill-health *per se –* is more common among disadvantaged people in disadvantaged places.

This paper therefore presents the results of a qualitative study that investigated the differential ability of people with different educational levels to avoid incapacity in the face of an impairment. The paper starts by reviewing evidence on work and incapacity, before presenting the methods and results, and concluding with the implications for research and policy.

### Literature review

To understand the limits of the hidden unemployment approach, we need to use the social model of disability, where ‘disability’ is not an inherent property of an individual but the result of individual functional impairments combined with a disabling social environment ([Barnes 2000](#_ENREF_2)).2 Incapacity (work disability) therefore cannot be a binary, medical determination; as the London School of Economics founder and social activist Sidney Webb put it in 1914, *‘incapable of any work whatsoever’* can only mean ‘*literally unconscious or asleep’* ([cited by Gulland 2011:7](#_ENREF_12)). Incapacity therefore fundamentally depends upon the nature of work – and while it also depends upon people’s beliefs and local labour demand, these three factors tend to be separated into three distinct literatures.

Still, there is an extensive quantitative literature that links working conditions to incapacity. One of the most influential models is Ilmarinen’s ‘work ability house’ ([Maltby 2011](#_ENREF_26)), which primarily considers health, professional competence, values, and the nature of work. There is good evidence that work-related factors influence the most common measure of work ability ([van den Berg et al. 2009](#_ENREF_39)), but this only offers a blurred measure of incapacity as it includes direct measures of health. This reflects a general problem with the wider quantitative literature, including studies using the demands-control model ([Baumberg 2014](#_ENREF_4)), which generally do not enable us to tease apart whether working conditions impact on ill-health *per se* vs. whether working conditions make it harder for a person with a given level of ill-health to work. This is a crucial distinction, given that health does not explain the observed socioeconomic inequalities in incapacity receipt ([Østby et al. 2011](#_ENREF_34)).

Qualitative research is potentially more promising in separating these two explanations, given that it can trace the complex processes through which factors have causal effects ([Maxwell 2004](#_ENREF_28)). Studies of incapacity nearly always thickly describe the incapacitating effect of the pace and intensity of work, and also the ways in which employer adjustments and phased returns-to-work can avoid incapacity (e.g. [Gewurtz and Kirs 2009](#_ENREF_10), [Sainsbury et al. 2008:64](#_ENREF_38)). Yet many of the medically-oriented studies simply list the factors that mattered within that particular sample (e.g. [Kennedy et al. 2007](#_ENREF_23), [Liedberg and Henriksson 2002](#_ENREF_24)), rather than constructing a theoretical account of how these factors *in combination* limit the possibilities available for different people. And while they sometimes consider biopsychosocial factors, they rarely offer any integration with Beatty & Fothergill’s account of hidden unemployment.

The gaps in knowledge can perhaps be most clearly seen when looking at two of the most nuanced accounts. Johansson’s illness flexibility model ([Johansson and Lundberg 2004](#_ENREF_18), [Hansson et al. 2006](#_ENREF_13)) considers how ‘requirements’ (constraints), ‘incentives’ and job flexibility (see below) influence sickness absence. Likewise, longitudinal qualitative research by the Social Policy Research Unit at the University of York ([Sainsbury and Davidson 2006](#_ENREF_37), [Irvine 2011](#_ENREF_17), [Sainsbury et al. 2008](#_ENREF_38)) captures the unfolding influence of nearly every known factor on employment among disabled people. Yet in their desire to capture multiple influences, neither study fully explores people’s *ability* to work, nor whether lower-skilled people with an impairment have fewer abilities to work – leaving us with a critical gap in this valuable comprehensive literature. To our knowledge, the present study is the first to combine these disparate literatures and focus specifically on whether there are educational inequalities in how impairment becomes incapacity.

