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Evaluation of the “Want2Work” Pilot

Evaluation of the “Want2Work” Pilot:

**Final Report
for the Welsh Assembly Government**

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Ms Carolyn Czoski Murray*

Dr Richard Edlin***

Dr Joanne Lindley**

Dr Steven McIntosh**

Professor Jennifer Roberts**

***Health Economics and Decision Science, University of Sheffield**

****Department of Economics, University of Sheffield**

*****Academic Unit of Health Economics, University of Leeds**

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Executive Summary

Chapter 1: Introduction

Want2Work is a labour market scheme that aimed to help people into employment, in selected areas of Wales. It ran from September 2004 to March 2008. The main focus was individuals in receipt of Incapacity Benefits. There was no compulsion to participate, with all clients involved doing so voluntarily.

The evaluation undertaken in this report comprises three elements:

- Labour market outcomes of Want2Work participants relative to non-participants.
- A postal survey that considers health outcomes for participants, and how these were related to other outcomes.
- A qualitative analysis of interviews and focus group meetings with Want2Work participants and providers.

Chapter 2: Labour Market Outcomes

The first part of the evaluation looked at the labour market outcomes of Want2Work participants compared to those of a control group of non-participants, primarily in terms of the probability of moving into work. The control group were derived from respondents to the Great British Labour Force Survey (LFS). Since the Want2Work participants, by definition, are individuals who are out of work but looking for work, the control group derived from the LFS were similarly defined. A statistical technique known as Propensity Score Matching was used to ensure that the outcomes for Want2Work participants were compared to those in the control group who were the same in terms of their observed characteristics.

Results:

Looking at the raw data, not controlling for any characteristics, 30% of Want2Work participants had moved into a job by the end of December 2007. A similar percentage (32%) of the LFS control group who wanted a job and were looking for a job managed to find a job during the observation period of that survey (up to 15 months).

Very few characteristics of Want2Work participants were associated with their chances of finding a job. Those characteristics that did seem to exert such an effect on the probability of finding a job included duration out of work when registering for Want2Work (a much lower re-employment probability amongst those with a longer period out of work), belonging to ethnic minority (positive effect on re-employment) and being in receipt of Income Support or other benefits (less likely to move into work, relative to being in receipt of Incapacity Benefits or no benefits at all).

When comparing the labour market outcomes of Want2Work participants relative to the LFS control group of non-participant job-seekers (controlling for individual characteristics through Propensity Score Matching) we found in our favoured specification that Want2Work participants were 4-7 percentage points more likely to have moved into work than control group individuals (where both groups had a maximum of 15 months to find work).

When the Want2Work and control groups were restricted to Incapacity Benefit claimants only, the association between Want2Work and the chances of finding work was much stronger, with Want2Work participants being around 13 percentage points more likely to have moved into a job.

The results also considered the type of job being moved into, whether full- or part-time, and whether permanent or temporary. For former Incapacity Benefit claimants, there was evidence that the Want2Work effect into full-time employment is smaller than the Want2Work effect into any employment, though it is still positive and statistically significant (Want2Work former Incapacity Benefit claimants being 9-11 percentage points more likely to move into a full-time job than non-Want2Work former Incapacity Benefit claimants, compared to the 13 percentage points effect mentioned above for moving into any job).

In terms of earnings, there were no statistically significant differences in the wages received by the Want2Work participants and the control group individuals who found work.

The analysis of the duration of jobs found by Want2Work participants was hampered by the quality of the data available to us to track individuals in work over time, both in terms of the administrative data and the survey data we collected ourselves. Based on the data that were available, there was no evidence that Want2Work was simply placing individuals into short-tenured jobs, and most of the jobs observed were lasting for more than one year, and counting.

Chapter 3: Health Outcomes and Other Results from the Postal Surveys

This section of the Want2Work evaluation considered extra information on the health, satisfaction and related outcomes of the Want2Work participants. Additional quantitative information was provided by two self-completed postal surveys sent to Want2Work participants. The first survey focused on respondents' health, their satisfaction with various aspects of their lives and also on their opinions about Want2Work. The follow up survey was administered in February 2008 to those individuals identified as being in employment at the end of 2006 (according to the Want2Work database); it contained questions on health, health change, overall life satisfaction and recent labour market and training experience. Analysis reveals that the data from the survey should be considered largely reflective of the full Want2Work sample.

Unfortunately very little baseline health information was available in the Want2Work database, and this severely limits the causal inferences that can be made concerning health impacts. We considered changes in self-reported health from the follow-up survey and related these to labour market experience, but because of the selected nature of the sample of respondents we cannot infer causality from labour market experience to health change.

Results:

a.) Client views

These were judged by asking clients their agreement with a set of statements about different aspects of Want2Work using a 7 point Likert response scale. Client views of Want2Work were generally positive, with the exception of the support from local GPs and nursing staff. The Return to Work Credit was highly rated by respondents and there was evidence that this rating (and that of the job preparation premium) was positively associated with health.

b.) Client health and labour outcomes

The survey used a series of questions to assess health status, contact with the NHS, the interventions provided by Want2Work, and labour market outcomes. Overall, self-assessed health was relatively poor in the Want2Work sample. Most of the respondents had had contact with GPs in the previous 3 months and 49 percent of respondents had had contact with hospitals or clinics as an outpatient or day case. 32 percent of clients within the main Want2work database achieved employment within the Want2Work period. Type of illness was significantly

related to job status, with the lowest employment rates amongst those with learning disabilities and respiratory disease, and the highest rates amongst those with hearing/speech/visual problems and musculoskeletal illnesses.

Self-assessed disability status and self-assessed health were significantly related to job status. It appears from the survey data that those who self-declare themselves in better health are more likely to have a job, although we cannot say why this is, or in which direction the causality runs.

c.) Comparing the experiences of Want2Work participants with a matched BHPS sample

The raw data showed that a higher proportion of Want2Work survey respondents got a job than in the matched British Household Panel Survey (BHPS) sample, and a higher proportion were actively looking for work. These findings add weight to those of Chapter 2 where the relevant comparison was the Labour Force Survey. In addition, our survey has shown that, of those who found employment, there is no significant difference between Want2Work and the BHPS respondents in terms of job tenure, salary, or the proportion in full-time work or self-employment. The raw data also showed that the Want2Work survey respondents have worse subjective health and lower life satisfaction than the BHPS sample, though this difference disappeared when we controlled for observable characteristics. This finding was true whether or not we controlled for specific health problems and disability status. Want2Work respondents had similar specific health problems to the BHPS sample, although one difference is that the Want2Work sample had a higher prevalence of mental health problems.

d.) Health changes and changes in overall life satisfaction

Getting a job and actively looking for a job were both associated with a positive health benefit, and job search had the larger effect. If we estimate models separately for the Want2Work respondents and the BHPS, it appears that these positive benefits only accrue to the Want2Work respondents. But it is important to stress that the lack of baseline health information makes it impossible to infer causality from these results. It could be that those with better health are more likely to look for, and get, a job, and also given the voluntary nature of Want2Work those with better health may be more likely to participate in the programme. The Want2Work and follow-up survey found no evidence that continuous employment improves health, as would be expected if working encourages health effects over time. If employment improves health, then it appears to do so only so long as a person remains employed and does not appear to be cumulative over time.

Chapter 4: The Qualitative Evaluation

What makes this study different from previous evaluations is the focus on the health advisor (HA) role and how that interacts with the role of the Personal Advisor (PA) and with the clients. This chapter described the findings from interviews with the health advisors attached to the pilot project, personal advisors and a number of clients including a small focus group.

We selected key informants who we thought would best contribute to our understanding and assist with the interpretation of the quantitative results, supplemented by recruiting some informants as part of a convenience sample. Four health professionals, eleven members of the teams and 14 clients were interviewed. Semi structured interviews allowed exploration in more depth by using supplementary questions and allowed participants to raise issues not covered in the topic guide. The transcripts were analysed using a framework approach. This is specifically for use in applied policy research, which is often constrained by time and the need to answer specific policy issues.

Results:

There was considerable flexibility in how the HAs interpreted their brief and what services they provided to the clients. All of the HAs did some form of knowledge cascade to the PAs which allowed them greater autonomy in decision making. This could account for the findings from the survey where few of the respondents had contact with the HA.

