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HARRIET COOMBS
RITHIKA MURALIDHARAN
JO PUDDICK
CHARLOTTE REFSUM
RYAN WAIN

An Emergency Handbrake for UK Welfare: Stabilising Spending, Supporting People

TONY BLAIR INSTITUTE FOR GLOBAL CHANGE

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Contributors: James Browne, Kayla Crowley-Carbery, Tone Langengen

Executive Summary

The government has rightly commissioned reviews to fundamentally reshape a welfare system that looks set to eclipse defence spending by the end of this decade. This will take time.

Meanwhile, on a daily basis, nearly 1,000 people in Britain sign on to benefits.[1] As part of the government's effort to restore trust in the welfare system, we believe it could and should pull an emergency handbrake now that will slow the rise of claimants.

The handbrake is based on a simple idea: there are certain conditions that in the vast majority of cases do not limit an individual's ability to work, and the default presumption should be that these "non-work-limiting" conditions no longer attract cash benefits. Many of these conditions are those that have proliferated since the pandemic, particularly mental-health conditions.

It is a handbrake that can be pulled now, using secondary legislation ahead of more significant reform later in this parliament.

There is a moral imperative behind reform. Britain is not alone in experiencing a deterioration in mental health since the pandemic. Other advanced economies have seen similar rises in anxiety and depression. What is distinctive in Britain, however, is how sharply this has translated into people moving out of the workforce and into long-term benefit receipt, which – according to several major studies – is the exact opposite of what's best for them.

There are now 2.8 million adults out of work due to ill health, including around 185,000 young people (aged 18 to 24) – a number that almost doubled between 2012 and 2022.[2,3] For young people in particular, early detachment from the labour market risks locking in a lifetime of diminished opportunity. Even relatively short periods away from the workforce can have

a negative impact on health and long-term prospects, with the risk of permanent exclusion rising rapidly the longer a person is away. Being in work, by contrast, provides purpose, structure and social contact – and, for most people, is beneficial to both mental and physical health.

There is also a fiscal imperative to reform the system. The cost of welfare payments has ballooned in recent years, with incapacity benefits (Employment and Support Allowance and Universal Credit for those entitled to the health element) accounting for nearly £30 billion of Department for Work & Pensions (DWP) spending in 2024-25 while disability benefit (Personal Independence Payments, or PIP) accounted for nearly £23 billion. Together, those benefits now account for around half of all payments to children and working-age adults.

For reform to be effective, the priorities of a sustainable welfare state must be clearly defined and the challenges fully understood. Not only is the world of work changing but the burden of illness is too. Mental health is now a dominant category of illness for working-age adults in Britain, while the impact of AI on the labour market is evolving in real time. These trends are not going away.

This is an emergency handbrake informed by public sentiment. Exclusive polling commissioned by the Tony Blair Institute for Global Change and conducted by YouGov shows people are starting to tire of a system so clearly unfit for purpose. Around half of respondents believe that some of the conditions currently recognised by the system do not, in practice, limit people's ability to work.

Our proposed emergency handbrake would be a three-tiered package that would:

1. **Introduce a category of a non-work-limiting conditions that applies to the benefits system.** The government should introduce a category of non-work-limiting conditions. These are conditions where the default assumption is that the condition is compatible with work – and therefore

does not attract out-of-work benefits or require additional cash support through PIP. This list would be regularly updated with each condition supported by evidence of its impact on work.

2. **Apply this principle consistently at every decision point in the application process for the health element of Universal Credit (UC health) and PIP.** Non-work-limiting conditions would become a key deciding factor for benefit eligibility, applied at each point in the application process for both UC health and PIP, including at the point of GP certification, DWP assessment, appeal and reassessment. It would create a default assumption – known as a rebuttable presumption – of function and need that claimants could challenge with clinical evidence.
3. **Provide targeted health and employment support for those no longer eligible for long-term incapacity benefits.** People who are no longer eligible for UC health and PIP following system reforms should be offered in-kind support including both medical treatment and socioeconomic support.

The potential gains from strengthening the welfare system's gateways are substantial. If incapacity benefit claimant numbers had remained at pre-pandemic levels – as in most comparable countries – the welfare bill would be around £11.5 billion lower by the end of this parliament.[4] And had the number of working-age PIP claimants remained at pre-Covid levels, spending would be around £19 billion lower.[5] These numbers underscore the scale and speed at which spending has spiralled.

As well as failing individuals with non-work-limiting conditions and causing fiscal damage, the welfare system as it stands has given rise to a crisis of confidence among the public, who increasingly believe it does not draw clear or credible boundaries between those who cannot work and those who could with the right support. Rebuilding public faith in welfare will take time, but to do so the government can and must pull a handbrake now.

01

Understanding Britain's Growing Welfare Bill

Britain's welfare bill is fast becoming the defining fiscal pressure of this parliament. In 2024–25, total spending on welfare benefits in Great Britain was £305 billion – more than the Department of Health & Social Care (£204.7 billion), the Department for Education (~£95 billion) or the Ministry of Defence (~£60 billion) that same year.[6,7]

Of that Department for Work & Pensions (DWP) spending, around three-fifths goes to pensioners (through benefits like the state pension) and two-fifths to people of working age and children.[8] Health and disability benefits for working-age people are a significant proportion of this – and of the £140 billion spent on children and working-age people in 2024–25, more than a third (£52.3 billion[9]) went on health and disability payments for working-age adults.

Health and disability payments comprise two main benefit types:

1. **Incapacity benefits:** This is primarily the health element of Universal Credit (UC health), a means-tested additional payment for welfare claimants assessed as having limited capability for work due to a health condition or disability. Incapacity benefits accounted for £29.7 billion of spending in 2024–25.[10]
2. **Disability benefits:** This is principally the Personal Independence Payment (PIP), intended to meet the extra costs associated with disability or long-term physical or mental-health conditions, regardless of whether a person is in work. Disability benefits for those of working age accounted for £22.6 billion of spending in 2024–25.[11]

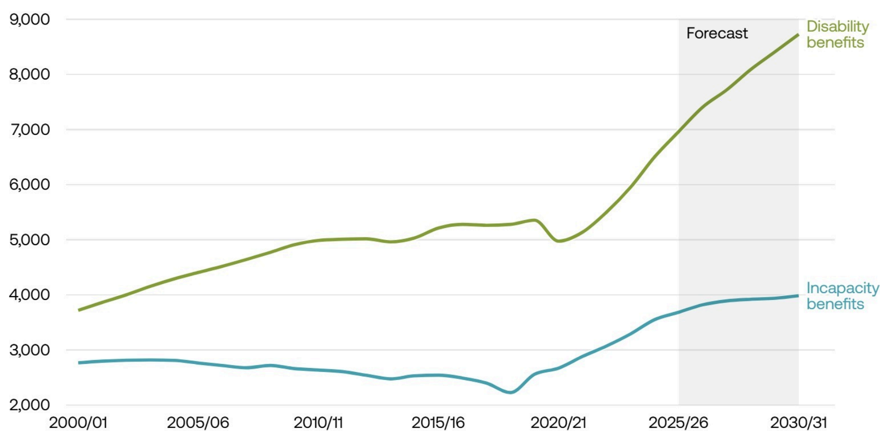
As well as making up a significant portion of the UK's benefit bill, spending on health and disability payments for working-age adults is also the fastest-rising category of welfare spending. Over the next three years, this category is expected to grow by an average of 4.2 per cent every year in real terms –

eclipsing projected growth in health, education and defence spending – and is estimated to reach £73.4 billion by 2030–31, equivalent to 2 per cent of GDP.[12]

It is important to note that this surge is not the result of a more generous system.[13] Benefit rates have not fundamentally changed; what has changed is caseload. Before the pandemic, 2.8 million working-age people were claiming benefits due to ill health or disability.[14] But by August 2025, this had climbed by more than 40 per cent to 4.5 million.[15]

FIGURE 1

Disability and incapacity benefit claims have risen sharply since the pandemic



Source: Institute for Fiscal Studies

The increase has been too large and too rapid to be explained by overall population growth or ageing. Instead, there are three core drivers:

1. **More claims linked to mental ill health:** The number of disability benefit claims driven by psychiatric disorders has more than doubled since the pandemic.[16] More than half of the total growth in claims in this period can be attributed to mental-health or behavioural conditions.[17] The impact on incapacity benefits is harder to isolate – because claimants can list

multiple conditions and are not required to specify a primary cause – but recent data from the DWP show that nearly 90 per cent of claimants found to have limited capability for work cited a mental or behavioural disorder.[18,19] This points to a profound shift in which mental-health conditions are now near universal among successful claimants.

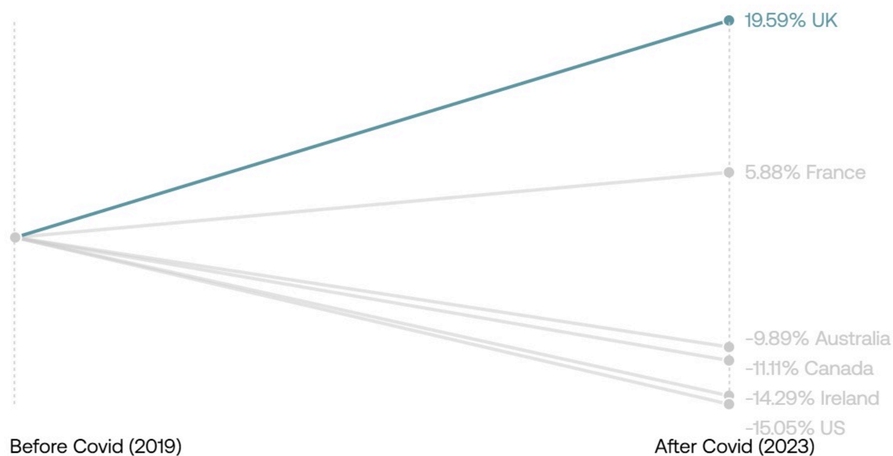
2. **Rapid growth in claims among young people:** The number of young people on incapacity benefits has surged by more than 50 per cent since the pandemic, reaching 239,000.[20] Four in five of these young people with a recorded condition on UC health are claiming due to mental-health or neurodevelopmental conditions.[21]

3. **Rising long-term benefit dependence:** Only around 0.9 per cent of people on UC health now move into work each month, highlighting very low exit rates.[22]

Britain is not alone in facing this underlying challenge. Across most advanced economies, rates of anxiety, depression and neurodevelopmental conditions are rising – especially among young people. What sets Britain apart, however, is how this trend has translated into public spending. As Figure 2 shows, no comparable country has seen rising rates of illness feed so directly into a substantial increase in benefit expenditure, essentially funnelling people with illness away from work and into long-term welfare.

FIGURE 2

The UK has seen a much sharper rise in spending on disability and incapacity benefits since the Covid-19 pandemic than comparable countries

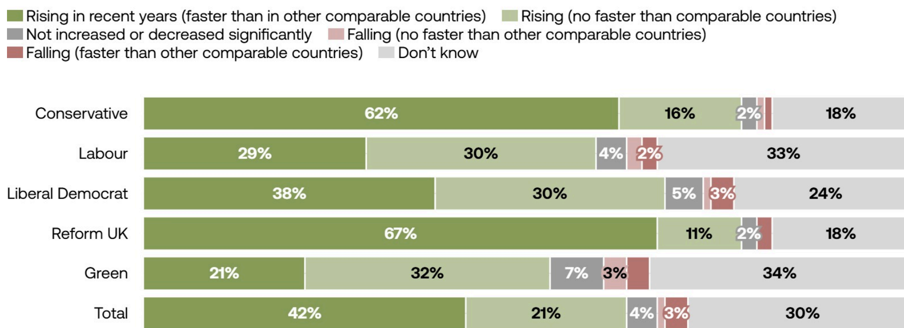


Source: TBI analysis of national data, first published in *Data Decoded: Charting the Trends and Costs of Declining Mental Health*. Note: French pre-Covid figures are from 2018. The UK, Australia and US post-Covid figures are from 2022, due to a lack of available data. It is difficult to directly compare health-related benefits across countries. TBI used the Institute for Fiscal Studies definitions of similar benefits here (in Table A4). The authors note that these may not include all health-related benefits in selected countries. The IFS analysis does not include New Zealand. No publicly accessible data were available for Germany.