# Methodology

Rather than aiming to be statistically representative, this sample aimed to cover the range of variation within the wider population ([Ritchie and Lewis 2003](#_ENREF_36)), focusing (i) type of health condition; (ii) whether the person left work; (iii) gender; and (iv) education level. Participants were purposively recruited through five GP practices across advantaged and disadvantaged areas, within which waiting patients were invited to take part. Volunteers were then screened by phone, selecting only working-age individuals who had recently had a health problem that interfered with their work, and achieving balance according to the criteria above. In total 341 people were approached, of whom 139 were successfully screened, 41 passed, and 28 interviews were conducted (October 2009 to June 2010). While the sample was varied in most respects, it became clear that it contained relatively few incapacity claimants, and 11 further claimants were obtained through three offices of a Welfare-to-Work provider.

A target of around 35-45 interviews was expected to be sufficient to obtain sufficient variation ([Manderbacka 1998:320](#_ENREF_27)), but this ‘saturation’ was actually reached at a slightly earlier point, and the analyses below are based on 32 interviews.3 This resulted in a sample that was varied in all key respects (see table 1); and also by type of work (see supplementary table A2).

**Table 1 about here**

The interviews focused on the extent to which impairments led to problems with fitness-for-work in a previous job and the options that people then had available, based on respondents’ descriptions of their impairments (see below). Depth interviews were chosen to investigate individual narratives and minimize social influence effects, using a topic guide developed through two pilot interviews. Participants were given a choice of interview location; most were at home but some were conducted in cafes/pubs, and several were conducted in a private room at the Welfare-to-Work provider. The research received ethical approval from the LSE Ethics Committee, the NHS Research Ethics Service (reference 08/H0714/110), and the Research Management team within each PCT.

The interviews lasted 35-135 minutes, and after transcription were analysed using a combination of thematic coding and the Framework method ([Ritchie and Lewis 2003](#_ENREF_36)). This meant that a draft coding frame was developed based on previous literature and an initial subsample. Each transcript was then read 2-3 times and coded in NVivo, before being summarised in a charting framework that covered key themes. The final analysis used both the framework (to compare cases) and the codes (to compare themes and extract quotes) to build a theoretical model linking impairment to incapacity, before examining the role of education and wider socioeconomic factors in these pathways.

# Results

From the outset, it was clear that people faced different levels of choices in responding to impairments, and that these partly reflected their educational level. This is vividly illustrated when we compare Lindsey (with GCSEs) to Maryah (with a degree).

Lindsey had managed her depression for many years while working in charity shops, but had been finding it increasingly difficult to cope. She said that everyone thought her assistant manager job ‘was a doddle’, but it was actually ‘very pressurised’ given the weekly targets from management – and trying to speak to the employer about the workload was simply seen as ‘making excuses’. This left a ‘vicious circle’ of pressure and depression, where she was isolating herself from friends and family. When her otherwise understanding manager took out a bad day on her, she thought *“I just thought ' no, I can't deal with this anymore', and I just... put my notice in”* – although if it had not been for this argument, she felt she could not have carried on much longer.

This was during the recession, and Lindsey soon realised it was a bad time to be looking for work –the ‘dole queues will be flooded with people’ looking for retail work. Yet applying for benefits would simply have been swapping the pressure of her old job for the pressure of the Jobcentre, so she instead got by on the little savings she had. Ten months after leaving her job her savings had run out and she ‘couldn’t see any hope’, so she took an overdose. Her sister came as soon as she received the suicide note, took her to hospital, and later filled in the benefit application forms. By the time she participated in this study she was somewhat better and thinking about returning-to-work. Employment in a supermarket seemed unlikely (an occupational health assessor had concerns about her ability to cope), but she had been doing a small amount of permitted work in a dry cleaners, who she felt were unusually understanding.

Maryah also suffered from ‘stress’, but in nearly every other way her experiences were different. She was a marketing director for a global cosmetics firm in a job she described as ‘un-doable’, being responsible for 16 countries across Europe, which she juggled with being a single mother. While loving the challenge, in the last six months of this job she began to struggle:

*“I was waking up every morning at 4 o’clock, just bad dreams, being on fire alive or jumping off a high tower or whatever. It was clearly stress-related.”*

When her child therapist said her daughter’s problems were related to her stress, she decided to change job. She felt that reducing the stress of her existing job was impossible – *“if [a boss] sees that you have been doing the job for a year without an extra assistant or manager, why get one?”* – but instead told her boss that she ‘wants out’. She moved to a less-stressful job with the same company, but this was less satisfying and she ultimately negotiated a leaving package before having another child with a new partner. At the time of our interview she was looking to work again but was avoiding stressful jobs after the ‘permanent damage’ inflicted by her old job. With her contacts, money and skills she was thinking of various types of self-employment, some of which thought would be ‘really easy’ to achieve.