Marketing the project was part of the learning curve and some approaches were more successful than others. With hindsight this aspect may have been managed more centrally. However, lessons were learned and communicated to the other pilot areas.

The health care professional smoothed the way for greater contact and interaction with locally available services provided by, for example, the mental health teams. Non-health professionals approaching these teams had previously had little impact. This facilitated a greater awareness from all parties involved as to what was available locally already and resulted in some 'joined up' action and referrals.

The one disappointing aspect was the difficulty of involving local GPs in the pilot. Some GPs were very supportive of the work and had team members leave publicity material and a physical presence in the surgery to attract clients.

There were differences in opinion as to the future role of the health care professional as health advisor. Should they be a hands-on provider of services or commissioner of services was raised as an issue. The balance of opinion was probably in favour of a more commissioning role which included facilitating training for the PAs.

In conclusion, the introduction of the health professional into the role of health advisor was a success. They contributed their skills and knowledge to the PAs which was empowering for them and their clients.

1. Introduction

1. Want2Work is a pilot scheme that has been developed jointly by Jobcentre Plus and the Welsh Assembly Government to increase economic activity levels in Wales. The pilot was funded from both Objective 1 and Objective 3 European Social Fund (ESF) grants, through ESF projects directly delivered and managed by Jobcentre Plus, and ran from September 2004 to March 2008. The project was spatially targeted with concentrated activity taking place in selected wards within the Cardiff, Neath Port Talbot, Merthyr Tydfil, Ceredigion and Denbighshire unitary authority areas. The selection basis for the communities was based on the levels of economic activity, together with the proximity of a buoyant labour market.

2. Although the project supported all economically inactive residents of the designated wards, the prime target was the stock of Incapacity Benefit (IB) recipients¹. The broad objective of the pilot was to test a range of elements and products designed to increase labour market participation within these communities. By engaging with those detached from existing core services, the pilot aimed to increase levels of participation in work/health related activities, thus moving individuals closer to the labour market and ultimately into sustainable employment.

3. The key features of the pilot included:

- a network of community based advisers to engage with residents and provide quality advice and guidance;
- a health professional attached to each team to support Personal Work Advisors, to develop links to local health services, and to explore the level of demand for - and opportunities to deliver - health information and advice for participants;
- provision of, or funding for, training, including the development of soft skills;
- a return to work bursary, consisting of a weekly payment to individuals to cover the costs of returning to work, which paid £60 during the first four months in work, £40 in the second four months and £20 in the third four-month period of the first year in work.
- in-work development and support during the first year of employment;
- discretionary funding to overcome other barriers to participation or employment;

¹ Since October 2008, new claimants who cannot work due to illness or disability receive a new benefit entitled Employment and Support Allowance. Existing IB claimants will continue to receive a benefit of this name. Since the data considered in this report cover the period up to the end of 2007, the name 'Incapacity Benefit' will be used throughout.

- a job preparation premium, paid to participants to cover the cost of undertaking additional work preparation activities.

4. The scheme was a voluntary programme, which has important consequences for the evaluation conducted here, as discussed later. The essence of the evaluation problem, however, is that participants in Want2Work are not a randomly selected sample, but have self-selected to be involved in the programme. Such individuals will not necessarily have been the one's already closest to the labour market, for example those attending their local Jobcentre Plus. Whilst the services offered by Want2Work have obviously been advertised there, the aim throughout Want2Work has been to advertise and engage people more widely in the community. A prime example is advertisements placed in GPs' surgeries, which was natural given the focus on IB claimants. Aside from posters in surgeries, active attempts to engage individuals have been undertaken, such as GPs providing premises for employment advisers to interview patients who wish to discuss the possibility of a return to work, and practice nursing staff discussing Want2Work with their patients and encouraging participation in the programme by those considered most appropriate for it. Poster advertising and active engagement by community workers has also been adopted in a range of other community settings.

5. The scheme just described bears many similarities to Pathways to Work. Pathways to Work was introduced on a pilot basis in selected areas of Britain in 2003, and since April 2008 has been rolled out nationally. In the pilot areas it was, and still is, administered by Jobcentre Plus. In the remaining, roll-out areas, it is administered by private suppliers. Pathways to Work is also a programme designed to help those on IB back into work. It is compulsory for all new IB/Employment and Support Allowance claimants, who must attend an initial 'Work-focussed interview, plus five further follow-ups, with their personal adviser. The scheme is optional and available to existing claimants. The adviser can offer a range of 'choices' as they see as appropriate for their client, such as (i) the Condition Management Programme, which helps clients better understand and manage their health condition or disability, (ii) supported work experience through the Work Preparation Programme which can help build confidence and gain work skills, (iii) the Permitted Work scheme, which is essentially accepting a temporary job to try it out, without risking a loss of benefits, (iv) help to find a suitable job through the New Deal provision, (v) the Return to Work Credit, which is a tax-free payment of £40 per week for up to 52 weeks paid to individuals who find work for at least 16 hours a week and earn less than £15,000 per year. The Pathways Personal Advisers can also access a discretionary fund to help

support a return to work activity, (vi) other help and support, such as the Travel to Interview scheme.

6. Pathways to Work therefore differs from Want2Work primarily in that it is compulsory for new claimants, whereas Want2Work is voluntary for all participants. Although there is provision for health support and advice through Pathways' Condition Management Programme, this is more formalised in Want2Work with a healthcare professional attached to each team of personal advisers. In addition, Want2Work is more involved in community outreach programmes, compared to Pathways where clients are compelled to attend formally through Jobcentre Plus or similar private sector providers. There is also a small difference between the two schemes in terms of the Return to Work Credit paid, specifically that it is tapered and declines over time in Want2Work, but is constant under Pathways.

7. Given that Want2Work is voluntary, it is important to obtain some information about take-up rates, in order to gain some understanding of how representative the participants are of the full population of IB recipients. Information on take-up rates can be provided by considering the stock of working-age inactive people in the pilot areas. Clearly not all inactive people should be considered, since a significant number do not want a job, such as the early-retired and homemakers, or are not able to work, such as those with severe illness or disability. Thus considering only those working-age inactive individuals who say that they want a job, the most recently available NOMIS data for July 2006 – June 2007 suggest a stock of 25,700 individuals in the Want2Work pilot areas. Given 6,424 individuals had engaged in Want2Work up to the end of 2007, this suggests a take-up rate amongst the target population of 25%. Of this stock of claimants, 11,600 (45%) are male and 14,100 (55%) are female. Amongst Want2Work participants, 49% are male and 51% female, suggesting that participants are representative by gender.

8. Unfortunately, NOMIS data for other characteristics are not disaggregated according to whether inactive individuals actually want to a job, but are only generally available for the whole group of inactive individuals. Of this group in the Want2Work pilot areas, the largest age grouping is the 50-64 year olds. As expected, this is not observed amongst Want2Work participants, however, who are more likely to be younger (the modal group being 35-49 year olds). Any impact results observed for Want2Work participants in the evaluation that follows would therefore be unlikely to be replicated across the full population of inactive individuals, given the greater number of harder to place over-50s in the latter group.

9. There are also differences between the population of inactive individuals in the pilot areas and Want2Work participants in terms of the nature of health problems. A similar proportion (41% amongst all inactive individuals versus 37% amongst Want2Work participants) have no health problem, but for those who do have a problem, this is most likely to be a mental health problem amongst Want2Work participants (25% of all participants), whilst amongst the group of all inactive participants, the most frequent complaints are cardiovascular and respiratory (19%), and musculoskeletal (15%). It would therefore appear that mental health problems such as depression provide fewer impediments to engaging in the labour market than physical disabilities. Again we therefore must be wary of extending the results obtained in the present report to the full population of inactive individuals, given this different nature of health complaints.

10. A final individual characteristic available for comparison, ethnicity, shows little difference between Want2Work participants and the full population of inactive individuals. 86% of the latter are white, compared to 90% of Want2Work participants.