Research commissioned by the Tony Blair Institute for Global Change and carried out by YouGov shows the public broadly recognises these shifts in both disease burden and increased welfare spending. Many people also suspect – rightly – that spending on health-related welfare benefits is increasing faster in the UK than in comparable countries. This perception is strongest among those currently intending to vote for the Conservatives or Reform UK, but it is not confined to them.

FIGURE 3

There is broad public awareness that the cost of health benefits is increasing, and a common perception that it is doing so more quickly in the UK than elsewhere



Q: To the best of your knowledge, which of the following statements about the cost of health benefits in the UK is closest to the truth?

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

The British welfare system is now a problem the government cannot afford to ignore. Reducing the number of incapacity and disability benefit claimants must be an explicit short-term objective of government within this parliament.

02 The Case for Change: Fiscal, Economic and Moral Imperatives

The impact of the UK's growing benefit bill is profound and creates a compelling case for welfare reform – not just on economic and fiscal grounds, but on moral grounds too.

The fiscal case is clear. The more a government spends on health and disability payments, the less it is able to spend on other priorities without resorting to either more tax or more borrowing. Neither of these is an attractive option for the government at present – especially with pressure to increase expenditure elsewhere, including on the defence budget or in mitigating the cost-of-living crisis.

The economic case is just as clear. In total, ill health among working-age people is thought to reduce economic output in the UK by up to £188 billion each year[23] with knock-on costs to public services adding significantly to the overall bill. The impact of lower tax revenues, higher welfare spending and additional NHS costs are estimated to cost the government an extra £70 billion every year.[24]

Then there's the moral case. Despite record spending on health-related welfare payments, high rates of ill health persist and deprivation remains widespread; three-quarters of all adults receiving incapacity benefits are experiencing material hardship.[25]

Young people are particularly hard hit. The government's most recent report on the issue, *Keep Britain Working*, found that a young person signed off work early in their working life could lose up to £1 million in lifetime earnings if they never re-enter the world of work.[26] Without reform, too many people will remain on health-related benefits without consistent access to effective treatment, sustained engagement or a clear pathway back into work, increasing the risk of long-term dependency.

Signing people off work – almost indefinitely – with ill health ignores the growing body of evidence that work has an overwhelmingly positive impact on both mental and physical health, life satisfaction and economic prospects, especially in the long term.[27,28]

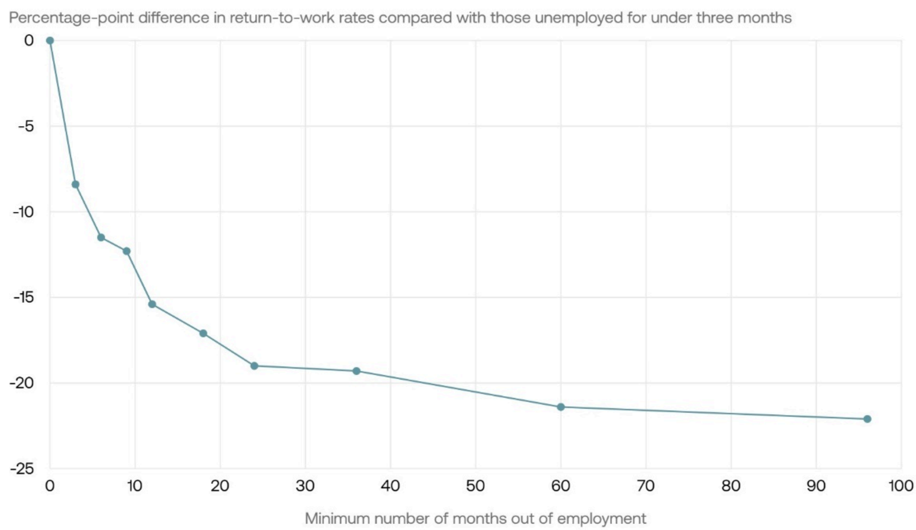
Studies show that routine, structure and social connection – qualities that often can be found through work – are protective against many common mental-health conditions including anxiety, depression and social isolation. In fact, moving from unemployment into paid work has been found to reduce the risk of mental-health problems by around 30 per cent, a level of improvement comparable to many established clinical treatments.[29]

The same is also true for many physical conditions.[30] Sustained inactivity is associated with poorer cardiovascular health, higher rates of chronic illness and slower recovery, while appropriate work – particularly when combined with support and reasonable adjustments – is linked to improved mobility, better long-term health outcomes and greater independence.

By contrast, prolonged worklessness has well-documented negative effects. Extended detachment from the labour market is associated with worsening mental health, increased risk of chronic disease and sharply declining chances of re-entry into work. As Figure 4 illustrates, the probability of returning to employment falls steeply the longer someone remains out of work, with the sharpest drop occurring early on. Each additional month compounds the risk of long-term dependency, making early intervention critical.

FIGURE 4

The likelihood of labour market re-engagement worsens with time out of work



Source: Office for National Statistics, first published in *Data Decoded: Charting the Trends and Costs of Declining Mental Health in the UK*

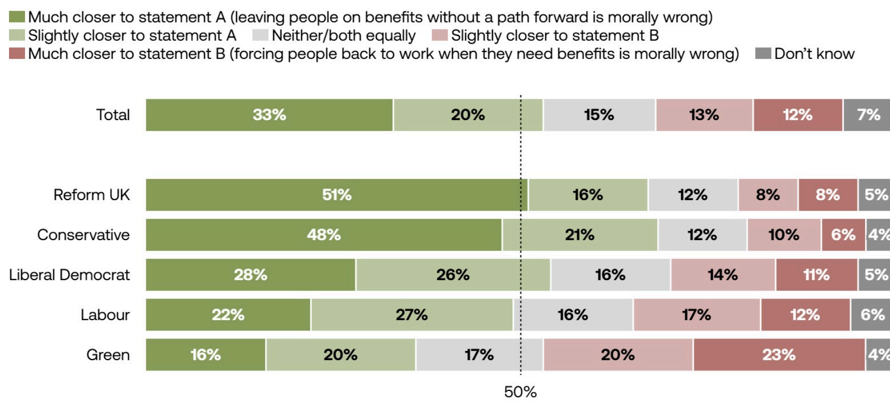
Our polling shows that public opinion is in line with the evidence. There is widespread recognition, for instance, that a system perceived to be open to misuse will struggle to sustain long-term public consent. Similarly, many adults in Great Britain believe that leaving people on financial benefits without a defined path forward is not just inefficient, it is morally wrong.

When asked to weigh two competing statements of principle (statement A, that leaving people on financial benefits without a clear path forward is morally wrong, versus statement B, that forcing people back into work when they need financial benefits is morally wrong), the balance of opinion is clear. A majority of 57 per cent align more closely with the first position. Just 22 per cent align more closely with the second.

The public instinct, in other words, leans towards progression rather than permanent dependency. Figure 5 shows how this view breaks down across different voter groups.

FIGURE 5

A majority of the public prioritise a clear path off benefits rather than permanent dependency



Q: Thinking of the following statements, does your view come closer to statement A or statement B?
Statement A: Leaving people on financial benefits without a clear path forward is morally wrong.
Statement B: Forcing people back into work when they need financial benefits is morally wrong.

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

03

A System Not Fit for Purpose

Such a high and growing benefits bill, coupled with 4 million people signed off work with ill health, points to a welfare system no longer fit for purpose. At its inception, the welfare state was designed to support people with mainly physical disabilities, unable to work in mainly physical jobs.[31] In the decades since, both the world of work and illness have changed. Jobs are far less dependent on either physical strength or presence, and mental health has become the dominant category of presenting illness.

This creates a challenge for the modern welfare state. Whereas physical conditions are often observable, permanent and relatively rare, mental-health conditions are more often fluctuating, subjective and common. The result is a system perceived as open-ended, vulnerable to misuse, and insufficiently focused on recovery and pathways into rewarding work – one that entrenches welfare dependency, even where conditions are treatable or manageable.

In the longer term, there must be a wholesale review of the welfare system to address these trends. That will take work, time and likely a substantial amount of primary legislation to enact. In the short term, however, the UK cannot afford to wait. This paper focuses therefore on what the government can do now – within this current parliament – through only secondary legislation and the issuance of guidance.

Here, we consider the ways in which the current system is failing those with ill health before looking at what could be done to address these issues. Broadly, these fall into three main categories:

1. Misaligned incentives for claimants
2. A failure to consider non-work-limiting conditions
3. Structural weaknesses across the system

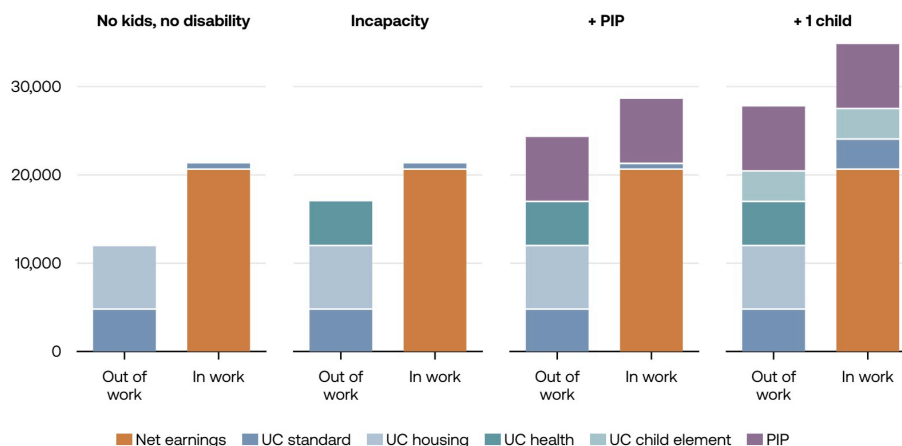
Misaligned Incentives for Claimants

Universal Credit was designed around the principle that work should always pay more than welfare. In practice, however, the combination of additional health-related support and disability benefits can narrow the financial gains from moving into work.

The inclusion of incapacity and disability benefits alongside standard Universal Credit, for example, can substantially increase the income available to those out of work. While on paper claimants remain financially better off in work, the difference is often modest, particularly for people entering lower-paid roles. This may help to explain some of the recent growth in claimant numbers, especially for young people who are more likely to start out in jobs paying closer to the minimum wage. The government has begun to address this disparity in the level of UC support, a welcome shift. But narrowing the payment gap alone does not remove the wider risks and structural disincentives attached to work.

FIGURE 6

The financial gains from work narrow when incapacity and disability benefits are included



Source: TBI calculations

While incapacity benefit claimants are permitted to work, doing so is widely perceived as risky. Survey evidence shows that almost three-quarters of recipients of incapacity benefits report fear of losing benefits as a significant or very significant barrier to work.[32] In a system where attempting work carries a high risk of losing benefits, even claimants who want to enter work may rationally choose not to.