While there are obvious similarities in these two stories – they are both people dealing with stress at work, albeit of different kinds – the options available to them were very different. But how can we understand these differences? To theorize what is happening more systematically, we need to break apart this complexity into several different responses to workplace impairments, of which there seemed to be three that span the diversity of the previous literatures: flexibility, employer adjustments, and changing job.

### Using flexibility

The quickest and most straightforward response to a fitness-for-work limitation was for workers to change their work themselves to fit around it, if they had sufficient autonomy ([Sainsbury et al. 2008:134](#_ENREF_38)). Workplace autonomy is a complex concept ([Hodgson 2004](#_ENREF_15)): irrespective of people’s meaningful levels of control over their work, what was crucial here was whether people had the right sort of flexibility for their impairments. For example, Cheryl’s office job enabled her to get up and stretch her back whenever she wanted – something that was simply not available to Khaled as a bus driver, causing him considerable pain (see below).

One form of flexibility that was particularly important was what Johansson et al ([2004:1859](#_ENREF_18)) call ‘adjustment latitude’: *“the opportunity people have to reduce or in other ways alter their work effort when e.g. feeling ill”* ([see also Gewurtz and Kirs 2009:40](#_ENREF_10)). This enabled people with fluctuating conditions to alter the order or pace of their work to reflect their moment-to-moment abilities, as Yvette explained for her auditing job:

*“‘Do I work as quickly when I’m in a lot of pain?' I think well hand on heart I’ve got to say no […] You know, the amount of work I do at the end of the day is the same, but it takes more effort and, you know, if I feel like one day I’ve had a crap day, then maybe the next day I’ll try and work harder.”*

At extremes, workers could pretend to work rather than taking sickness absence, even on days when they were unable to do any work at all:

*“I said I was going looking for properties […] and I’d come home and I’d just lie down all day, and not get a sick note”* – Nick, property finance

Without adjustment latitude, impaired performance was more visible to employers. Sarah worked ‘incredibly hard’ as a supermarket supervisor on some days, but had other days where her depression made her unable to work productively. That she managed to stay in her job so long was not because she had the adjustment latitude to conceal this, but rather because of her previous manager:

“I remember my direct manager saying to me one time, “You know what? You’re the best supervisor I’ve ever had. Because even though you’ve got your illness, some days you get really unmotivated and you can’t actually do anything […] But on the days that you’re on the ball, you try so hard.” […] And if it weren’t for that man, my direct manager, I don’t think I would’ve survived the last eight years […] If it weren’t for [him] protecting me and backing me up, [the management] would’ve gone full-pelt at me because there’s been many times they tried to get me sacked.”

As this suggests, flexibility was not available to everyone. Khaled’s bus driving was inflexible, partly governed by passengers and partly by managerial surveillance (motion sensors, cameras). While the present study focused on processes of incapacity rather than of work design, adjustment latitude appeared to be an integral feature of jobs where managerial control was exercised through targets or the allocation of discrete packages of work. We have already seen how Nick had very high levels of adjustment latitude that enabled him to avoid sickness absence, and elsewhere he described his job as follows:

 “If you want to take longer for lunch, take longer for lunch. If you want to turn up late, turn up late. But you’re going to have to do the work somewhere along the way, it’s up to you when you do it”

But what of the link between education and autonomy? The qualitative design of the present study does not enable us to make robust generalisations based on patterns of association, much as lower-educated respondents like Khaled and Sarah tended to have less flexibility, while higher-educated respondents like Nick and Yvette had more flexibility. There are also many influences on autonomy for any given job in any given workplace, ranging from the structural to the individual manager. Still, it is clear from other, quantitative research that forms of autonomy tend to cluster together, and that autonomy is strongly socially patterned ([Baumberg 2011](#_ENREF_3)); indeed, autonomy is part of the *definition* of NS-SEC social classes. Flexibility can help prevent impairments turning into incapacity, and as we return to below, it is more likely to be available for some people than others.