11. The preceding figures show that there is clearly self-selection onto the Want2Work programme. It should be clear that any control group of non-Want2Work participants used in the subsequent analysis below should also therefore be individuals who are out of work, but who want to work and are looking for work. Of the population of job-seekers in the pilot areas, however, the Want2Work participants are still a self-selected group, as the statistic of 25% in the previous paragraph showed. Ideally, therefore, we would also like to further limit the control group with similar selection criteria used by the Want2Work participants. However, without further information on the population of possible participants, it is not possible to say what those selection criteria might have been. For example, was it the most motivated out of the pool of inactive job-seekers who participated in Want2Work, or those most in need of assistance? If the former, then our estimate of the impact of Want2Work would be upward-biased, though if the latter the evaluation would produce an under-estimate of the Want2Work effect. Without knowledge of the unobserved characteristics possessed by Want2Work participants, we therefore cannot sign any potential bias in the evaluation results. However, with the list of control variables available to us, including qualifications, type of illness, time spent out of work, and benefit type being claimed, the main differences between the Want2Work participants and any control group of out-of-work job seekers should be minimised, and any biases should be small.

12. There are three main sections to this evaluation of Want2Work. The next section considers labour market outcomes, in particular whether Want2Work helps people to move into a job or not, and if so, who benefits most. For those who do move into a job, other characteristics of those jobs will be considered, such as wages, full-time or part-time status, permanent or temporary status, and duration. This will provide some indication, not only of whether Want2Work is successful in getting people into work, but also of the quality of such jobs that are being acquired. The third section primarily makes use of a postal survey of Want2Work participants, to conduct a quantitative analysis of their health, and how this interacts with other Want2Work outcomes. The final substantive section describes the results of a qualitative analysis, based on interviews and focus group meetings with both Want2Work participants and Want2Work providers. A final section will then offer some conclusions.

2. Labour Market Outcomes

2.1 Introduction

13. The first aspect of the evaluation, and ultimately the aspect against which the programme will most be judged, is the labour market outcomes of those who participated in Want2Work. Certainly other outcomes from Want2Work are possible, and will be considered below, particularly potentially improved health but also potentially improved employability through involvement in re-training or closer involvement to the labour market. The primary objective, however, was to help people back into sustainable employment, and so this should be the first focus of the evaluation.

14. It should be stressed at this point that the evaluation has a micro rather than a macro focus, concentrating on the individuals involved rather than the whole labour markets in the pilot areas. Thus, the question that the first part of the evaluation will answer is; ‘are individuals more likely to find work by participating in Want2Work than if they had not participated in Want2Work.’ Other, more aggregate questions, such as; ‘by how much is the employment rate increased, or the inactivity rate reduced, in the pilot areas by introducing Want2Work,’ are interesting in their own right, but not the focus of the evaluation here. Given the large amount of data on Want2Work participants available in the Want2Work database, it was decided that the micro approach was the best use of the available resources. In the language of evaluations, therefore, we are estimating an ‘average treatment effect on the treated’, which tells us how much individuals who participated in Want2Work benefited on average, compared to if they had not participated, rather than how much a random person would benefit.

15. The next section outlines the methodology that will be used in the evaluation of labour market outcomes. Section 2.3 describes the various data sets that are used to perform the evaluation. The subsequent two sections present the results of the analysis. The first of these considers Want2Work participants only, and investigates the characteristics of individuals most associated with the likelihood of obtaining a job, and so answers the question of for whom Want2Work is most successful in finding employment. The second section of results compares the outcomes of the Want2Work participants to those of a control group, and so answers the

question of how successful Want2Work has been in getting people into work. A final section summarises the findings.

2.2 Methodology²

16. The key to a successful evaluation is finding good quality data on a control group. We can observe the factual evidence of what happens to individuals following their participation in Want2Work, but what we can never observe is the *counterfactual* of what *would* have happened to those individuals, had they not participated in Want2Work. Thus we use a control group, and use their outcomes as an estimate of the outcomes that the Want2Work participants would have achieved if they had not participated in Want2Work. Obviously, a potential problem with this is that the individuals in the treatment group (those who participated in Want2Work) and the control group may differ systematically in their characteristics, and it could be this difference in characteristics, rather than the participation in Want2Work *per se*, that is causing any observed difference in outcomes. In the absence of a controlled experiment, where individuals are randomly assigned to be part of the treatment group or part of the control group, the best we can do is to control for (or ‘hold constant’) the characteristics of the individuals that differ between the two groups. As the opening sentence of this section said, the data on a control group must be of good quality, and this means that they must provide detailed information on the characteristics of the individuals involved, so that these characteristics can be controlled for.

17. The most commonly used method of controlling for the characteristics of individuals included in the treatment group and the control group is some sort of regression analysis. It is a property of regression analysis that the estimated coefficient on any variable included in the equation provides an estimate of the change in the outcome variable, for a one unit change in the explanatory variable of interest, *holding constant the impact of all other included variables in the equation on the outcome variable*.

18. Modifications to the standard regression model (Ordinary Least Squares) are needed for the analysis considered here, because of the nature of the outcome variables that we have. Most of the analysis that follows focuses on whether individuals move into a job or not. As such, the dependent variable in this analysis takes only two values; yes or no (or 1 and 0 in numeric terms). To allow for the nature of this dependent variable, a probit model is estimated. In the

² A fuller description of the methodology used can be found in the initial methodological report for the project.

probit model, it is assumed that there is an underlying relationship between likelihood of moving into work, e^* , and a vector of characteristics, X :

$$e^* = bX + u$$

All that is observed in the data, however, is an indicator variable, e , taking the values of 1 or zero, showing whether individuals move into employment or not. Thus, e takes the value of 1 if e^* is above a certain cut-off value, c , scaled to take the value of zero. Therefore the probability that an individual moves into employment is the probability that $e^* > 0$, which can be written as:

$$\begin{aligned}\Pr(e = 1) &= \Pr(bX + u > 0) \\ &= \Pr(u > -bX) \\ &= 1 - \Phi(-bX) \\ &= \Phi(bX)\end{aligned}$$

where Φ is the cumulative normal distribution (thus assuming the disturbance term u is normally distributed). Similarly:

$$\begin{aligned}\Pr(e = 0) &= \Pr(bX + u < 0) \\ &= \Pr(u < -bX) \\ &= \Phi(-bX) \\ &= 1 - \Phi(bX)\end{aligned}$$

Taking the log of each probability and summing, with a suitable indicator to show whether each individual actually obtained a job or not, gives the log likelihood function. This can then be maximized, using a suitable optimization technique, with respect to the parameters of interest, β .

19. Essentially, this model looks at the probability of moving into employment or not, and the coefficients can be used to provide an estimate of the impact of each explanatory variable on the probability of obtaining a job, again holding the influence of all other variables in the equation constant in each case. This is called the ‘marginal effect’ of the variable in question. As almost all of the explanatory variables in our analysis are dummy variables themselves (i.e. they only take the value of 0 or 1), then the interpretation of their estimated coefficients is the change in the probability of entering employment, if the situation represented by the dummy variable occurs, relative to the reference category.

20. The other main outcome variable analysed in this section is annual earnings, for those who find a full-time job. As described in the data section below, respondents to the Want2Work survey do not report their actual earnings, but only the band in which their annual earnings fall, from a choice of five bands. There are two methods commonly used in the literature to deal with such banded data. One solution is simply to assign the wage at the midpoint of each band, to

every individual who falls into the relevant band³. A more sophisticated approach is the so-called interval regression approach. This estimates the probability of an individual falling within each of the bands given their characteristics, and then translates the effect on the probability into an effect on earnings themselves using the cut-off values of the bands. Both methods will be used in this report, whenever earnings are considered.

21. A newer method of controlling for the characteristics of individuals in the treatment and control groups, that is increasingly popular in the evaluation literature, is propensity score matching (PSM). The idea behind PSM is to find, for each person in the Want2Work treatment group, a person who looks like them in the control group, in terms of the observable characteristics available in the data set. Then, the treatment effect of Want2Work (called ATT, the average treatment effect on the treated), is calculated as the expected value of the difference in outcomes between the treatment group and the matched control group:

$$ATT = E(Y_{1i} | D_i = 1) - E(Y_{0i} | D_i = 0)$$

where D_i takes the value of 1 for the Want2Work treatment group and zero for a member of the matched control group, e is again an indicator of whether an individual moves into employment, and E is the expectations operator.