This is because in the UK, incapacity is primarily met with a cash transfer. There is limited structured assistance to manage phased returns to work, coordinate with employers or adapt roles to fluctuating conditions. By contrast, systems such as those found in the Netherlands or Denmark feature income support that is more tightly integrated with active case management and employer engagement.[33] That approach is built around recovery and work retention; Britain's is largely built around maintenance.

The system's incentives tilt away from work. Modest financial gains, the perceived risk of losing benefits and limited support for returning to work all contribute to this. When someone moves into employment, there is a perception that their benefits may be withdrawn entirely, creating a cliff edge rather than a supported transition. Employment may be permitted, but it is not systematically rewarded, protected or promoted.

Over time, this has fundamentally reshaped the underlying assumption in the system. The category of people implicitly treated as unable to work has widened. In seeking to protect those with the most severe conditions, the system has extended that presumption too broadly. The result is not just higher caseloads, but a framework in which work is no longer clearly the expected outcome.

A Failure to Consider Non-Work-Limiting Conditions

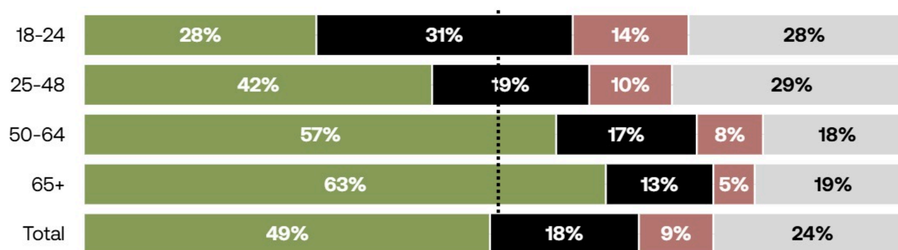
Health-related unemployment benefits were designed to support people whose conditions prevent them from working. Over time, the boundary between those who cannot work and those who could, with support, remain in or return to work has blurred. Common, fluctuating and often treatable conditions are increasingly channelled into long-term support.

Public attitudes reflect concern: nearly half of respondents believe too many conditions are currently viewed as "work-limiting", compared with fewer than one in ten who think too few are.

FIGURE 7

Close to half of respondents believe that too many conditions today are classed as "work-limiting"

Too many conditions are now being viewed as "work-limiting"
About the right range of conditions are classed as "work-limiting"
Too few conditions are classed as "work-limiting"
Don't know



Q: For the following question, by "work-limiting" we mean a condition that usually prevents someone from being able to work at all, even with adjustments or support. Thinking about health-related welfare benefits overall, which of the following, if any, comes closest to your view?
Too many conditions are now being viewed as "work-limiting".
About the right range of conditions are classed as "work-limiting".
Too few conditions are classed as "work-limiting".
Don't know.

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

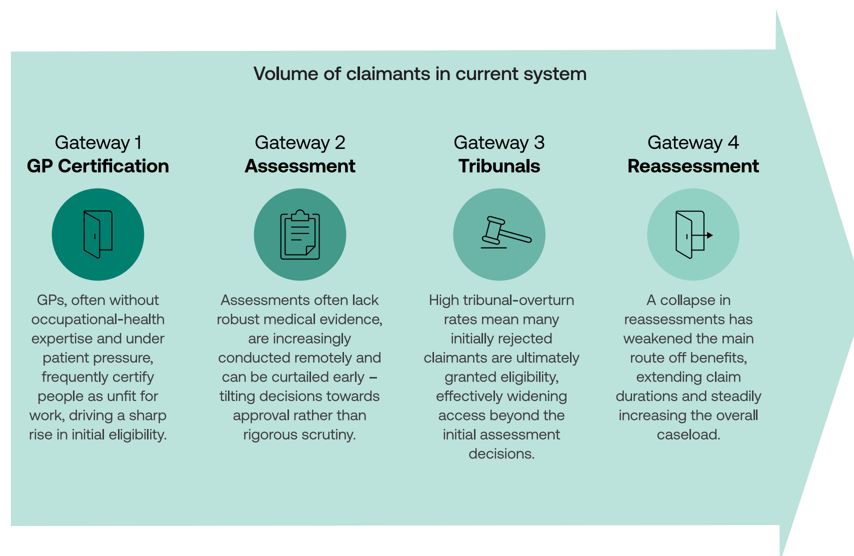
Illness does not automatically mean incapacity. For many common mental-health and musculoskeletal conditions, there is substantial evidence that good, supported work is compatible with recovery and may improve long-term outcomes. The system must reflect this reality.

Structural Weaknesses Across the System

There are structural weaknesses across the four key gateways in the system: GP certification, assessment, tribunal and reassessment. Taken together, these weaknesses are wearing away the system's gateways, widening the path onto benefits.

FIGURE 8

The system has structural weaknesses at each of its four key gateways



Source: TBI

AT GATEWAY 1: GP CERTIFICATION

In order to claim incapacity benefit, claimants must have a Fit Note. This note provides the DWP with evidence that the claimant has a medical condition and that the doctor (usually a GP) considers the claimant unable to work normally as a result. In theory, the note allows doctors to specify whether they consider the claimant wholly unable to work, or whether the individual could work with adjustments. In reality, 93 per cent of notes are currently designated "not fit for work", with no adjustments suggested.[34]

There are well-recognised issues with the Fit Note process. GPs have no formal training in occupational health (necessary to determine an individual's fitness to work) and often lack critical information from the employer about the claimant's current work duties (if the person is in work). In addition to this, GPs often report feeling pressured into signing Fit Notes because they

are advocates for patients and do not feel in a place to challenge personal accounts of illness or function.[35,36] As a result, the number of Fit Notes issued annually has more than doubled since 2015.[37]

Even more strikingly, for PIP there is effectively no first gateway. There is no requirement for a formal diagnosis, and eligibility is determined primarily through functional assessment rather than medical certification.

AT GATEWAY 2: ASSESSMENT

Claimants of both incapacity and disability benefits must undergo an assessment to determine their eligibility. These assessments are a combination of medical evidence, written submissions from the applicant and the impressions of the assessor (taken during either an in-person or online interview). The purpose is to provide a structured and consistent test of eligibility and to assess function rather than looking simply at conditions. Those with less function are entitled to higher rates of benefit.

However, there are also well-recognised issues with the DWP assessment process. For instance, claimants are not required to provide medical evidence as part of the assessment, meaning around 20 per cent of Work Capability Assessments (WCAs, the assessment for UC health) and around a third of PIP assessments are completed without any external clinical input.[38] GPs are not obligated to provide reports, and the modest fee associated if they do offer the service – around £40 per report – offers little incentive for them to do so.[39]

Another problem lies in the growing use of a practice known as curtailment – a process by which an assessor can end an assessment early once full benefit eligibility is established. The effect is to reward assessors for speed over rigour, a point that is frequently referenced by so-called sickfluencers who create online content advising claimants on how best to maximise chances of a successful claim.

A switch to predominantly online assessments may also have had an effect on the rigour of the assessment process. During the pandemic, most assessments were shifted rapidly to remote consultations, and in-person

assessments have not returned to pre-pandemic levels. Since then, it is worth noting that approval rates have risen, dropout rates (the share of claims withdrawn before reaching a decision) have fallen and a greater proportion of applicants have successfully moved through to entitlement.[40]

Recent changes to guidance suggest the government has recognised this, with a target set for face-to-face assessments of 30 per cent for both PIP and the WCA – up from lows of 6 per cent for PIP in 2024 and 13 per cent for the WCA[41] – though the impact of these proposed changes is yet to be demonstrated.

AT GATEWAY 3: TRIBUNALS

Claimants who are unsuccessful in their original claim can appeal and will have their case considered by a tribunal. However, the evidence indicates that tribunals overturn a substantial share of decisions. Around 70 per cent of PIP appeals heard are decided in the claimant's favour; incapacity benefit appeals relating to Employment and Support Allowance (ESA) and UC health are similarly high, with roughly half or more of decisions revised at tribunal.[42,43] This persistent gap between assessment and tribunal outcome suggests the same judgement criteria are not being applied across the board. Whether because evidentiary thresholds shift or oral testimony carries greater weight, the message is evident: the credibility of the assessment gateway is fragile. When first decisions are routinely reversed, confidence in the entire assessment system is undermined.

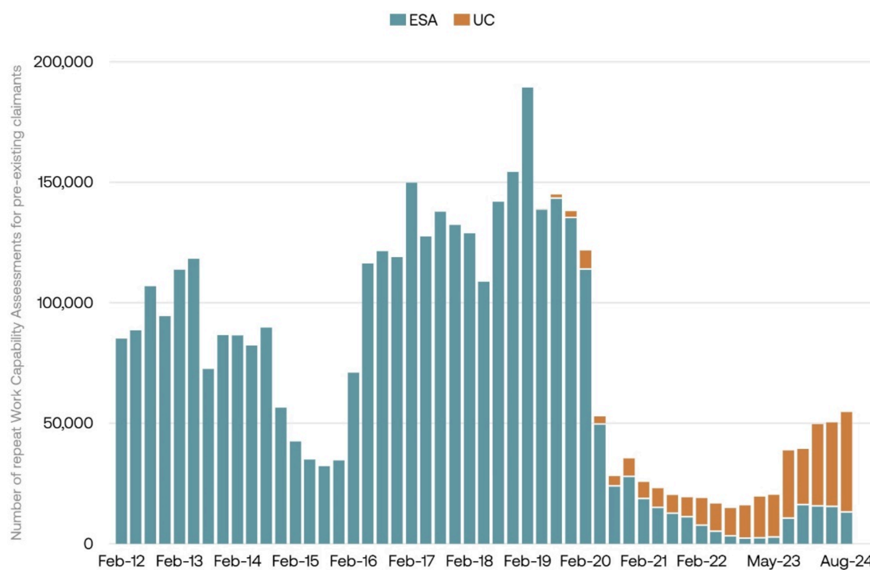
AT GATEWAY 4: REASSESSMENT

Reassessment is the main formal mechanism for removing eligibility for health and disability benefits. It is not the only off-ramp – other reasons for leaving include moving into work voluntarily, transferring to another benefit, stopping claiming (for example, because of non-compliance, administrative reasons or personal choice) and death – but is the main means by which government can address the stock of claimants.

In recent years, however, the number of people exiting health and disability benefits as a result of reassessment has fallen. Prior to the pandemic, reassessments accounted for around a third of all exits from incapacity benefits. But, as Figure 9 demonstrates, by 2023, reassessments had fallen by around 80 per cent.[44] This collapse has extended durations on benefits and accelerated the growth of the overall caseload.

FIGURE 9

Covid-era changes led to a sustained reduction in reassessments of incapacity benefit claimants



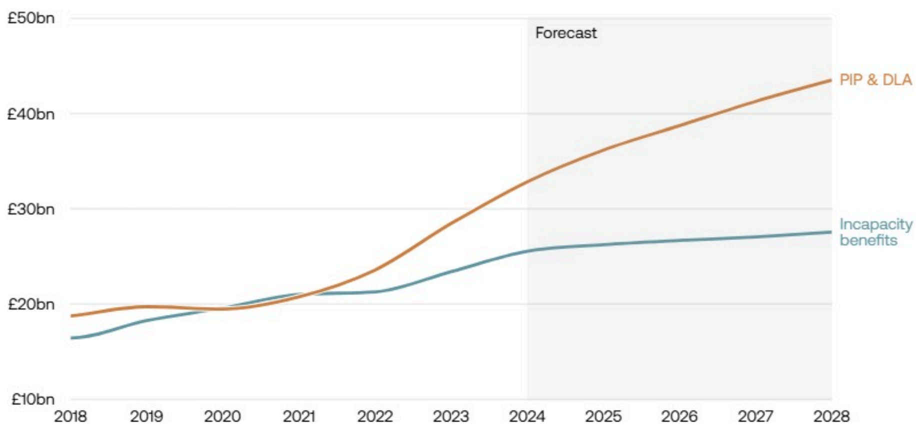
Source: DWP Stat-Xplore

The government has pledged to increase the rate of WCA reassessments, but it will take time and money. To fund this, it is lengthening PIP reassessment intervals for most claimants aged 25 and over to a minimum of three years for new claims, extending to five years at subsequent review if

eligibility persists.[45] Yet Office for Budget Responsibility (OBR) forecasts make clear that PIP is a principal driver of welfare spending growth, making it difficult to justify easing scrutiny in this area.