### Employer adjustments

At times, flexibility could be replaced by employer adjustments. In particular, for people who struggled to maintain a fixed posture for long periods, employers could allow more frequent breaks to reduce pain and physical strain. Hence while Cheryl (above) had the flexibility to take breaks within her job, Helen was granted permission by her employer to get up from her desk and stretch her back regularly.

Yet the importance of employer adjustments went far beyond this ([Sainsbury et al. 2008:157](#_ENREF_38)). A lot of people’s physical impairments were *task-specific* – that is, they struggled with a specific aspect of the job, such as holding fixed postures, lifting heavy objects, bending etc. Employers could therefore make adjustments to either modify the physical environment (e.g. Nick received a phone headset to reduce neck pain), or to remove the specific disabling aspects of people’s jobs. Adjustments could be formal or informal, and could also occur for people with mental health difficulties: cleaning the shopping centre on busy, rainy dates was too chaotic for Yusuf to deal with given his PTSD, so on these days he was sent to clean empty stairwells instead.

These adjustments helped people stay in work, but again they were not available for everyone. One disadvantage of adjustments *vis-à-vis* flexibility is that people had to disclose their impairment to their employer, and some people were unwilling to do this for fear of losing the job. Khaled would have benefited from being allowed regular breaks to stretch his back, as we have already seen for Helen and Cheryl. However, he said that *“I’d rather not [tell them about my disability] because... I don’t feel that they would appreciate the fact that I have back problem […] Anything under five years [working there] they can get rid of you easily.”* Nor would adjustments occur where they involved tasks that were central to the job, such as Tessa’s epilepsy making it hard for her to care for children.

Adjustments were valuable where they were possible, where an employee was confident enough to request them, and where an employer was happy to grant them. Small adjustments around desk-based work were sometimes possible for people in office jobs with little flexibility, and more significant adjustments were sometimes possible for people with physical impairments in physical jobs – and these people were *not* necessarily highly-educated.

#### Adjusting demands

Another type of adjustment was a phased return-to-work, where workload was temporarily reduced after absence ([Gewurtz and Kirs 2009](#_ENREF_10), [Sainsbury et al. 2008:64](#_ENREF_38)) – an adjustment that can be thought of as responding to temporary ‘sickness’ rather than (semi-)permanent ‘disability’. This was important for many impairments relating to the pace/intensity of work, which could be physical (e.g. standing/sitting for long periods) or stress-related. Yet there seemed to participants almost no scope whatsoever for *permanently* reducing demands, other than reducing the hours of work (see below). Marjorie would have been able to do her cleaning work without bending down if she could reduce her work pace, but instead had to give up the job. Scott put it similarly:

*“There is no room for manoeuvre. I know as far as I was concerned, the pressure was always going to be there if I went back to that job.”*

Others tried and failed to persuade their employers to reduce their demands, and as shown for Lindsey and Maryah above, this applied irrespective of their education. People also sometimes felt that their mental health made it difficult to deal with demands that other people could cope with:

*“I'm not [my manager]. I'm me. It's what I can reasonably do. What my strength is suited for. But they don't see it like that”* – Lindsey

Indeed, employees with impairments may actually find themselves with a higher workload than others, to the extent that their impairment makes it more difficult to resist excessive workload demands. As Sarah put it, other supermarket staff would say *‘just don’t pressure me’* to managers*,* but “*I can’t do that, I’d end up bursting into tears*”.