22. Clearly, with a long list of characteristics, it would become a complicated calculation to determine the person in the control group with exactly the same characteristics as a treated Want2Work participant. What PSM does is estimate a single number (the propensity score) for each individual, which is their likelihood of being in the treatment group. If, for example, people with better qualifications are more likely to be in the treatment group than the control group, then qualifications will obtain a positive coefficient in the estimation of the propensity score, and so on for all other observable characteristics in the data set. When an individual in the control group has a similar propensity score to an individual in the treatment group, then we can say that the control group individual has the characteristics of a treatment group person. By comparing the labour market outcomes for each person in the Want2Work treatment group, with their ‘look-a-like’ in the control group, we obtain estimates of the average effect of Want2Work on those outcomes, as in the equation above. Basically, the outcome of the ‘look-a-like’ is taken as an estimate of the outcome the Want2Work participant *would have* achieved if they had *not* participated in Want2Work.

³ For the open-ended top category (£30000+), the value assigned to individuals is 1.5 times the opening point of this category, i.e. £45000. Since so few participants achieve a wage in this band, the results are not significantly affected if this value is arbitrarily changed.

23. It remains to be decided how ‘similar’ is to be defined, in determining whether a match has been found. One approach is one-to-one, or ‘nearest neighbour’ matching, where each individual in the treatment group is matched to the person in the control group who has the closest propensity score (where a ‘caliper’ or tolerance level for acceptable matches can be set). Another approach that will be used side-by-side in all results tables is kernel matching, which uses a weighted average of *all* of the observations in the control group to provide the match (and therefore does not waste data), with larger weights attached to observations with a closer propensity score to the treatment group individual being considered.

24. One other issue when using PSM is that the true propensity to participate in Want2Work for any individual in either group is obviously unknown, and so is predicted based on an estimated participation equation. In the second stage of the research, where the outcomes of the treatment group are compared to the matched control group, the computation of the standard errors on the treatment effect needs to take into account the fact that the propensity score was only an estimate in the first stage. In the absence of an exact formula for the standard errors in these circumstances, the usual approach is to ‘bootstrap’ the standard errors, which essentially involves repeatedly calculating the treatment effect with random samples of the available data, to ascertain the degree of uncertainty attached to the result. This procedure was therefore used in all PSM analyses discussed below. For one-to-one matching 500 replications were used, while for kernel matching, 50 replications were used, due to its greater computational demands.

25. PSM is said to have two advantages over traditional regression-based methodologies. First, it does not impose any functional form on the relationship (compared to, for example, Ordinary Least Squares, which imposes a linear relationship). Second, the technique identifies those observations in the treatment group for which there is no ‘common support’, i.e. there is nobody in the control group who looks at all like this treatment group individual, and so no accurate way of estimating the counterfactual of what would have happened to such an individual if they had not participated in Want2Work. Observations without common support can be dropped from the evaluation, which we do here.

2.3 Data

26. Information on Want2Work participants was collected at the point of their entry to the scheme and placed in a database. Any future changes in status, such as a movement into

employment or training, were also monitored and recorded in the database, together with some information about the new status. Anyone who joined Want2Work between January 2005 and December 2007 is included in the database, so we have information on the population of Want2Work participants between these dates (approximately 6400 individuals). The database also contains detailed information on their background characteristics, allowing us to control for a range of factors that may influence their final outcomes. Key amongst these are age, gender, ethnicity, whether a single parent or not, highest qualification, type of welfare benefit being received when first registered with Want2Work, whether suffering from an illness or disability and if so what type, time spent out of work, whether the person speaks Welsh, whether they have a criminal record, and whether they have misused alcohol or drugs. If the individual finds a job during the observation period, then certain characteristics of that job are also recorded, such as annual earnings, full- or part-time status and permanent or temporary status, as well as the date that the job started. Unfortunately the earnings information is only included in bands, with individuals indicating whether their annual earnings are below £10,000, between £10,000 and £15,000, between £15,000 and £20,000, between £20,000 and £30,000, or above £30,000. The choice of which variables to include in the analysis, producing the list just described, was largely determined by data availability, though many have been used previously in the literature. It is commonly found⁴ that older workers find it harder to return to work from unemployment, for reasons of skill obsolescence, health, or age discrimination. Similarly, many studies find that prior qualifications, or engagement in training / lifelong learning, are positively associated with the likelihood of returning to work.⁵ Health states and in particular poor health have been shown to strongly affect the re-employment likelihoods of individuals.⁶ The final key block of variables included in our analysis is the duration of the current unemployment spell. Many studies of unemployment have found duration dependence, in that the longer an individual has been unemployed, the harder it becomes for them to leave this state.⁷

27. The counterfactual data used for the control group are drawn from the *Quarterly Labour Force Survey* (QLFS) for the period 2005 to 2007 for Great Britain.⁸ Anyone QLFS respondent who happened to live in a Want2Work pilot area was excluded from the control group. The QLFS has a wealth of information on employment outcomes and job characteristics, as well as individual level characteristics such as marital status, ethnicity, highest qualifications and wages.

⁴ For example, Koeber and Wright (2001).

⁵ See for example Jenkins *et al.* (2002).

⁶ For example, Schuring *et al.* (2007)

⁷ see Groot (1990) and the references therein.

⁸ Details of the sampling methodology and questionnaires are available from the Office for National Statistics at <http://www.ons.gov.uk>. The sample is for Great Britain and therefore excludes Northern Ireland.

Since 1992 the QLFS has been based on a systematic random sample design, which makes it representative of the whole of Great Britain. Each quarter's QLFS sample of 60,000 private households is made up of 5 'waves', each of approximately 12,000 households so that the QLFS has a rotating panel element where each wave is interviewed in 5 successive quarters. In any one quarter, one wave will be receiving their first interview, one wave their second, and so on, with one wave receiving their fifth and final interview.

28. Since the Want2Work data cover the period 2005 and 2007, QLFS data for the same period were used, as far as possible. Nine quarterly data sets were appropriate and available: March-May 2005, June-August 2005, and so on through to March-May 2007. In order to observe how the economic position of individuals initially out of work changes, it is necessary to make use of the panel element of the QLFS, repeatedly observing the same individuals for five consecutive quarters. Each cohort of QLFS respondents is in the survey for five quarters. This means that all five appearances in the data set could be observed for **five** different cohorts, the first appearing in the QLFS for the first time in March-May 2005, and the last appearing in the QLFS for the first time in March-May 2006. The fifth and last appearance of this final cohort was therefore March-May 2007, the most recent data available to us. Although we observed later cohorts *entering* the QLFS after March-May 2006, we could not observe their final appearances in the survey, and so they were not included in the sample, as we wanted to observe the control group individuals for as long as possible, to give the longest possible time frame for observing potential movements into work.

29. Once the data were restricted to individuals who were out of work the first time that they were observed, excluding full time students and those who had taken early retirement, and to those who responded to the survey in each subsequent wave, the sample consisted of 8,994 men and women aged 16-65. Of these, 3,427 reported that they wanted a job and were looking for a job. An indicator of moving into employment was then created by tracking the labour force status of each individual over the subsequent waves that they were observed, to establish whether they gained employment or not. With respect to the wages of those who found employment, income questions are only asked to respondents in their first and final waves of the QLFS. Since our sample are by definition not employed in their first wave, we can only observe wages for respondents who have moved into employment and stayed in employment by the time of their final, fifth wave appearance in the QLFS. This is the case for 838 individuals. Actual

gross weekly earnings are used and then converted to banded annual earnings to be consistent with the Want2Work earnings data⁹.

30. The type of information available from the QLFS was mostly consistent with that found in the Want2Work database. For the dependent variable of moving into employment, in both data sets this was measured simply by observing whether the individual in question was in employment at each point in time they were observed. There is a difference in that the Want2Work participants were observed continuously, whereas the QLFS respondents were only observed at 3 month intervals. Potentially, therefore, some incidents of re-employment in the QLFS could be unobserved, if the individual had fallen back into unemployment or inactivity within the 3 month period before they are next surveyed. The QLFS could therefore under-report the likelihood of finding work for the control group, and so bias upwards the estimated Want2Work effect, though it is open to debate whether we would want to consider jobs with a shorter duration than 3 months anyway, and the number of such jobs is likely to be small. In terms of the other dependent variable used, earnings, as described above there was much more detail on earnings in the QLFS than in the Want2Work database, though the former were recoded to make them consistent with the latter.