FIGURE 10

Spending on incapacity and disability benefits has risen sharply in the past six years – and the increase is expected to continue



Source: TBI analysis of OBR Welfare Trends Report and OBR Welfare spending: disability benefits data, first published in *Data Decoded: Charting the Trends and Costs of Declining Mental Health*. Note: Orange line shows Personal Independence Payment (PIP) and Disability Living Allowance (DLA) spending over time

04

The Public Has Lost Trust in the System

The debate around welfare reform in Westminster is often framed as a binary choice between compassion and cuts. But our polling suggests the public view the issue in more nuanced terms. Voters are not hostile to welfare itself. They are concerned that the system no longer draws clear and credible boundaries between those who cannot work and those who could, with the right support, remain engaged in or return to employment.

We worked with YouGov to conduct two polls to measure views on the welfare debate across Britain: an exploratory questionnaire to understand attitudes across the different dimensions of affordability, fairness and flexibility, followed by an MRP (multilevel regression and post-stratification) that mapped attitudes across every parliamentary constituency in England, Scotland and Wales.

This approach allowed us, for the first time, to examine views on welfare reform at a constituency-by-constituency level, explore the attitudes of those currently grappling with the system and analyse how these views interact with party politics – including analysis of the Labour Party's 2024 electoral coalition, with a large enough sample to look at voters who have moved from Labour both to the right (Reform UK and Conservative) and to other progressive parties (such as the Greens and the Liberal Democrats) since July 2024.

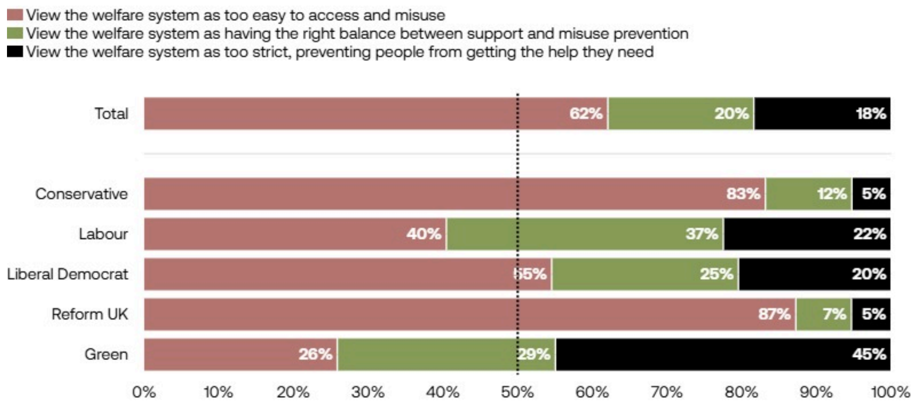
The findings challenge some assumptions, but they also reveal something deeper: a system that has lost legitimacy across much of the electorate, and a significant political opening for welfare reform grounded in fairness, contribution and progression off benefits and into work.

The Public Thinks the Current System Is Unaffordable and Unsustainable

Voters across the political spectrum believe the current welfare system is failing. Excluding those who say they don't know, the majority – 62 per cent – say the system is too easy to access and prone to misuse. Current Labour supporters (again, excluding those who say they don't know) are nearly twice as likely to say the system is too easy to access than they are to say it is too strict.

FIGURE 11

Perceptions of the welfare system differ by party, but a majority say it is too easy to access



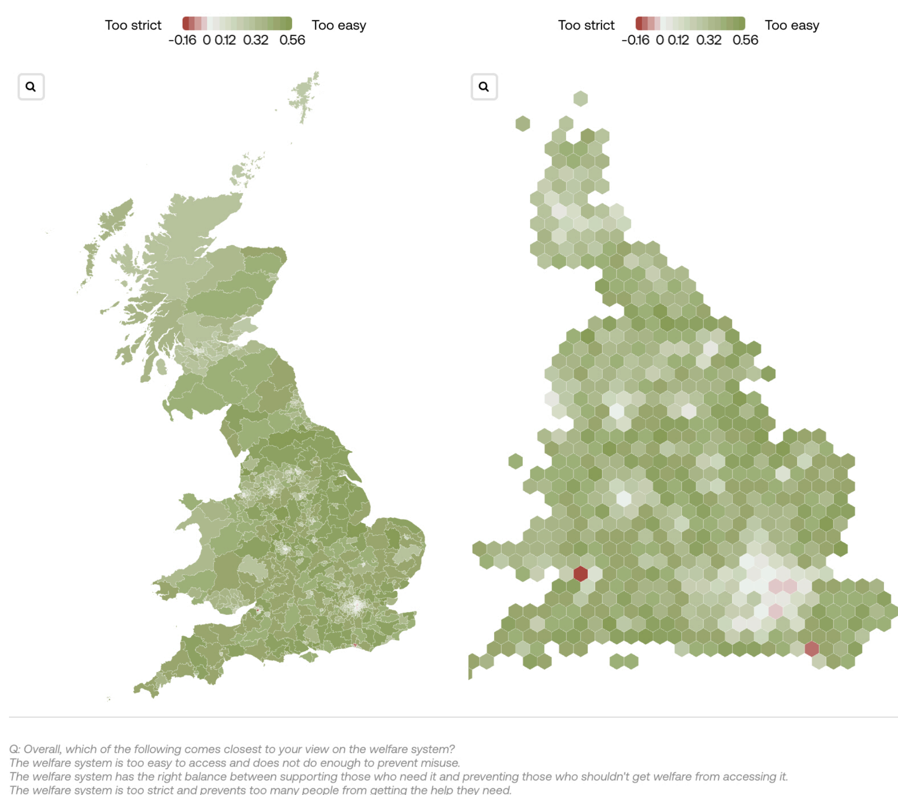
Q: Overall, which of the following comes closest to your view on the welfare system?
The welfare system is too easy to access and does not do enough to prevent misuse.
The welfare system has the right balance between supporting those who need it and preventing those who shouldn't get welfare from accessing it.
The welfare system is too strict and prevents too many people from getting the help they need.
Note: "Don't know" responses have been excluded from this graph.

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

Mapped geographically, this creates a striking picture. In only five of the 632 constituencies in Great Britain do more voters say the system is “too strict” than say it is “too easy to access”. The interactive map presented in Figure 12 shows how attitudes towards the principle of welfare reform break down across every constituency in England, Scotland and Wales.

FIGURE 12

Across many constituencies in Great Britain, voters are more likely to view the welfare system as “too easy to access” than “too strict”



Source: YouGov for TBI, Office for National Statistics (England & Wales boundaries), Boundary Commission for Scotland, Open Innovations

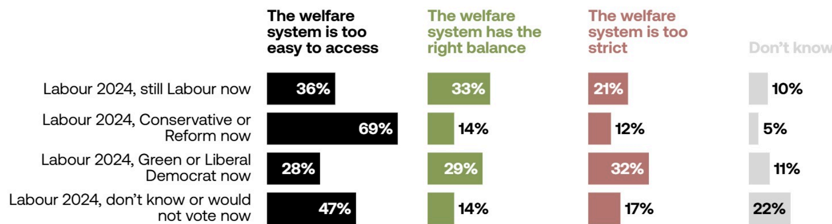
Looking beyond this broad but varied consensus – with most constituencies showing majorities that think reform is overdue – there are some clear geographical patterns. In many rural and southern constituencies, around 60 per cent believe it is too easy to claim welfare. In many inner-city seats – particularly inner London, major cities and parts of Scotland – that figure falls towards 30 to 45 per cent, and the share saying it is too strict rises to around a quarter or more.

Analysing these findings through the lens of Labour's 2024 electoral coalition reveals an emerging tension. Among those who still say they will vote Labour, and among those the party has since "lost" to other parties, attitudes are split between seeing the system as too easy to access, about right or too strict. There is no settled pro-status-quo majority within this group.

The picture looks markedly different among those who voted Labour in 2024 but now say they would back Reform UK or the Conservatives. According to the nationally and politically representative sample of 12,068 adults collected as part of the MRP process, 69 per cent of this group believe the system is too easy to access and too prone to misuse. The often-overlooked group of voters who supported Labour in 2024 but now say they would not vote or do not know who they would back are also more likely to describe the system as too permissive than too strict. By contrast, those who have shifted from Labour to the Greens or the Liberal Democrats are more evenly split, though slightly more likely to see the system as too strict than too easy to access.

FIGURE 13

Views among Labour's 2024 voters on whether welfare is too easy to access versus too strict diverge by current vote intention



Q: Overall, which of the following comes closest to your view on the welfare system?
The welfare system is too easy to access and does not do enough to prevent misuse.
The welfare system has the right balance between supporting those who need it and preventing those who shouldn't get welfare from accessing it.
The welfare system is too strict and prevents too many people from getting the help they need.

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

The pattern is one of geographically and politically widespread concern over welfare's permissiveness. This is not confined to traditionally Conservative areas and is visible across much of the electoral map.

The Public Supports the Moral Case for Reform and Thinks the Current System Is Unfair

At the heart of the case for reforming welfare are two moral considerations. The first is whether the system risks trapping people in long-term dependency, leaving them without a clear route back into work or independence. The second is whether it retains public legitimacy as a safety net, commanding confidence that support is directed fairly, responsibly and to those who genuinely need it.

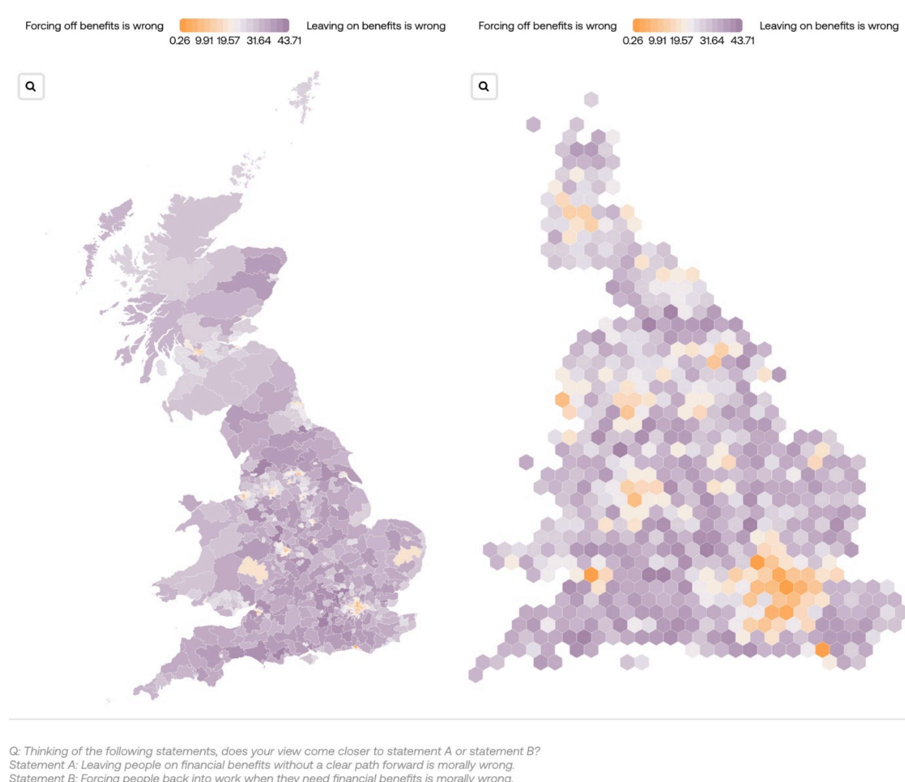
As set out earlier, many British people view long-term dependency without progression as problematic. To test this directly, we asked respondents to weigh two competing statements of principle: that leaving people on

financial benefits without a clear path forward is morally wrong (statement A), or that forcing people back into work when they need support is morally wrong (statement B). The balance of opinion is decisive. A majority of 57 per cent align with statement A, compared with 22 per cent with the latter; the remainder select neither option or are unsure. The public instinct therefore leans towards progression and recovery rather than permanent dependency.