In the face of a near-universal inability to permanently reduce demands, perhaps the most revealing situation was that of Ricardo. He had been in bed for ten months after a serious motorbike accident, and when his health started to improve, he found a job through a friend as a caretaker at a church. This job was perfect for his situation, with a low and flexible pace of work – he reported that his boss said:

“I don’t care about the time, there’s room for five months, I don’t care. Just do it nicely.’ […] If you don’t come tomorrow don’t worry about it, just take your time and do your work you can”

Uniquely here, this situation was allowed to continue indefinitely. Tellingly, Ricardo described this job as *‘a gesture’.* By this he implied that it was an act of charity by a religious organization, which in its exceptional nature highlights the impossibility of permanently reducing demands within the normal logic of work.

### Changing job

The final way to make impairments less-disabling was to move to a more suitable job – a major feature of people’s accounts, but surprisingly rarely studied in the wider literature, even in the ‘hidden unemployment’ literature that it most closely relates to.

Almost by definition, more ‘employable’ people found it easier to move. (While we use ‘employability’ to refer to an individual’s ability to find work, this is obviously specific to particular labour markets at particular times ([see McQuaid and Lindsay 2005](#_ENREF_29))). Employability was partly a matter of qualifications, but also reflected age and language skills and a general difficulty in finding work in late 2009/early 2010. Even those with some relevant skills/experience were sometimes concerned, with Cheryl having experience and a childcare diploma but still feeling that childcare work is *“difficult because there’s lots of mum’s that want it*”. This is also described by Beatty & Fothergill, where the ‘hidden unemployed’ are formed of those with genuine impairments who find themselves out of work at times and places where there is a shortage of jobs.

But there is more to it than this. When people were moving jobs, they were not just trying to get *any* job, they were trying to get a *suitable* job, one that did not conflict with their particular impairment – and this does not feature in Beatty & Fothergill’s account. Often this meant changing career entirely, to fields that did not match their experience or qualifications, and even higher-educated respondents could find this challenging. Elizabeth and Naveed both felt that changing careers in their 40s (from nursing and martial arts instruction respectively) would be hard. Nevertheless, while Naveed was worried – *“what other skills have I got to offer that would attract employers apart from the fact that I’m a graduate?”* – he was still considering retraining in social work if necessary.

Better-qualified people may have been reluctant to change career, but the greatest difficulties were for those with lower qualifications. Damian was a case in point. His depression made him unable to concentrate sufficiently to continue working as an electrician; *“I nearly killed a bunch of work mates just by not concentrating on my wiring of things.”*  While it would have been easy to continue as an electrician – he had friends working in the trade who kept offering him work – but the wooziness from his medication made this impossible. With no relevant experience or qualifications he was therefore looking for ‘menial jobs’, and *“like a mug [I was] thinking I’m going to walk straight back into another job […] It was like everyone says, it’s not that easy at the moment.”* This left him in a ‘Catch-22 situation’ where he was not employable enough to get the jobs he was fit to do, and not fit enough to do the jobs he could get.

Ali also fell into this Catch-22. His previous work as a chef in an Indian restaurant was now too physically demanding, and he had to try and find a job despite his poor English language skills and lack of qualifications:

“If I got a good education, then I got a choice, I can do [chef work] or not, take it or leave it. Because I haven’t got any education. I have to do it”

He was therefore resigned to claiming incapacity benefits, until whichever among death and retirement came first. Similar binds also applied to some lower-qualified workers who were struggling and unable to change to a more suitable job, as we explore further below.

Yet it is not as simple as saying that all higher-educated people could find suitable work while lower-educated people could not. Irrespective of people’s level of education, if their impairment still allowed them to do work that used use some of their previous skills, then it was easier to find suitable work. This applied to several people who wanted to do less stressful versions of their previous jobs, such as Scott and Steve who expected to find voluntary-sector IT roles at a much lower level of intensity. In contrast, better-educated people in the sample with more severe disabilities were still unlikely to find suitable work. Disability discrimination was also widely-reported, with many reporting that no-one would employ them if they revealed their disability.