31. As for the explanatory variables used, most were characteristics of individuals that are defined unambiguously, and so were consistent across the two data sets, such as age, gender, ethnicity and family situation. In the case of some categorical variables, however, there were some differences between the categories used in the two datasets. For example, with respect to highest qualification, the QLFS variable ranks almost 50 qualifications, whereas the Want2Work database simply asks respondents to report at which National Qualification Framework (NQF) level their highest qualification is found. Therefore efforts were made to allocate an NQF level to each qualification in the QLFS, to make the datasets consistent. Similarly, with respect to health problems of respondents, a greater number (17) were listed in the QLFS than in the Want2Work database (7). Again, the QLFS categories were collapsed, in order to make the categories as similar as possible between datasets¹⁰. Finally, there were also slight differences in the categories of benefits listed in the two data sets. The list in each dataset was collapsed, to produce a list of benefits common to each.

⁹ Gross weekly pay is multiplied by 52 and then a categorical variable with 5 outcomes is generated.

¹⁰ For example, 'arms and hands', 'legs and feet' and 'back and neck' are three different categories of health problem in the QLFS, but were collapsed into a single category 'musculoskeletal' to match the category in the Want2Work database.

32. The final source of information used in this report is the National Benefits Database, made available to us by the Department for Work and Pensions (DWP). The data provided contain all individuals in the country who registered a new claim for Incapacity or related Benefits at some point during 2005 and 2006¹¹. By matching this data set to employment records, it was possible to observe which of these individuals moved off benefits again and into a job. The big advantage of this dataset is that it covers the entire population who are on benefits, and so sample sizes are huge. There are two disadvantages, however. The first is that the dataset contains only individuals who began a claim during 2005 and 2006, as all people in the middle of a claim during this time would have created an unmanageable dataset. The individuals in the DWP dataset are therefore not comparable to the individuals in the Want2Work database, since many of the latter have been out of work for significant lengths of time. The more serious weakness of the DWP dataset for present purposes, however, is that it contains virtually no background information on the individuals¹², and so does not allow us to control for their characteristics. These data will therefore not be used as a control group in the evaluation of Want2Work, although they do provide useful raw data for comparison purposes.

33. Table 2.1 compares employment and full time earnings outcomes for the Want2Work participants with the QLFS respondents and the individuals in the DWP dataset. These are simply the re-employment rates and average earnings levels observed in the raw data, without controlling for *any* of the possibly different characteristics of the individuals in the various data sets. The raw data show that 30 percent of Want2Work participants found a job at some point in the period between them joining the scheme and the end of 2007, compared to only 19 percent for the GB QLFS respondents in the period that they were observed in that survey. As discussed above, however, the group of individuals in the QLFS who want a job and are looking for work are a more legitimate comparison group, since the Want2Work participants clearly want a job. The third panel of results, for job seekers in the QLFS only, reveals 32 percent found a job during the time that they were in the QLFS, which is slightly higher than the Want2Work re-employment probability of 30 percent. Thus, without conditioning on individual characteristics, Want2Work participants are slightly *less* likely to have found work than job-seekers in the QLFS¹³.

¹¹ Since the dataset contains *all* individuals registering for IB or related benefits, some such individuals will live in areas where they have benefited from the provision of *Pathways to Work*, another scheme intended to help those on benefits back into work.

¹² Only information on gender, age and region is available in the DWP dataset.

¹³ Job-seekers in the QLFS are identified by two questions in the survey asked of people not in work. If a respondent is not currently working, they are asked if they want a job, and if yes, are they looking for a job. Clearly, the accuracy of our definition of job-seekers depends on truthful answers to these questions. Potentially, individuals may feel moved to state they are looking for work even if they are not, for fear of their benefits (specifically Job

34. The final panel in the upper half of Table 2.1 reports that 14 percent of benefit recipients in the DWP data set (which does not include an indicator of job-seeking) obtained a job within a year. The probability of finding work specifically in the Torfaen area is 15 percent in the DWP data set. Torfaen is economically similar to the Want2Work regions, and had no labour market programmes in operation, and so is a useful comparator.

35. Recalling that IB recipients are the principal target of Want2Work, Table 2.1 also reports re-employment rates of IB claimants in each data set. Amongst the Want2Work sample, the re-employment rate remains high, at 29 percent, but this figure was only 4 percent in the QLFS data, and still only 8 percent when the latter were restricted to job-seekers. In terms of the other benefit receipt categories ('other' or 'none'), the re-employment rate amongst Want2Work participants is higher relative to all in the QLFS sample, but lower than that of job-seekers only in the QLFS.

36. For earnings, 90 percent of the Want2Work participants who found work accepted jobs for which they were paid less than £15,000 per year, compared to 78 percent of the QLFS respondents. The QLFS distribution generally shows more individuals at the extremes. Thus at the very bottom of the distribution, 55 percent of Want2Work participants who found work accepted a job that paid less than £10,000 per year compared to 62 percent in the QLFS, whilst at the top, 2.2 percent of Want2Work participants found a job paying over £20,000, compared to 13 percent of QLFS respondents.

37. Table 2.2 provides the average characteristics of the Want2Work participants and the QLFS respondents (both for the full QLFS sample, and for job seekers only). Given the voluntary nature of the Want2Work scheme, the samples are likely to differ in terms of their average characteristics. Comparing the Want2Work sample with the full QLFS sample first, Want2Work participants are on average younger than QLFS respondents, with 76 percent of the Want2Work participants aged below 44, compared to 53 percent for the QLFS. Exactly half of the Want2Work sample have no qualifications, with only 4 percent educated to the highest National Qualifications Framework (NQF) level. Comparative numbers for the QLFS sample are 34 percent with no qualifications and 9 percent educated to NQF Level 5. The QLFS respondents are therefore significantly better educated, on average, than the Want2Work respondents. The

Seekers Allowance) being affected, so our group who we assume are motivated job-seekers may contain people who are not actually looking for work. All we can say in response to this is that respondents are assured that their responses are totally anonymous, and that information on an identifiable individual basis is not made available to any outside body, removing any incentive to provide false answers.

Want2Work sample has a larger proportion of men (50 percent) compared to the QLFS (36 percent). The Want2Work sample has a higher percentage of single parents (21 percent compared to 16 percent) and a lower percentage of non-whites (10 percent compared to 12 percent) relative to the QLFS data.

38. With respect to illness, it is perhaps surprising that the percentage reporting no illness differs by only 4 percentage points, with only 41 percent of the QLFS sample saying they have no illness, since the QLFS contains a representative sample of all people not in work, while Want2Work was targeted at those on IB, though this is consistent with illness or disability being an increasingly common reason for being out of work. Type of illness suffered does, however, differ substantially across the two samples. The majority of those with illness in the Want2Work sample have mental health problems (25 percent compared to only 9 percent in QLFS), whereas the QLFS has a much higher proportion with Cardio illnesses (12 percent compared to 3 percent in the Want2Work sample).

39. In terms of history of unemployment experience, Table 2.2 shows that only 5 percent of Want2Work participants have never had a job, compared to 16% of QLFS respondents. For those who have previously worked, the 'last worked' variables indicate the duration since they last had a job. Want2Work participants on average have worked more recently than QLFS respondents, with 30 percent and 16 percent respectively out of work for less than 12 months. At the other end of the scale, only 11 percent of Want2Work participants have been out of work for more than 10 years, compared to 24 percent of QLFS respondents. In terms of benefits being received whilst out of work, we would expect IB benefits to be over-represented in the Want2Work sample, given that recipients of such benefits were the target group of this programme, and this is indeed the case, with 60 percent of Want2Work participants being in receipt of IB, compared to just 34 percent of QLFS respondents. The latter are much more likely to be claiming no benefits at all¹⁴.

40. Regional unemployment rates were calculated from the QLFS local area datasets. These were matched by local authority district and year joined the Want2Work scheme or QLFS survey. On average, regional unemployment rates were higher in the Want2Work pilot areas (5.9 percent)

¹⁴ Although Want2Work was not intended for such individuals, a small number report receiving Job Seeker's Allowance (JSA) benefits, and are included in the 'other' category. There is often confusion about benefits, and this may simply reflect mistaken beliefs. Similarly, a small number of inactive respondents in the QLFS report receiving JSA.

compared to the average across the rest of the Great Britain for those out of work in the QLFS (4.9 percent).