The constituencies with the highest proportions aligning with statement A are concentrated mainly in the South East, including North East Hampshire, Mid Dorset and North Poole, Wokingham, Godalming and Ash, Mid Buckinghamshire and Beaconsfield. Many of these areas are affluent, Remain-voting southern seats that the Liberal Democrats won at the 2024 election. The moral case against long-term dependency, in other words, is not confined to traditionally Conservative or "left behind" areas. It is particularly strong in parts of the country often seen as socially liberal but fiscally cautious – underscoring the breadth of support for reform framed around progression and responsibility.

FIGURE 14

Views on welfare and work vary geographically, with many areas leaning towards seeing it as wrong to leave people on financial benefits without a clear path back into work or independence



Q: Thinking of the following statements, does your view come closer to statement A or statement B?
Statement A: Leaving people on financial benefits without a clear path forward is morally wrong.
Statement B: Forcing people back into work when they need financial benefits is morally wrong.

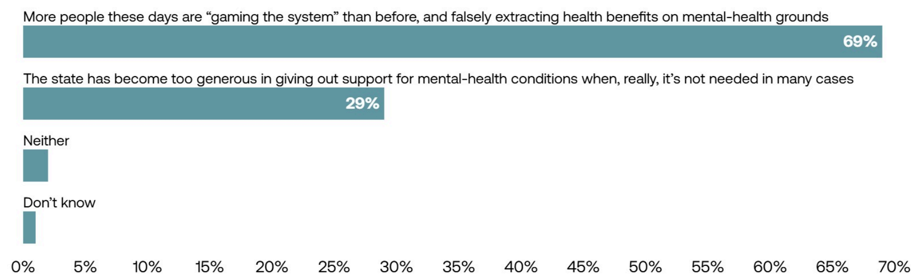
Source: YouGov for TBI, Office for National Statistics (England & Wales boundaries), Boundary Commission for Scotland

Voters also express deep concern about fairness. The idea that some people are “taking advantage of the system” remains a major driver of scepticism, particularly among 2024 Conservative voters, Reform UK voters,

older respondents, and lower-middle and working-class respondents. For these groups, the issue is not simply the level of spending, but whether the system draws credible boundaries around eligibility.

FIGURE 15

Among respondents who believe support is increasingly going to people falsely claiming mental-health benefits, most attribute this to more people "gaming the system"



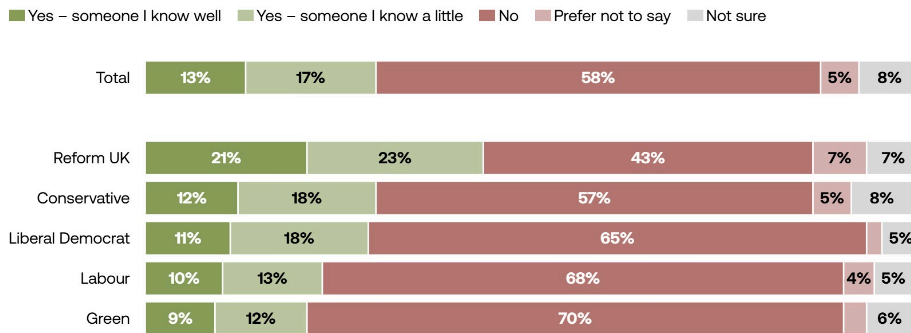
Q: You previously told us you believe that there has been a rise in support falsely going to people claiming welfare benefits on mental-health grounds in recent years. Which of the following reasons, if either, do you think best explains why?

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

These perceptions are often reinforced by lived experience: around a third of respondents say they personally know someone they believe is receiving health-related welfare benefits that, in the respondent's view, are not genuinely needed.

FIGURE 16

When asked if they know someone they believe is receiving health-related benefits that aren't necessary, nearly a third of respondents said yes



Q: Do you personally know anyone who you believe is receiving health-related welfare benefits, but you think does not genuinely need them?

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

What these findings reveal is not blanket hostility to welfare, but a sense that its rules are insufficiently clear and its safeguards insufficiently robust – a legitimacy problem rooted as much in perception as in policy. Voters are not rejecting the principle of a safety net; they are questioning whether it is administered in a way that feels firm, fair and oriented towards recovery and contribution.

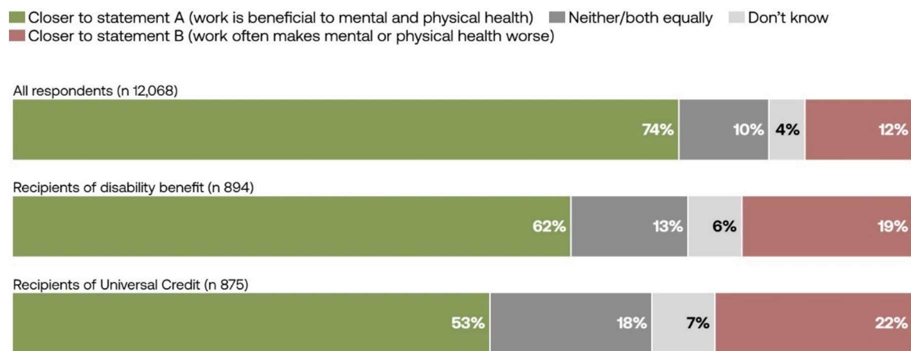
Greater Flexibility and New Pathways of Support Could Rebuild Faith in the System

The question then is not whether reform is needed, but what kind of reform could command broad and lasting support. A crucial element of this is what principles would form the foundation of a system that could be seen as legitimate both by taxpayers and by welfare claimants.

To understand this, we asked a further question in our large MRP sample: whether respondents sat closer to the belief that being in work is beneficial for most people's mental and physical health, or whether being in work often makes people's mental or physical health worse.

FIGURE 17

A majority of respondents – including benefit recipients – believe that work is beneficial to mental and physical health



Thinking of the following statements, does your view come closer to statement A or statement B?
Statement A: In general, being in work is beneficial for most people's mental and physical health.
Statement B: In general, being in work often makes people's mental or physical health worse.

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

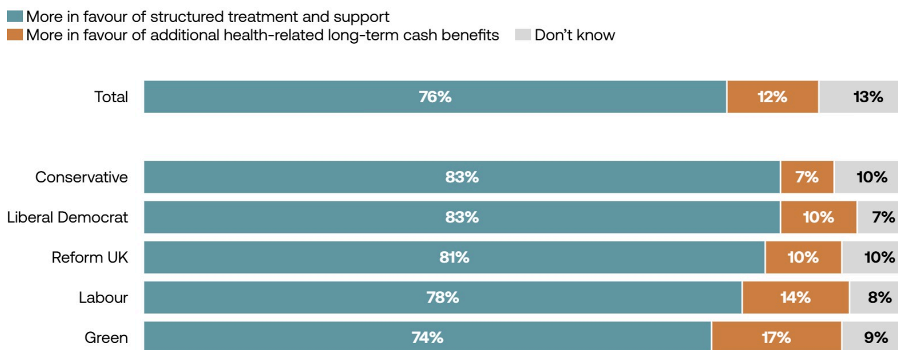
A substantial majority align more closely with the view that work is, in general, beneficial. This principle holds across much of the electorate, including among many people who are themselves receiving benefits.

Support for this underlying principle was reinforced when respondents were asked about practical policy choices. When presented with a choice between expanding structured mental-health treatment and personalised support versus providing additional long-term cash benefits for those out of work with anxiety or depression, the public consistently favours the former.

They express a preference for systems that help people recover, build confidence and return to employment where possible, rather than systems that default to long-term benefit reliance.

FIGURE 18

Across the political spectrum, respondents overwhelmingly favour a government focus on structured treatment and support for those out of work with anxiety or depression



Q: Below are statements regarding what sort of approach the government should take to support people with mental-health conditions like anxiety and depression who are currently out of work. Which of them, if either, comes closest to your own view?
The government should focus on providing structured treatment and support until they are ready to rejoin the workforce.
The government should focus on providing additional health-related long-term cash benefits while they get better and are ready to rejoin the workforce.

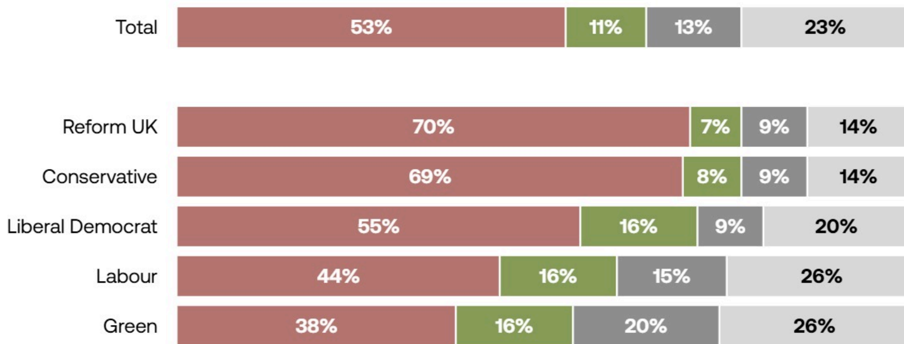
Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

These concerns extend to the system's impact on younger people. Around half of respondents believe the current welfare system pushes young people with mental-health problems out of work or education, rather than helping them remain engaged or return. The worry is not simply about cost, but about long-term detachment from work at the start of adult life and the consequences that may follow.

FIGURE 19

A majority of respondents think that, in its current state, the welfare system makes it more likely that young people with mental-health problems leave work or education altogether

Believe the system makes it more likely that young people with mental-health problems leave work or education altogether
Believe the system supports young people with mental-health problems to stay in, or return to, work or education
Neither of these
Don't know



Q: Which, if any, of the following statements comes closest to your view? The welfare system as it is generally ...
Makes it more likely that young people with mental-health problems leave work or education altogether.
Supports young people with mental-health problems to stay in, or return to, work or education.
Neither of these.
Don't know.

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

The belief that work supports mental health is shared by the wider public and by many welfare claimants themselves. Across much of the electorate, there is recognition that employment, where possible, provides structure, purpose and social connection. A system that strengthens pathways back to work, while flexibly assessing and managing different conditions, could therefore command broad support.

05

The Emergency Handbrake: Immediate Steps Towards Welfare Reform

In the longer term, a fulsome review of welfare is required to take account of the seismic shifts occurring in both the world of work and the country's health. In the shorter term, however, fairness and rigour must be restored to the current system. To do this, we propose three core reforms as part of an emergency handbrake on spending:

1. **Define what constitutes a non-work-limiting condition**, grounding eligibility for health and disability benefits more firmly in demonstrable severity and sustained functional incapacity.
2. **Apply this definition consistently at every decision point** in the benefits application process, from GP certification through assessment, tribunal and reassessment.
3. **Provide targeted health and employment support for those no longer eligible for long-term incapacity benefits**, ensuring the emphasis is on strengthening pathways to recovery and work rather than simply withdrawing assistance.