Finding suitable work also had an element of chance. Redeployment, for example, was only possible in certain large employers such as the police force; Helen said that otherwise *“I’d be out of work. I don't think anyone would employ me with my medical history.”* Perhaps the luckiest people, though, were where someone else found them an unusually understanding employer. Ricardo’s exceptional caretaking job (above) was found for him through a church friend; Yusuf’s sympathetic cleaning job by his welfare-to-work provider; and it was Cheryl’s mother who found her a job that eased her back to work gently, working only until lunchtime until she felt capable of doing more:

“[The job] fell in my lap really. I didn't actively go out, my mum phoned me one day and she said 'We need some temps' [...] …when I had to go home, and I had to go home because I was just getting in a state, it was, “Fine, go on, off you go.” […] I’m thankful for that because I don't know how I would get back into employment otherwise”

Cheryl, Yusuf, Ricardo and Helen all recognised their good fortune in finding suitable jobs. Without this, they all expected to face the Catch-22 of not being employable enough to get the jobs they were fit to do, and not fit enough to do the jobs they could get.

### Choice and constraint

The analysis in this paper has suggested that some people with impairments were able to find non-disabling work environments, through job flexibility, job adjustments, or moving to a more suitable job. However, this did not result in a black-and-white situation where people were either fully fit-for-work or fully incapacitated. Instead there was a sizeable grey area where people were ‘struggling on’ ([Sainsbury and Davidson 2006](#_ENREF_37)) with impairments that partially interfered with their job. This introduces the possibility of further inequalities in the extent to which are allowed to – and feel compelled to – struggle on.

Some inequalities were around whether employers would accept sickness absence and/or reduced performance. While this varied from manager-to-manager, employers generally seemed sympathetic for temporary sickness (such as an operation), but less so for chronic disability (long-term or repeated short-term absences). Melanie was not alone in feeling pressures to minimize absence:

“You’re just forever getting warnings whenever you’re sick... When an ambulance is called to work [after going into a diabetic coma], I won’t let them take me away because that will by my percentage [that monitors absence] gone up again…So it’s not a good place to be”

Moreover, sickness absence policies were a way dealing with poor performance. No-one ([at least in this sample, but see Sainsbury et al. 2008](#_ENREF_38)) was sacked directly on performance grounds, but poor performance instead could be *transformed into* a problem of absence by applying continual pressure. For example, Sarah suspected that pressure – which she experienced as ‘bullying’ – was being deliberately applied to her in order for her to take sickness absence, a tactic that was ultimately successful.

Some struggling workers therefore had decisions taken out of their hands. The remainder had to decide whether to accept the physical and psychological burden of struggling ([Wilton 2008](#_ENREF_42)). Continuing to work sometimes damaged their health or put them in considerable pain, and the effort of staying in work often came to dominate their lives. As Erica put it, talking about her job with a major budget clothing retailer with a workload she described as ‘mental’:

 “I’m not physically capable of this 20 hours a week, running this house - which isn’t a lot because you can see the state of it (laughs) - and a private life. I’m not capable of it all and I just literally don’t have a private life. No friends, no boyfriend – no nothing.”

Given that it was almost unheard of for employers to permanently reduce job demands, the main options left were to reduce hours, change job, or leave work. Crucially, though, individuals not employers bore this cost, and this was only a ‘choice’ if people could cope with reduced income. Khaled was one of those who felt financially trapped. He was forced to sit down for nine hours in his job as a bus driver, leading to back pain he described as *‘like having a knife in your back, cutting across’,* and he was too exhausted when he got home to socialise, even after ceasing overtime. Khaled felt he could have claimed incapacity benefits (his injury was visible on MRI scans), or changed to a retail job (with his cousin) – but both of these would lead to what he considered to be an unacceptable drop in income, forcing him to deny his kids the right *‘to have that just* little bit *extra*’. While this may sound like a ‘choice’, it certainly wasn’t experienced as such – *“It's recommended [by doctors] to do something else, but (...) there's not much that can be done.”*

In other words, some people not only had more options available to find non-disabling work (above), but when they had partial fitness-for-work limitations, they also had more choice about whether to struggle on.