41. The final four rows in Table 2.2 refer to characteristics that are available in the Want2Work database but not in the QLFS. These show that 51 percent of the Want2Work participants have some kind of disability, 3 percent are Welsh speakers, 5 percent are ex-offenders and 6 percent reported some kind of drug or alcohol misuse.

42. Overall, then, some characteristics of the Want2Work sample are favourable to them finding a job, relative to the QLFS sample, such as the fact that the former are younger on average, are less likely to have never worked, and have spent less time out of work. Set against these factors, however, are the facts that the Want2Work sample are more likely to hold no qualifications, more likely to be a single parent, more likely to be in receipt of benefits, and living in an area with a higher rate of unemployment, compared to the QLFS sample, all of which are associated with a lower likelihood of finding work.

43. Of course, the crucial difference between the Want2Work and full QLFS samples is that everyone in the former is presumably looking for work, whilst not everyone in the latter necessarily wants a job. As mentioned above, a more useful control group is those individuals in the QLFS who wanted a job and were looking for a job. The final two columns of Table 2.2 show the characteristics of this sub-sample of the QLFS. In some respects they are more alike the Want2Work participants than the full QLFS sample, as we would expect since both now consist of groups of job seekers. Thus, although the Want2Work participants are still younger on average, the sample of QLFS job-seekers is of a more similar age than the full QLFS sample. Also, the length of time since last worked is significantly lower for the job seekers than the full sample in the QLFS, making the former group appear more like the Want2Work participants. Age and duration out of work are two crucial factors in determining likelihood of job success, and so the increased similarity between samples is another reason for using job-seekers in the QLFS as the control group. In one other crucial characteristic they are actually more different however. Recall that Want2Work participants were already less educated, on average, than the full QLFS sample, with a significantly higher number with no qualifications. When the control group is restricted to job seekers, this difference is amplified, with 50 percent of Want2Work participants reporting no qualifications, compared to only 27 percent in the sample of QLFS job-seekers (34 percent in the full QLFS out-of-work sample).

44. The following sections report the results of the multivariate analyses, which control for all of these other characteristics.

2.4 Outcomes for Want2Work Participants

45. Before considering employment outcomes, the Want2Work database also collected information on intermediary outcomes (or ‘soft outcomes’) that may help recipients find employment in the future. Table 2.3 details the proportion of Want2Work participants involved in each of these soft outcomes. It is clear that employment is actually the most likely destination of people who change status following their involvement in Want2Work. None of the other possible outcomes come close to being followed by the 30 percent of Want2Work participants who move into employment. The most common alternative outcome is ‘other training’ which is reported by 13 percent of participants. Voluntary work is a chosen option of 3 percent of the participants, but none of the other options are taken up by more than 2 percent of Want2Work participants.

46. The first piece of multivariate analysis was undertaken for Want2Work participants only, and estimated a probit equation to determine the characteristics of the Want2Work participants that were associated with them moving into employment. This is defined as moving into a job at any point of registration with Want2Work, regardless of type of job or duration (which will be considered later). The results are shown in Table 2.4, which reports the marginal effects on the probability of obtaining a job for each variable in question (i.e. the change in the probability of obtaining a job relative to the reference category, or the ‘omitted category’, of that characteristic), holding the influences of all other variables constant.

47. Only an NQF Level 3 qualification is associated with a higher probability of moving into work, by 4 percentage points relative to those with no qualifications. With respect to illness, all effects (with the exception of that associated with musculoskeletal problems) are negative, showing that having some illness is associated with a lower likelihood of finding work compared to having no illness, though none of these effects are statistically significant. Individuals who have worked recently are much more likely to find a job through Want2Work, with, for example, individuals who were last in work up to 6 months ago being 25 percentage points more likely to find a job through Want2Work than individuals who were last in work over 20 years ago. The local unemployment rate, however, is unrelated to the likelihood of moving into work through Want2Work. Those not receiving benefits whilst out of work are more likely to move into work,

presumably due to a lack of a disincentive effect of benefit receipt. The gap is particularly large relative to income support and ‘other’ benefits, rather than IB.

48. The only other statistically significant effects observed in Table 2.4 are that individuals with previous histories of drug or alcohol misuse are less likely to move into employment, while controlling for all other factors, individuals from an ethnic minority are more likely than white individuals to find a job through Want2Work. No other variable in the estimated equation attracts a statistically significant coefficient. An interpretation of this general lack of statistical significance is that Want2Work largely does not favour some groups more than others, but to the extent that it has a beneficial effect, it benefits most groups equally.

49. One question is whether the ‘soft’ or intermediary outcomes discussed above increase a Want2Work participant’s chance of moving into employment. The final column of results in Table 2.4 therefore adds variables indicating involvement in each of these activities. The first thing to note is that, comparing effects in the two columns, the inclusion of the intermediary outcomes does not affect any of the other estimated coefficients. Interpretation of the new coefficients results in the final column is however not straightforward, due to the endogenous nature of these variables¹⁵. For example, any positive effect of such activities on the likelihood of finding employment may not be observed in the estimated equation, if only individuals with a particularly low likelihood of finding a job in the first place are chosen to participate in such intermediate outcomes, which would offset the positive relationship between the variables. Only one of the intermediate outcomes, ‘other training’ turns out to be positively and statistically significantly related to the probability of finding a job. No further description of this category is provided in the Want2Work database. It is simply a catch-all category for any type of training not covered by the other possible categories in Table 2.3. As such, its significance is difficult to interpret. In addition, participation in Further Education and the probability of obtaining a job are negatively related, but that may simply be the result of a long period of time in the former reducing the time available to move into the latter. All other intermediate outcomes are not significantly related to the probability of moving into a job. It should *not* be concluded, however, that such strategies are ineffective in helping people into work, for two reasons. First, the time frame being considered is relatively short, and the time available for such participants to be observed finding work is shortened due to the very fact that they are involved in the work preparation scheme. Second, as was seen in Table 2.3, these options are followed by very few

¹⁵ That is to say, individuals either self-selected into participation in these activities or were themselves chosen, on the basis of certain characteristics that they hold.

people out of the total Want2Work population, therefore making it extremely difficult to observe statistically significant effects¹⁶. For example, individuals who undertake a work placement are 13.5 percentage points more likely to move into full employment than individuals who do not undertake a work placement, giving work placement one of the highest marginal effects in Table 2.4. However, because so few individuals undertake work placement, the standard error on this estimated coefficient is similarly large, and the effect is statistically insignificant.

50. We also investigated using the intermediary outcomes as dependent rather than explanatory variables, to determine whether involvement in such activities was associated with particular characteristics of individuals. However, given the small numbers of people involved in each of the ‘soft outcomes’, this did not produce strong statistical results, and so they are not presented in full. Summarising the few statistically significant associations that did emerge, one pattern observed was that individuals recorded in the Want2Work database as having a disability were significantly more likely to be involved in voluntary work, Work-Based Learning for Adults, Further Education and other training. It may be that individuals with a disability are more detached from the labour market, and require these intermediary stages, before being equipped for permanent employment. With respect to gender, men are significantly less likely than women to enrol in Further Education or voluntary work, amongst Want2Work participants. Finally, as might be expected, younger individuals are often more likely to undertake some of the learning activities than older persons, with statistically significant effects observed for work placements and Work-Based Learning for Adults schemes.

51. Table 2.5 reports the results of an analysis of earnings for those who find work through Want2Work. As described above, the earnings information in the Want2Work dataset is banded into 5 groups. The first column of results provides estimates for the interval regression model, whilst the second column provides OLS estimates for the midpoints for each of the five earnings categories, as described in the methodology section above. The dependent variable is simply the actual value of annual earnings, rather than the more usual log earnings that is commonly used in estimated wage equations. Actual earnings were used rather than their log, because of the better performance of the former equation. It is likely that the restriction of the wage information to just five categories, with over half of all Want2Work participants in just one category and over 90% in the lowest two categories, explains this deviation from the usual findings.

¹⁶ The number of people following any particular programme will be inversely proportional to the size of the standard error on that programme’s coefficient. Programmes with few participants therefore have large standard error, making statistically significant coefficients unlikely, even when the observed effect is large.