These measures would moderate the growth of health-related welfare spending while improving the targeting of support – ensuring that long-term benefits are reserved for those who genuinely need them, and that others are better supported to recover, rebuild and return to work.

1. Define What Constitutes a Non-Work-Limiting Condition

In the first instance, government should more clearly define what constitutes a non-work-limiting condition. This should be based on the most up-to-date evidence about individual conditions and whether the evidence shows that, for most people with these conditions, work is beneficial. This would

support assessors at each point in the benefits application process – application, assessment, appeal and reassessment – to decide whether a claimant with that condition is or isn't eligible for benefits.

Government should start with conditions where the evidence is strongest but where objective assessment is hardest. People with conditions such as depression, anxiety and some musculoskeletal problems show clear benefits from being in work, but these conditions are often difficult to assess. This is because assessors often need to rely on self-reporting of symptoms, or because what might be in the best interests of the claimant in the long term (such as being in work) may not look like it at the time of assessment. This is where objective evidence is most needed and where evidence of what is "typical" for people with those conditions will help.

As a result of this reform, government would have a list of conditions that it considers typically non-work-limiting and not requiring additional cash support through PIP. For each of the conditions, a level of function would be described, compatible with work, that a person with a typical presentation of that condition might be expected to have. That Standard Functional Profile would also have a corresponding level of need, not requiring additional cash benefits, that a person with a typical presentation of that condition might be expected to have. Those with an atypical presentation or comorbidities could still qualify for benefits but they would have to provide additional evidence from a medical professional to qualify.

The Role of Good Work in Health and Recovery

Across a large and consistent evidence base, being in suitable work is associated with better physical and mental-health outcomes than prolonged worklessness for many people of working age. The World Health Organization is clear that decent work supports good mental health and can contribute to recovery for people with mental-health conditions.[46] This applies not only to the general population but also to many people with common health conditions, particularly where work is safe, stable and appropriately adjusted.

The case is strongest for common mental-health conditions such as depression and anxiety. Consistent evidence shows that unemployment is associated with higher risks of psychological distress, while re-employment is associated with improvements in mental health.[47] Researchers and policymakers increasingly recognise employment not only as a meaningful outcome, but also as a critical component of recovery for people with serious mental-health conditions, including bipolar disorder and depression.[48]

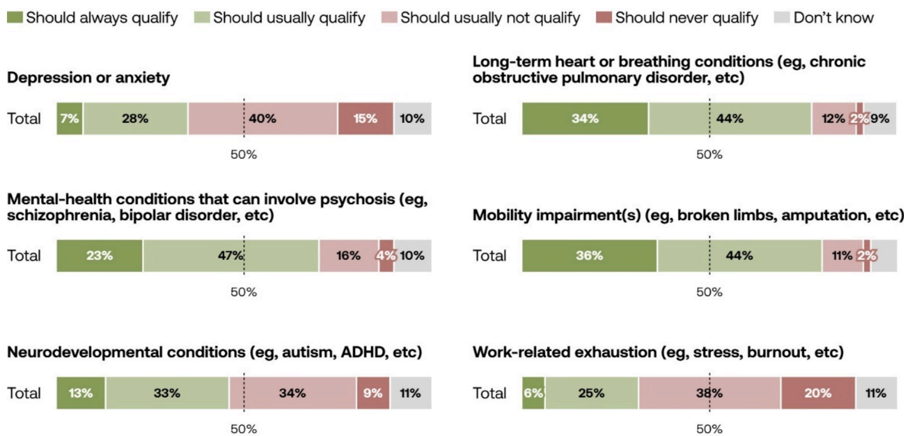
A similar pattern is seen for many musculoskeletal and chronic-pain conditions. Evidence suggests that remaining in, or returning to, appropriate work is generally associated with better outcomes than long-term absence, particularly where adjustments are made to reduce physical strain and support recovery.[49]

Taken together, the evidence supports a clear conclusion: a number of common, often fluctuating conditions – including depression, anxiety and many forms of chronic pain – are frequently compatible with work.

Our polling suggests this would more accurately reflect where the public are on this issue. A majority of respondents say those with severe and clearly defined incapacity (such as mobility impairments or long-term heart or breathing conditions) should qualify for cash benefits, but the view that conditions should qualify for cash benefits weakens substantially for conditions perceived as treatable, fluctuating or compatible with work.

FIGURE 20

Public views reflect a clear distinction between conditions that should and should not qualify for cash benefits



Q: Thinking about health conditions that last three months or more, to what extent do you think people with the following should qualify for cash benefits?
Should always qualify for cash benefits.
Should usually qualify for cash benefits, with some exceptions.
Should usually not qualify for cash benefits, with some exceptions.
Should never qualify for cash benefits.
Don't know.

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

A welfare system is only as strong as the public support behind it: if confidence erodes, the social contract weakens. Creating a category of non-work-limiting conditions and applying this to incapacity and disability benefits aligns the system with public sentiment and protects support for those with severe and enduring conditions.

INCAPACITY BENEFITS: A STANDARD FUNCTIONAL PROFILE

UC health is an additional benefit, over and above standard Universal Credit, for those unable to work due to long-term illness. Eligibility is based on an individual's ability to function – not their diagnosis – and is assessed against criteria set out in Schedule 6 of the Universal Credit Regulations 2013.[50] This includes descriptors of both physical and mental function that are critical to work, and claimants are scored on their ability to perform those functions, with higher levels of incapacity attracting a higher number of points (and therefore cash benefits).

Currently, assessment for incapacity benefits is based on self-reported symptoms, evidence and interview. However, for some conditions, where there is no validated test for diagnosis or where symptoms are self-reported, it can be difficult for assessors to determine objectively if a person's condition genuinely limits their function and ability to work or not. For others' conditions, it can be difficult for assessors to decide in the long-term interest of the claimant (in other words, that returning to or remaining in work would be beneficial) when the experience of the claimant in front of them presents as so painful or distressing in the short term.

To help assessors with these decisions, we suggest the use of Standard Functional Profiles for common conditions that are typically non-work-limiting. Standard Functional Profiles would be based on the most up-to-date evidence, setting out the level of function expected for a typical presentation of that condition. Where the evidence supports it, that level of function would be also considered compatible with work.

For the purposes of assessment, claimants with that condition would be legally presumed to possess the typical, uncomplicated presentation and score zero points for it in their WCA assessment – unless they could provide evidence to the contrary or had another diagnosed condition that could explain their functional impairment. This is what's known as a rebuttable presumption: those able to prove they have an atypical presentation would be able to overturn the presumption at assessment or challenge it at appeal. This would ensure the system remains responsive to individual circumstances.

We suggest the initial focus is on conditions that have driven the recent growth in incapacity claims, where the evidence base for work compatibility is strongest and where it is most difficult to objectively determine function. This could include:

- Mild to moderate depression and anxiety disorders
- Stress-related and adjustment disorders
- Attention deficit hyperactivity disorder (ADHD) and related neurodevelopmental conditions where evidence supports work compatibility
- Non-specific low back pain and common musculoskeletal conditions

To ensure credibility, the Standard Functional Profiles should be developed by the DWP with formal input from an independent Work and Health Evidence Panel comprising occupational-health specialists, psychiatrists with expertise in common mental disorders, musculoskeletal experts, labour-market economists and senior DWP representation. The panel should publish transparent evidence reviews and be subject to periodic oversight.

We believe such changes could be made using secondary legislation only. The power to introduce presumptions of work capability is explicitly granted to the secretary of state under section 37(6) of the Welfare Reform Act 2012,[51] the primary legislation governing work conditionality for Universal Credit. In fact, the Universal Credit Regulations already create such presumptions for certain conditions; regulation 39(6), for instance, creates an irrebuttable presumption that someone *has* limited capability for work, for example when they are receiving treatment for cancer.

DISABILITY BENEFITS: A STANDARD NEEDS PROFILE

PIP is a cash benefit to cover the additional costs associated with disability. Although it is not an “out-of-work benefit”, that doesn’t mean it has no impact on a claimant’s incentive to work. As illustrated earlier in this paper, in

Figure 6, receipt of PIP reduces the financial benefit of being in work compared to being out, weakening the incentive to move from unemployment into employment.

Like UC health, eligibility is based on an individual's ability to function – not their diagnosis – and is assessed against criteria set out in Schedule 1 of the Social Security (Personal Independence Payment) Regulations 2013. These criteria include descriptors of both physical and mental function critical to mobility and activities of daily living, with higher levels of disability attracting a higher number of points and therefore cash benefits.

Currently, claimants do not need a formal medical diagnosis to claim or receive PIP. Application requires only that a claimant state they have a functional impairment, that it has been present for at least the past three months and that they expect that functional impairment to last at least another nine months. A GP Fit Note is not required and while GP evidence can be requested, it is not mandated.

This can make it very difficult for assessors to objectively determine if a person's condition truly limits function or not, especially if that assessment is carried out virtually as opposed to in person. To help assessors make more accurate assessments of a claimant's function and therefore need, we suggest that medical evidence of both diagnosis and prognosis are mandated from a medical professional and that for some conditions (what we term "non-work-limiting conditions") assessors use a Standard Needs Profile to determine need, rather than self-reporting.

The same list of non-work-limiting conditions identified by DWP and detailed above would apply to the PIP process – so in addition to having an associated Standard Functional Profile, each condition on the list would also have a Standard Needs Profile, describing the level of need typically associated with that level of function. For the purposes of PIP assessment, claimants medically diagnosed with a condition would be legally presumed to possess the typical, uncomplicated presentation of it.

Critically, however, this presumption should also be rebuttable. Those able to prove they have an atypical presentation – for example through a secondary care note or formal occupational-health assessment – would be able to overturn the presumption at assessment or challenge it at appeal. This would ensure the system remains responsive to individual circumstances.

To ensure credibility, the Standard Needs Profiles should be developed by the DWP with formal input from an independent Work and Health Evidence Panel comprising occupational-health specialists, psychiatrists with expertise in common mental disorders, musculoskeletal experts, labour-market economists and senior DWP representation. The panel should publish transparent evidence reviews and be subject to periodic oversight.

We believe such changes could be made using secondary legislation only. The primary legislation governing PIP is the Welfare Reform Act 2012, but the power to assess a claimant's eligibility for PIP is delegated to the Social Security Regulations 2013 – secondary legislation. This is where Standard Needs Profiles could be described.

There is also a section in the primary legislation (Section 80 (4)(a)/b) that expressly permits regulations to require a claimant to provide information or evidence, and to dictate the way in which it is provided. This is where the mandating of medical evidence could be introduced.

Could the Emergency Handbrake Be Successfully Challenged Under Equalities Law?

TBI took independent legal advice from barristers on the proposals in this paper.

Their view is that the emergency handbrake is unlikely to be successfully challenged under equalities law as it is supported by a clear and robust evidence base.

As the proposed policy differentiates eligibility based on medical diagnosis, it would lead to different outcomes for claimants. However, the key test under human-rights discrimination law is whether the policy itself can be objectively justified – not whether it results in differential impacts.

In practice, equalities law permits such distinctions where they pursue a legitimate aim and are proportionate. It does not require support to be the same across conditions, but does require any differences in treatment to be properly justified.

The justification rests on setting out a clear rationale, supported by evidence. This includes the fiscal pressure from rising welfare expenditure, evidence that work can lead to better outcomes than long-term benefit receipt and research indicating that this is particularly true for some conditions. It would also draw on the greater subjectivity and diagnostic complexity associated with certain conditions.