# Discussion

In reflecting on these findings, it is important to be mindful of the study’s limitations. This method does not aim for a survey’s ‘representational generalisation’; instead it aims for ‘theoretical generalisation’ based on a sample that contains variety in the phenomenon of interest ([Ritchie and Lewis 2003](#_ENREF_36)). This is subject to several caveats: that some less common experiences have been missed (e.g. bipolar disorder), as will those who avoid formal services (GPs, welfare-to-work providers), and the interviews were limited to London. Furthermore, the interview data was treated as a valid account of people’s experiences, and while we make our own judgements as to the degree that people were incapacitated, this builds from people’s own accounts of how their impairments affected their lives. Interviews will also be affected both by the author’s own particular social position and the embedding of such interviews within participants’ wider narratives.

A further issue – rarely addressed explicitly – concerns causal inference in qualitative research. The analysis here focused on ‘process tracing’: that is, examining the unfolding sequences of events within each person, looking for evidence of which complex constellation of factors leads to the observed outcomes, comparing all the cases to one another and paying particular attention to exceptions ([Maxwell 2004](#_ENREF_28)). No method of causal inference is infallible, however. Furthermore, while we trace the processes through which impairment becomes incapacity, some of these processes are only indirectly related to education. For these we draw on wider evidence, and suggest further avenues for research below. With these limitations in mind, this discussion summarises the paper’s results in the context of the wider literature, and draws out the implications for research and policy.

### Findings

Based on an in-depth analysis of interviews with 32 individuals with physical and mental impairments, this paper has suggested that some people have systematic advantages in preventing their impairments from becoming incapacitating, going beyond the existing literatures on hidden unemployment and working conditions. More precisely, it suggests that both workplace inequalities and labour market inequalities are at work:

* Job flexibility enabled people to work around their impairment, as found in both qualitative ([Sainsbury et al. 2008:134](#_ENREF_38), [Gewurtz and Kirs 2009:40](#_ENREF_10)) and quantitative research ([Allebeck and Mastekaasa 2004:57](#_ENREF_1), [Baumberg 2014](#_ENREF_4)). Such flexibility was more common among better-educated people – but the present, qualitative study cannot offer robust evidence of such patterns of association. However, nationally representative surveys of work confirm that high-autonomy jobs tend to be more common among better-educated people ([Baumberg 2011](#_ENREF_3)).
* Changing to a more suitable job also enabled people to find non-disabling work environments, for which better qualifications directly helped. This goes beyond the important Beatty & Fothergill account: it is not (just) that less employable people found it harder to find work (‘hidden unemployment’), but that they found it harder to find *suitable* work, which meant they were *genuinely* incapacitated. Some low-qualified people who had to move field therefore faced a ‘Catch-22’ situation where they were not employable enough to get the jobs that their health allowed them to do, but not fit enough to do the jobs that they were skilled or experienced enough to get – leaving only a remote possibility of finding suitable work.

This is not to suggest that all lower-qualified people had no options. They too were sometimes able to move into more suitable jobs through a fortuitous combination of events, or could be in the sorts of jobs where employer adjustments could make a difference. Yet while it is a legal obligation in many countries to make ‘reasonable’ adjustments, the bar of ‘reasonableness’ is high – some tasks are too important to be removed; studies of employers found they are worried about the resentment they induce among colleagues ([Sainsbury et al. 2008:89](#_ENREF_38)); and permanent reductions in workload are rare (as also found in [Gewurtz and Kirs 2009](#_ENREF_10), [Sainsbury et al. 2008:91-2](#_ENREF_38)). While education did not determine outcomes on its own, there were simply fewer ways of avoiding incapacity among lower-educated respondents.

Beyond this, there is a further dimension of inequality around whether people had control over ‘struggling on’ ([Sainsbury and Davidson 2006](#_ENREF_37)) in a partly-disabling environment. Employers sometimes pressurised struggling workers to take sickness absence, and then terminated the contracts of workers with long-term absence or repeated short-term absence ([Sainsbury and Davidson 2006:38-51](#_ENREF_37)). Furthermore, people themselves questioned whether they wanted to continue struggling in the face of pain and exhaustion ([Wilton 2008](#_ENREF_42)). Reduced hours were a common response, yet it is notable that the costs of this are borne by the worker themselves. The viability of both reduced hours and stopping work therefore depended on their ability to cope with reduced income, and again, there is extensive evidence that income/wealth are associated with education ([Karagiannaki 2011](#_ENREF_21)).