52. Unfortunately, the results of the wage analysis are not strong. This is due to the facts that, firstly, the sample size is much reduced, since only 1884 Want2Work participants find work and have non-missing information on their wages and all other explanatory variables, and particularly, because there are only five wage bands and as Table 2.1 b.) showed, over half of those who find work are in the first band, while virtually no-one is in the top two bands. This means that there is very little variation in the earnings information across Want2Work participants, and so little for the regression equation to ‘explain’. Coupled with the smaller sample size, it would then be expected that very few statistically significant findings would emerge. Table 2.5 shows that this is indeed the case. The statistically significant results that do exist show that some qualifications (in particular NQF Levels 2 and 5) are associated with significantly higher pay. Whilst it should not be surprising that the highest qualified individuals earn the highest wage if they find work, it is slightly surprising that the next highest wages are earned by those at NQF Level 2 (GCSEs or equivalent). However, the differences across levels are not large and are not themselves statistically significant (with the exception of the unusual negative NQF 4 coefficient, though this sub-degree category is held by very few individuals), so probably not too much should be made of these results. Finally, men earn around £2,000-3,000 per annum more than women, those with respiratory illnesses earn around £2,000 per annum more than those with no illness, whilst single parents and disabled people each earn about £1,000 per annum less, on average.

2.5 The Impact of Want2Work

2.5.1 Standard Regression Models

53. The previous section considered the characteristics of Want2Work respondents that were most associated with them moving into employment, or some form of learning or training. What the previous analysis could not answer, however, is how successful the Want2Work scheme has been. Has Want2Work been helpful in getting people out of non-work situations (predominantly on Incapacity Benefit) and into a job, or would such people have found employment anyway, regardless of their involvement in Want2Work? This section answers such questions.

54. The control group of people out of work in the QLFS is therefore introduced at this point. The question asked is; ‘do Want2Work participants have a higher rate of moving into employment than similar non-Want2Work individuals in the QLFS?’ We have already seen, in

Table 2.1a.), that a higher proportion of Want2Work participants than out-of-work individuals in the QLFS moved into employment during the observation period. However, we have also seen, in Table 2.2, that the characteristics of the Want2Work participants are quite different to those of the QLFS respondents. It may be that the relative success of those involved in Want2Work is more to do with those characteristics, rather than the Want2Work scheme *per se*. This is why the word ‘similar’ was inserted in the previous question. If the success of the Want2Work participants was still greater than that of a control group with the same characteristics, then this would provide stronger evidence in support of Want2Work. Regression analysis allows us to condition on, and so in effect ‘hold constant’, all characteristics included in the regression equation, and so observe the pure treatment effect of involvement in Want2Work on employment, independent of the influence of those characteristics.

55. The first column of results in Table 2.6 reveals the results of a probit equation on whether individuals obtained a job or not, on the pooled Want2Work-QLFS sample. As before, the employment variable is defined as *ever* moving into a job in the observation period, regardless of the type of job or its duration. The key result is the coefficient on the variable identifying individuals in the Want2Work treatment group. This coefficient is positive and statistically significant, and suggests that, controlling for all of the other characteristics in the estimated equation, individuals who enrolled in the Want2Work scheme are 11.3 percentage points more likely to have moved into employment, compared to the control group of initially out-of-work individuals in the QLFS. Given the quite small transition rate into employment across the pooled sample (around 23%), the 11.3 percentage point difference is not only statistically significant, but is also a large effect, and is economically significant. Also, recall from the discussion of the raw data above in Table 2.1a.), that the raw difference in employment-transition rates between the Want2Work and QLFS samples was 11.1 percentage points. Given that the multivariate results suggest a very slightly wider difference in re-employability once other characteristics are controlled for, this suggests that individuals in the Want2Work sample have characteristics that, on average, are very slightly worse for their chances of finding a job, relative to the control group of QLFS respondents. The discussion of sample means in Table 2.2 above suggested that the key adverse characteristic amongst the Want2Work participants was that they were less likely to hold qualifications than the QLFS respondents.

56. Briefly considering the other coefficients in the first column of Table 2.6, with the significantly increased sample size afforded by the inclusion of the QLFS control group, many more coefficients are now statistically significant, compared to the employment probit equation

in Table 2.4 for the Want2Work participants only. Most of these effects are as would be expected. Thus the chance of moving back into employment declines with age, but only after the age of 50, there being little variation in the re-employment probabilities amongst the various groups aged under 50. With respect to education, the estimation of these coefficients benefits first from the increased sample size, but also from the much greater variation in qualification attainment, relative to the Want2Work only sample. In the pooled sample, we therefore observe the probability of moving into work increasing uniformly with the highest level of qualification achieved. Men are 2.1 percentage points more likely to find a job than women, whilst whites are 2.7 percentage points more likely to find a job than non-whites. A number of illnesses or disabilities are shown to be associated with a significantly lower likelihood of moving into employment, namely cardiovascular illness, learning difficulties or sight/hearing problems, and ‘other’ illnesses. The chances of finding a job decline monotonically with time spent out of work. Even those who have never worked are more likely to find a job than those who have experienced more than twenty years since their last job. A higher local unemployment rate also significantly reduces the chances of moving into work. Finally, those individuals on IB or income support benefits are less likely to move into work than those not in receipt of benefits, which is to be expected given benefits will raise individuals’ reservation wages¹⁷. The only result that is perhaps surprising in the employment equation is that single parents are 6.2 percentage points more likely than non single parents to have moved into employment in this sample, an effect that is statistically significant. Perhaps this is due to a need for increased income amongst lone parents, or government initiatives targeting this group.

57. There is one key difference between Want2Work participants and QLFS respondents that is not accounted for in the first column of Table 2.6, which is that only some of the latter group actually want a job and are looking for one, whereas all in the former group presumably are, given that they have registered for Want2Work. Column 2 therefore introduces a dummy variable indicating individuals who are looking for work, which therefore takes the value of 1 for all Want2Work participants. It can be seen that this has a large effect on the estimated Want2Work coefficient, reducing it substantially. Thus, when Want2Work participants are compared to QLFS respondents *who are seeking work* and have other similar characteristics, they are 3.2 percentage points more likely to move into job. This effect is still statistically significant.

¹⁷ A reservation wage is the minimum wage that an individual will accept to persuade them to accept a job.

58. Most of the other coefficients in column 2 are similar to their counterparts in column 1, suggesting that most of the observed differences between groups in finding a job are not due to differences in job seeking behaviour. An exception to this is the male coefficient, which becomes tiny and statistically insignificant, suggesting that when men are compared to women who are actually looking for work, the difference in their re-employment likelihoods is minimal.

59. Table 2.7 analyses the determinants of annual earnings for those who obtain a full-time job in the pooled sample, again using the two methods for dealing with the grouped nature of the wage information. The coefficient on the Want2Work variable is negative in both models, suggesting that Want2Work participants who obtain a job earn £900-£1,700 per annum less on average in that job than similar respondents in the QLFS. One possible reason for this finding is that, given that they receive a Return To Work Credit Payment, Want2Work participants are more willing to accept a lower wage from an employer, given it will be topped up by the credit.

60. As before with the Want2Work sample on its own, few of the other coefficients in the estimated wage equations are statistically significant, due to the small sample size and the lack of variation in the wage data across the sample. The statistically significant effects that do emerge suggest that earnings rise with qualifications, with those qualified to NQF Level 5 earning around £4,000 more per annum on average after moving out of unemployment, relative to those with no qualifications. Males in this pooled sample earn £3,000-£4,500 more than women on average, holding other things constant, whilst there is also evidence that young people, single parents and those who had been out of work for a long time all accept lower wages if they move into work.