Provided this is clearly articulated and embedded in the policy rationale and decision-making process, the risk of a successful challenge is low.

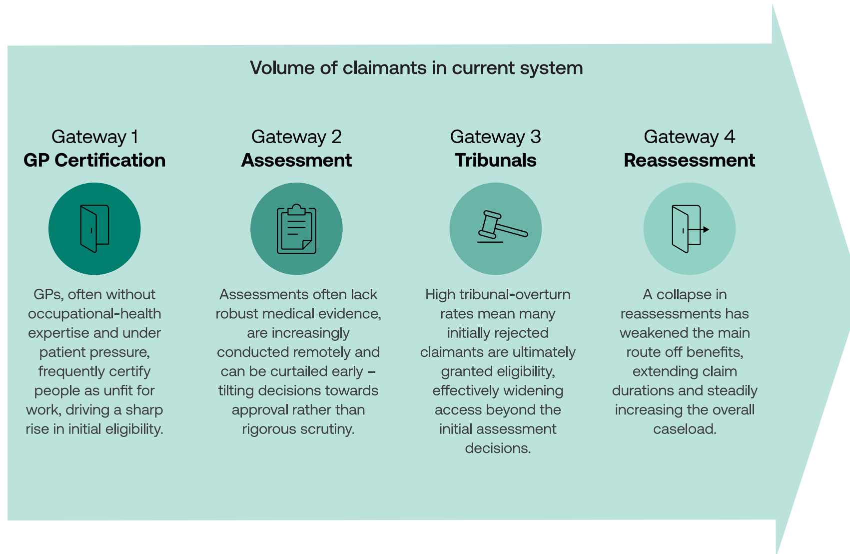
2. Apply This Consistently at Every Decision Point

Having more clearly defined non-work-limiting conditions, this should be applied consistently across the key gateways in the benefits process: GP certification, assessment, tribunal and reassessment.

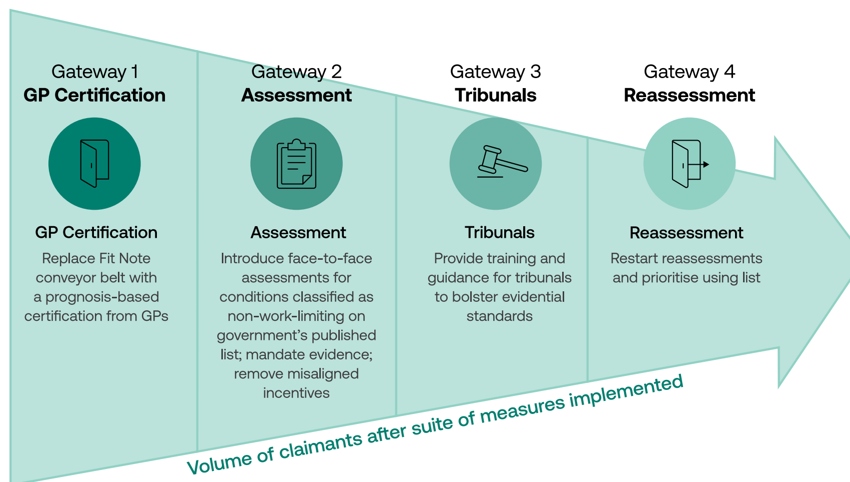
FIGURE 21

An emergency handbrake of welfare reforms would deliver a system-wide reset of how eligibility is interpreted and enforced

CURRENT WELFARE SYSTEM



PROPOSED WELFARE SYSTEM



Source: TBI

GATEWAY 1: GP CERTIFICATION

Currently, there are different processes involved in applying for UC health and PIP.

To apply for UC health, claimants must have a GP Fit Note, declaring they are medically unfit for work – but it is not necessary for the GP to specify the medical reason, whether the claimant has initiated treatment or how long the condition is expected to last for.

To apply for PIP, claimants are not required to provide any medical certification, but they do need to certify that they have a disability, that they have had it for three months and that they expect to have it for at least a further nine months.

We propose that the application process for both is standardised and aligned. In particular, the provision of medical evidence for application and assessment should be mandated, with a requirement that claimants provide certification from an NHS GP or consultant setting out:

- The claimant's medical diagnoses
- The severity of those conditions (in particular, if the claimant has a non-work-limiting condition, additional evidence would be required to demonstrate at assessment that their individual circumstances are exceptional)
- The treatments tried and currently used
- The length of time the claimant has had those conditions
- The expected prognosis for those conditions

For UC health, this shifts the application process from a dependence on subjective assessment of work capability to a clinical and objective certification of diagnosis and prognosis. It also applies a duration requirement that stops short-term, fluctuating illnesses escalating into long-term incapacity status.

For PIP, this process shifts the application process away from a dependence on self-reported symptoms to a more objective and evidence-based process.

This recommendation falls short of abolishing the GP Fit Note entirely, as a Fit Note is still required for people to present to their employer when they are in employment but unable to work due to ill health. The GP Fit Note would no longer be required to apply for incapacity.

Guidance should be issued by the Department of Health & Social Care, informed by a Work and Health Evidence Panel, clearly setting out the certification requirements, durability threshold, evidentiary indicators of sustained functional limitation, and the distinction between diagnosis and work capability. The obligation to provide structured clinical certification should be formalised within the GP contract and properly funded, replacing the current discretionary, low-value model.

Delivery should be supported through standardised digital forms embedded in primary-care systems, targeted training on applying the durability framework and clear escalation routes for complex cases. The intention is not to turn GPs into work-capability assessors. Their role remains clinical: confirming diagnosis, treatment and prognosis. The determination of work capability remains with the formal assessment process. But entry into long-term incapacity benefits should be grounded in structured, evidence-based clinical certification rather than informal or open-ended judgement.

GATEWAY 2: ASSESSMENT

The assessment process for incapacity benefits and disability benefits is different.

Incapacity Benefits

Eligibility for UC health is assessed at a WCA. This is a functional assessment designed to elicit the extent to which an individual's medical conditions affect their capacity to work. Assessors rely on a combination of

written evidence and claimant interviews to make this assessment, and claimants score points against a set of descriptors set out in secondary legislation. Claimants are then classified as either LCW or LCWRA:

- **Limited Capacity for Work (LCW):** Scores of up to 15 points classify claimants as LCW, which means they may not be able to work right now but they are able to job seek and are likely to be well enough to work soon. This does not typically qualify them for any money (unless their claim started before April 2017, in which case they qualify for £158 per month).
- **Limited Capacity for Work and Work-Related Activity (LCWRA):** Claimants with 15 points or more, with a particularly high level of functional impairment, are categorised as LCWRA. This entitles them to a payment of the LCWRA "extra amount". This extra amount is paid at either a higher rate of £430 per month, or a lower rate of £217 per month, depending on the claimant's situation. There are also other ways to be classified as LCWRA – for instance, a claimant can qualify for the higher rate of the LCWRA extra amount if they also have a lifelong medical disease or disablement that has been diagnosed by an NHS medical professional.

Under our proposed reforms, any claimant citing a non-work-limiting condition (even if it were part of a group of conditions) would be presumed to possess the typical, uncomplicated presentation of that condition and score zero points for it in their WCA assessment. It would be up to the discretion of the assessor to change that functional assessment if qualifying functional impairment were observed in the assessment. If the functional impairment were the result of **a non-work-limiting condition,** the assessor would have to cite objective medical evidence of severity. If the functional impairment were the result of **another condition,** the assessor should record this in the assessment and justify reasoning.

Where possible, claimants citing a non-work-limiting condition should be prioritised for face-to-face assessment to enable a more complete and accurate evaluation. The government has already signalled its intention to increase face-to-face assessments to 30 per cent for both PIP

assessments and WCA.[52] This is a positive step, but it should go further by committing to face-to-face assessments for any claimant whose primary condition is classified as non–work-limiting, or who is claiming solely on that basis.

A separate but simple recommendation would be to end curtailment. Curtailment allows assessors to terminate assessments early if eligibility for the higher tier of UC health is already established. This creates a perverse incentive to find in favour of the higher tier because, while assessors are salaried, throughput targets and reporting cycles create structural pressures to prioritise speed over depth. Removing curtailment would ensure all assessments are completed in full, with decisions taken only once the complete evidential picture has been established.

Disability Benefits

Eligibility for PIP is assessed at PIP assessment. This is a functional assessment designed to ascertain the extent to which an individual's disabilities impact their mobility and their ability to conduct daily activities. For both the daily-living component and the mobility component, claimants require eight points to obtain the standard rate and 12 points to obtain the enhanced rate.

Under our proposed reforms, any claimant citing a non-work-limiting condition would be subject to higher thresholds of evidence.

GATEWAY 3: TRIBUNALS

Tribunals for both incapacity and disability benefits should remain a fully independent safeguard within the claims process, but they are currently functioning like a backdoor to the system. To restore integrity, they need to operate within a clear and more consistent evidentiary framework aligned with the new system principle.

At present, there is significant divergence between initial assessment decisions and tribunal outcomes – around 50 per cent of WCA appeals and around 70 per cent of appeals for PIP succeed. This does not necessarily

reflect poor decision-making at either stage. Rather, it suggests a lack of sufficiently clear and structured guidance on how evidential thresholds should be interpreted and applied.

Where evidential standards are not consistently framed across the system, appeal can become a routine extension of primary assessment rather than a safeguard of last resort. This increases delays, adds administrative cost and weakens confidence in the coherence of the overall process.

Tribunals are judicial bodies that review administrative decisions. Government cannot instruct them how to decide cases, and it cannot mandate either outcomes, reasoning or training in a directive way. However, it can support greater alignment by clarifying the evidentiary framework that underpins decision-making.

Greater consistency could be achieved by embedding the application of Standard Functional and Standard Needs Profiles for common conditions within tribunal guidance, alongside the existing evidence on how different levels of functioning relate to work capability and daily-living needs. These profiles would act as a structured reference point for decision-making. Where panels depart from these baseline assumptions, they should set out explicitly how the evidential threshold for severity, durability and functional limitation has been met.

In parallel, a formal feedback mechanism should be established to capture patterns in tribunal reasoning across both incapacity and disability benefits and feed these insights back into assessment practice and policy design. This would help improve consistency and decision quality across the system while fully preserving tribunal independence.