It is worth clarifying the basis on which these conclusions have been made. The study itself showed the processes through which certain people had choices in responding to impairments, whereas others had none. Education’s role in increasing the choices available was partly direct (for employability), but partly a matter of indirect probabilistic relationships (for flexibility and wealth) confirmed in other studies. While further research is necessary (see below), it is clear that incapacity results from the *combination* of impairments with disabling work environments, and it seems that better-educated people were better-able to stop impairments becoming incapacitating – a finding whose implications we now consider for both research and policy.

### Implications

A first implication relates to academic debates. This study suggests that the concentration of incapacity claims in lower-qualified people may not just be a matter of ‘hidden unemployment’ as Beatty & Fothergill suggest, but because lower-qualified people are genuinely more incapacitated, due to workplace factors and their interactions with labour market factors. However, while the processes underlying hidden unemployment are extensively documented, the processes underlying incapacity are less so. De Raeve et al ([2009](#_ENREF_9)) found people were more likely to change jobs after becoming psychologically distressed; Gignac ([2008](#_ENREF_11)) found that 21% of people with arthritis changed jobs; and Jones ([2011](#_ENREF_19)) found that disabled people were more likely to become self-employed – but otherwise there are surprisingly few studies focused on occupational change as a response to impairments. Moreover, while we know that highly-educated disabled people suffer a pay penalty compared to non-disabled people ([Longhi et al. 2009](#_ENREF_25)), it is unclear if this penalty extends to other factors such as adjustment latitude. Further research is necessary, including quantitative research that looks directly at the respective prevalence of job flexibility, adjustments and occupational change among people with impairments, and how this varies across people of different educational levels in different local labour markets.

The findings also directly relate to debates around how we should assess incapacity within the benefits system. If incapacity by definition depends on labour market disadvantage as well as impairment, then there is a strong case for considering such factors when assessing incapacity. This has been done in e.g. Sweden up until the late 1990s ([Kemp et al. 2006](#_ENREF_22)) and there have been calls to introduce such a ‘real-world’ assessment in the UK ([Citizens Advice Bureau 2010](#_ENREF_8)). However, the Government’s independent reviewer of the incapacity assessment recently dismissed this policy because we “lacked the necessary detail and evidence base” ([Harrington 2011:37](#_ENREF_14)). Furthermore, while space precludes a full discussion (see [Baumberg 2011](#_ENREF_3), [Baumberg 2014](#_ENREF_4)), it may be possible to reduce incapacity by both better-matching people with impairments to suitable jobs, and by making workplaces generally less disabling.

If further study confirms and extends the findings here, then there is therefore the possibility of creating a fairer system of incapacity assessment, and of reducing the rate of incapacity *per se*. On these grounds, inequalities in responses to impairments would seem worth exploring in future research.

# Notes

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1. LFS figures for 2013 <http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/search_database> [accessed 23/5/2014]
2. ‘Impairment’ here refers to an inability to perform specific tasks, while ‘disability’ refers to the inability to perform a given social role. This follows analogous distinctions in e.g. the WHO *International Classification of Functioning, Disability and Health*.
3. After analysing 24 transcripts it became clear that saturation was being reached for some types of claimant; 8 further interviews were therefore purposively selected for analysis.

# Tables

**Table 1: Properties of the main sample**

|  |  |  |  |
| --- | --- | --- | --- |
| Aged 20s/30s | 12 | Male | 16 |
| Age 40s | 13 | Female | 16 |
| Age 50+ | 7 | Mental health condition | 13 |
| No qualifications  | 6 | Physical health condition | 19 |
| NVQ Level 1 qualifications | 3 | Has claimed incapacity benefits (IB/ESA) | 14 |
| NVQ Level 2 qualifications | 8 | Not claimed incapacity benefits | 18 |
| NVQ Level 3 qualifications | 6 | Left work due to health problem | 18 |
| Degree-level qualifications | 8 | Stayed in work | 14 |

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