GATEWAY 4: REASSESSMENTS

Reassessment is the system's primary exit point, but it has become infrequent and, in many cases, light-touch. As a result, claimants with temporary, fluctuating or improving conditions can remain on benefits well

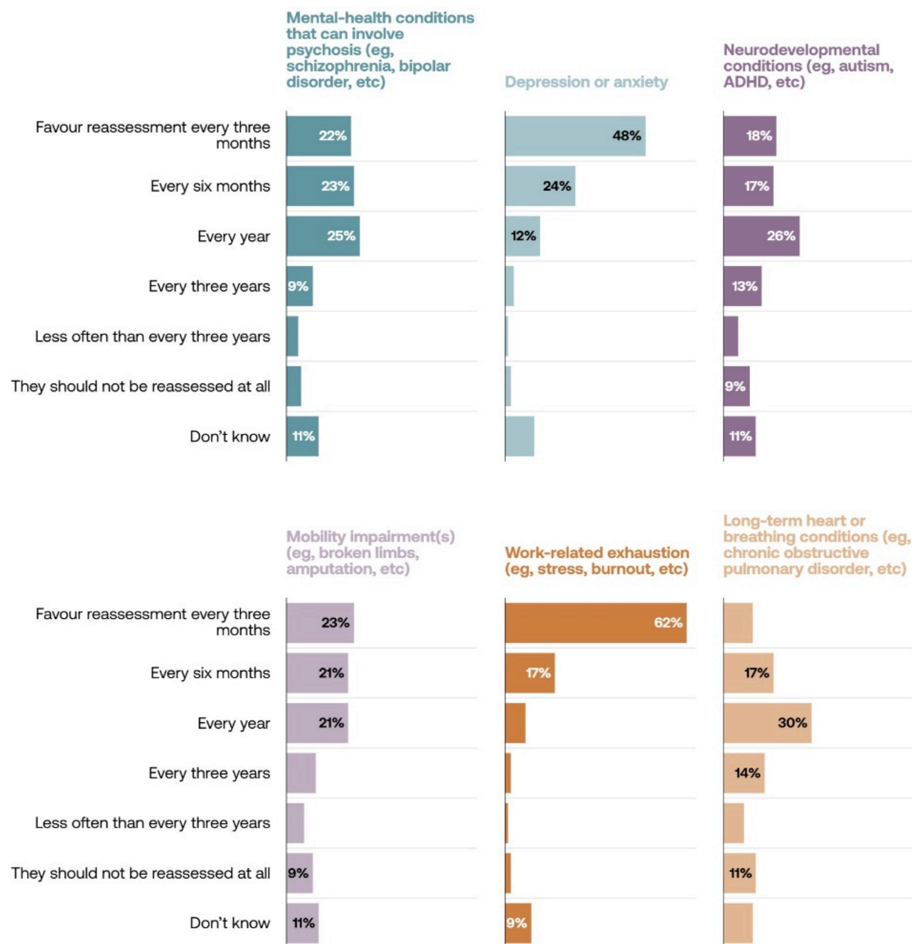
beyond the point at which a return to work is possible. What is intended as support for sustained incapacity risks becoming indefinite status through administrative inertia.

Reform must therefore address not only the inflows but also the existing stock of claimants. Long-term entitlement should be sustained only where ongoing severity and functional limitation are demonstrable. Regular reassessment should be restored at scale and re-established as a normal feature of the system, with frequency varying by condition.

For conditions such as depression, anxiety and work-related exhaustion, most respondents in our polling favour reassessment every three to six months, while preferring longer intervals for severe or long-term conditions. The public distinguishes between conditions that are likely to change and those that are not – and it expects the system to do the same.

FIGURE 22

Views on reassessment frequency vary by condition, with support for shorter intervals for some conditions and longer intervals for others



Q: Generally speaking, how often, if at all, do you think that people receiving support for the following types of conditions should be reassessed for disability benefits?

Source: YouGov for TBI

The same presumption applied at entry should apply at reassessment. For conditions typically compatible with work, reassessment should begin from the expectation that work is possible and require updated evidence that severity and durability thresholds continue to be met. Reviews should explicitly consider changes in treatment, prognosis and functional capacity since the original award.

Reassessment should be targeted and proportionate. Conditions that are fluctuating or treatable, or where recovery is clinically plausible, should be prioritised for more frequent review. By contrast, severe and enduring conditions should be subject to longer award periods, reducing unnecessary reassessment while maintaining system credibility.

Across both incapacity and disability benefits, reassessment should be re-established as a routine and expected part of the system, rather than an irregular or administrative exercise. Current practice is inconsistent, with many claimants remaining on support without regular review. Intervals should be more systematically defined, with shorter review periods for conditions where Standard Functional Profiles indicate compatibility with work, and longer periods for severe and enduring cases.

At each reassessment, the presumption of capability should be reapplied where appropriate, requiring updated evidence that the claimant continues to meet the threshold for sustained functional limitation. Guidance and decision-making frameworks should be updated to ensure that reassessment actively tests continued eligibility, rather than passively rolling awards forward. While the legislative frameworks differ between incapacity benefits and PIP, both systems allow for substantial improvement through clearer guidance, more structured review processes, and stronger alignment between clinical reality and award duration.

3. Targeted Health and Employment Support for People No Longer Eligible for Benefits

Tightening eligibility for UC health will mean that some individuals who might previously have entered the incapacity system will instead remain on standard Universal Credit. Where a condition does not prevent work, this is the correct outcome.

But it brings a responsibility. If the state expects people to remain connected to work, it must provide meaningful support to help them do so. For many claimants, health conditions sit alongside structural challenges: weak labour-market attachment, skills gaps, child-care constraints or limited local job opportunities. Health can become a proxy for deeper economic disconnection. Addressing this requires a twin-track response: a targeted package of health support and broader socioeconomic support.

In considering the cost of these interventions – both the proposed health and employment support – the government should consider the benefits expected to accrue to the Treasury. The government's own research shows that each person who re-enters employment from health-related unemployment saves the Treasury around £18,000 per year in lower benefits and higher tax revenue.[53] Any intervention that costs less than this delivers a net saving to the state.

It is also worth considering public attitudes to these reforms. Polling shows that when presented with a choice, most of the public (76 per cent) favours structured mental-health-treatment support over expanded long-term cash payments for anxiety and depression. Reform must therefore combine firmer eligibility rules with serious investment in recovery.

A HEALTH SUPPORT PACKAGE

Where a condition is judged not to be enduring but likely to improve with treatment, the system should move swiftly to provide that treatment. Early intervention is associated with better clinical outcomes and a higher likelihood of sustained return to work.

The government should therefore commission, at scale, evidence-based interventions targeting the conditions that have driven recent growth in incapacity claims. These should include:

- **For common mental-health conditions:** rapid-access digital and in-person mental-health provision
- **For musculoskeletal conditions:** structured physiotherapy and pain-management programmes
- **For obesity:** broader access to weight-management services, with the ability to prescribe GLP-1-type drugs

Access to these interventions should be integrated into the UC journey, with referral pathways triggered at the point an individual does not qualify for long-term incapacity benefits. The objective is not simply to reduce benefit receipt, but to reduce the underlying health barriers that prevent sustained employment.

A SOCIOECONOMIC SUPPORT PACKAGE

Alongside health treatment, those no longer eligible for the health element of Universal Credit will also need employment support. If the government is going to draw clearer boundaries around access to cash benefits, then it must also invest in credible pathways back to work. Such support must address the structural barriers that often underpin worklessness: health is rarely the only reason people struggle to find and retain work – so health programmes alone will not help people back into work.

Delivery of such support programmes should be locally led, reflecting the needs of communities and labour markets, but central government can contribute too. We suggest the government introduce digital support for claimants that augments the role of the employment advisor. This could help claimants understand how their skills map onto the current job market and identify the courses that would add value to their employability locally.

Government should encourage local areas to innovate to maximise impact and could even explore the use of financing mechanisms like social-outcome funds. Central government should set the framework but not prescribe the model. Health and employment services should operate in parallel, not sequentially, so that treatment and labour-market support reinforce one another.

Support cannot wait for every element of wider reform to be settled. Just as fiscal pressures require immediate action, so too does the need to provide practical help to those with conditions compatible with work. Health and socioeconomic support pathways are both currently underdeveloped or absent in many areas; building them now would provide immediate assistance while also generating the evidence and infrastructure needed for more fundamental redesign.

The Political Opportunity in Successful Reform

Taken together, these reforms would restore clarity at assessment, discipline in decision-making and proportionality in support. They would re-establish the principle that long-term incapacity benefits are reserved for demonstrable and sustained functional limitation, while investing seriously in recovery and return to work. But reform is not only an administrative challenge. It is a political one.

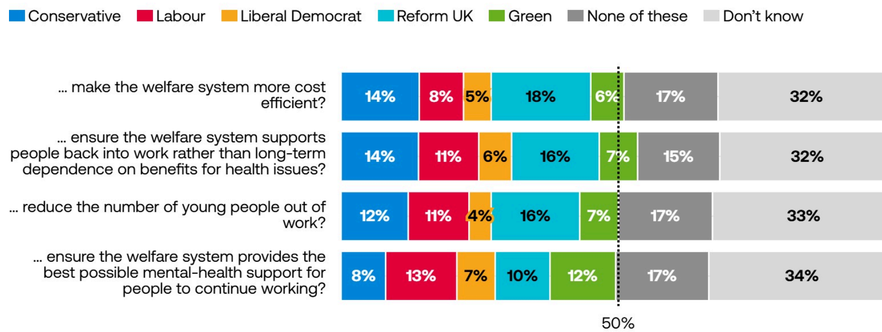
The areas of consensus identified in our polling around fairness, flexibility and clear expectations sit alongside a more sobering finding: a deep and pervasive lack of trust in political leadership.

Public confidence in political parties' ability to reform welfare is limited and dispersed. No single party commands clear trust on the core tests voters apply – controlling costs, supporting people with mental-health conditions or improving employment outcomes. Many voters see a system that is not working as it should. But they currently do not yet see a political actor capable of fixing it.

FIGURE 23

Public perceptions of party strengths on welfare are fragmented

Which political party is most likely to ...



Q: Which of the following political parties, if any, do you think would be most likely to ...

Source: YouGov for TBI. Note: Rounding to 100 may cause slight discrepancies between figures and tables.

Yet this fragmentation also creates an opportunity. Because no party currently commands public confidence on this issue, there is space for political leadership that can combine moral clarity with administrative credibility. The public appetite for reform is real and geographically widespread.

To succeed, reform must therefore command consent not only at the level of principle, but in its application. Voters need confidence that changes will be fair in practice, that those who genuinely cannot work will be protected; that support will be better tailored to help people recover and progress; and that clear boundaries will be enforced where the system is open to misuse. Fairness, in the public mind, runs in both directions – to those who depend on the system and to those who fund it.

06

Conclusion

The UK welfare system has long-standing structural weaknesses that will require sustained government intervention well beyond our proposed emergency handbrake. The measures set out in this paper are intended as a short-term intervention to restore control over entry into long-term benefits, strengthen decision-making and rebuild confidence in the system, creating the conditions for more fundamental reform.

A welfare system that enables people to live more independent and fulfilling lives – while supporting a strong, thriving economy – must place work at its centre. Work remains the most reliable route to dignity, stability and prosperity, and this is a view widely shared by the public.

The polling shows there is no majority for the status quo. Across much of the country, including in Labour-held constituencies and among key parts of Labour's 2024 coalition, voters see the current system as unsustainable and insufficiently robust. Reform that restores clarity to the system's rules, strengthens its focus on recovery and contribution, and is delivered with credibility would align with a broad current of public opinion. It also presents a political opportunity to meet a widespread desire for a welfare state that is sustainable, credible and fair – and that works to help those in genuine need.

Facing the welfare challenge head on is not optional. It is central to the country's economic strength and social renewal. Now is the time for government to act.

07

Methodology

All figures, unless otherwise stated, are from YouGov Plc. YouGov fielded two surveys on behalf of TBI between 30 January and 9 February 2026. The first was a 10-minute survey between 30 January and 2 February 2026 to 4,241 adults across Great Britain. This survey was sampled and weighted to be representative of all GB adults (aged 18+).

Subsequently, a second survey was fielded to top up the sample to 12,068 British adults for multilevel regression and post-stratification (MRP) analysis. Results were then projected across all Westminster parliamentary constituencies in Great Britain, with the multilevel model run with 4,000 iterations across seven chains, and the post-stratification process running across random draws of the 14,000 model estimates. The model uses an extensive combination of different factors at both the individual and constituency level to make sure we provide the most robust estimates possible of constituency opinions. The YouGov MRP model successfully projected the results of the 2024 UK General Election, with a 92 per cent accuracy on constituency calls making it the best publicly available model.

YouGov data cited in this report can be found at the following links.

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info@institute.global

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