2.5.2 Propensity Score Matching Results

61. We move now onto the results of the propensity score matching (PSM) analysis of the impact of Want2Work, which has certain benefits over the standard regression-based analyses of the previous sub-section, as discussed in Section 2.2 above. Propensity score matching techniques do not report estimated effects for the control variables, which is why the probit equations showing these effects were reported above. From this point onwards, therefore, only the effect of Want2Work will be reported. For each specification, the results from two propensity score analyses will be presented, using one-to-one (nearest neighbour) and kernel matching respectively. As intuition and previous results both suggest that the group of QLFS respondents who want a job and are looking for a job are the most similar to the Want2Work participants, and

so form the most appropriate control group, *the QLFS respondents are restricted to the group of job-seekers only, in all results in this section from this point on.*

62. The first panel in Table 2.8 considers the full combined Want2Work and job-seeking QLFS sample. The first row of results concerns movement into any employment at any point, regardless of type of job and duration. The results show that those who participated in Want2Work are 5.3-8.3 percentage points more likely to move into employment than similar job-seekers in the QLFS control group. The main result of the analysis is therefore robust to whether probit or PSM analysis is used. The key finding of the report, that involvement in Want2Work has a large impact on the likelihood of moving into employment, therefore remains. This effect is both statistically and economically significant.

63. So far in the analysis of employment effects, any job that individuals find has been considered, regardless of its quality. One possibility to explain their higher rate of moving into work is that Want2Work participants might be accepting jobs of lower quality. Two indicators of job quality that are available to us in both the Want2Work database and the QLFS, other than wages which are considered later, are whether or not the job acquired is full-time¹⁸, and whether or not the job acquired is permanent, or temporary and time-limited in some way. The second and third rows of results consider these two possibilities in turn. The results show a larger Want2Work effect on the probability of obtaining a permanent job than obtaining any job, with Want2Work participants being 10-11 percentage points more likely to acquire a permanent job than QLFS job-seekers. There is therefore no evidence that Want2Work is placing participants into casual jobs, in order to increase re-employment rates. When the analysis focuses on full-time jobs only, the results are slightly smaller than for ‘any jobs’, with Want2Work participants being 6-7 percentage points more likely to move into full-time work than job-seekers in the QLFS (compared to effects in the range 5-8 percentage points for any jobs).

64. One caveat still remains with the results presented in the first panel of Table 2.8, however, which could have loaded the results in favour of Want2Work. Individuals respond to the QLFS for five successive quarters, meaning that respondents in the QLFS control group are observed for a maximum of 15 months. Want2Work participants, however, are observed joining the scheme any time between the beginning of 2005 and the end of 2007, and so could be observed for a lot longer than 15 months, thus giving them more time to be observed finding a job, relative to the QLFS out-of-work respondents. It could be this additional time available to them that is

¹⁸ A full-time job is defined as one that involves 30 hours or more per week.

driving the positive impact of Want2Work on the likelihood of finding a job. To allow for this, we created a new dependent variable that took the value of 1 if the Want2Work participant obtained a job within a maximum of 15 months of joining the scheme, to make the comparison with the control group more equal. Thus, anyone we obtained a job through Want2Work, but took longer than 15 months to do so was regarded as being unsuccessful, on the basis of this new variable. In actual fact, this meant that the analysis was now loaded against the Want2Work participants, who if they joined the scheme in 2007 (which is 45% of the Want2Work sample) were observed for fewer than 12 months, whereas the individuals in the QLFS control group are observed for a minimum of 12 months, and so had longer to find a job than these late-comers to Want2Work. Any positive results that emerge for Want2Work in such circumstances can therefore be taken to be particularly strong results.

65. The second panel in Table 2.8 shows the results of this analysis. In actual fact, the results are not too dissimilar to those in the first panel. This is because, of the 1,917 respondents who obtained a job through Want2Work, all but 69 did so within 15 months anyway. Considering the ‘any job’ results in the first row, the estimated marginal effects are each 1 percentage point lower than the equivalent marginal effects for the uncensored sample in the first panel. Thus, Want2Work participants are 4-7 percentage points more likely to obtain a job *within 15 months* than similar job-seekers in the QLFS. This estimate is the most conservative estimate produced in the report, taking account of as many differences between treatment and control groups as possible, and so is our preferred result, highlighted in bold.

66. Limiting the Want2Work participants to 15 months to find a job does have a larger impact on the marginal effects for finding a permanent or full-time job, relative to the uncensored results in the first panel, with falls of 3-4 percentage points in the marginal effects between panels. Perhaps Want2Work is more successful in moving individuals into permanent and/or full-time jobs when more time is available to work with the individuals. However, the permanent and full-time effects in the second panel are still positive and statistically significant, suggesting that Want2Work participants are still more likely to move into a permanent or full-time job than similar job-seekers in the QLFS, even when given a maximum of 15 months to do so.

67. The analyses in the third and fourth panels of Table 2.8 repeat the analyses of the first two panels, but restrict the sample to those on Incapacity Benefits only. The original target group of the Want2Work scheme was those individuals in receipt of IB, and an important aspect of the scheme is the availability of health care professionals to provide advice and support to help IB-

recipients overcome their difficulties and find suitable work. It might be expected, therefore, that if Want2Work is successful in helping people into employment, it will be most successful for this specifically-targeted group. The results in the lower 2 panels confirm that this is indeed the case, with all estimated marginal effects being substantially larger than their equivalents in the upper two panels. Thus, the first row in the third panel shows that Want2Work participants who are in receipt of Incapacity Benefits are 14-15 percentage points more likely to move into employment than job-seeking IB-recipients with similar characteristics in the control group. Therefore, Want2Work is particularly effective in helping its target group of IB-recipients back into work. When only movements into jobs within 15 months of registering for Want2Work are considered, for compatibility reasons with the QLFS, Want2Work participants originally in receipt of IB are still 13 percentage points more likely to find a job than their equivalents in the QLFS (panel 4, row 1). The impacts of Want2Work on finding permanent and full-time jobs are similarly larger for IB recipients only than for the full out-of-work population.

68. In summary, the employment effects of Want2Work seem to be particularly strong and robust. No matter what estimation method is used, how the control group is defined, or which types of job are considered, the Want2Work effect turns out to be positive and statistically significant. The evidence does therefore seem generally supportive of the idea that Want2Work has helped people back into employment, with the caveat that the possibility remains that there are unobserved characteristics of individuals who voluntarily sign up for Want2Work that we could not control for and that could make them more likely to find work than the average person out of work in the control group.

69. Full-time/part-time and permanent/temporary status of jobs are two indicators of their quality, but another to be considered is the earnings received by placed workers. The next piece of investigation is therefore a propensity score matching analysis of the earnings received by Want2Work participants who find a job relative to similar QLFS respondents. The results are reported in Table 2.9 for the usual two methods of matching that have been adopted here.¹⁹ As has been found earlier in the report, however, the results of any analysis of earnings produces weak results, because of smaller sample sizes, and little variation in the earnings data across individuals due to their grouped nature. Three of the four estimates in Table 2.9 are negative, suggesting Want2Work participants who find work earn less than similar individuals in the control group who find work, but none of these estimated effects even approach achieving

¹⁹ Only the 'mid-point' method of allowing for banded earnings is consistent with PSM, and so only these results are reported in Table 2.9.

statistical significance. It would therefore seem that there is little difference in annual earnings achieved by the Want2Work and control group participants who find work.

2.5.3 Duration of Jobs

70. All of the analysis presented so far has simply considered whether individuals move into a job or not. No attention has been given to how long they remain in that job. A potential worry is that Want2Work successfully moves its participants into a job, but they do not stay in work very long, and soon end up back in receipt of benefits. This sub-section considers such issues, with the limited information that is available.

71. The Want2Work database contains information on every individual who has participated in Want2Work. The date that they joined the programme is recorded, as is the date that any job started, and the date that they left the programme. In the case of most individuals who obtained a job, the recorded date that they left the programme is after the date that they obtained a job, because they remain classified as ‘on-programme’ whilst they are in receipt of the Return to Work Credit, which can be paid for up to one year. We therefore have information on duration in work, as long as individuals remain part of the programme. Finally, at the point that an individual leaves the programme, for whatever reason including that they are still in work but no longer in receipt of the Return to Work Credit, then their final outcome in terms of labour market status is recorded in the database.

72. In this section we consider all those individuals in the Want2Work database who had obtained a job by the end of 2006, thus allowing them to be observed for up to another 12 months, when the database ended in December 2007. This was 870 individuals. Table 2.10 tabulates their recorded final outcome. As can be seen, the majority (65 percent) are in some form of employment, with virtually all of these in full-time work, rather than part-time work or self-employment. However, it must be pointed out that significant numbers of this group left the Want2Work project soon after finding a job, and so their ‘final outcome’ was determined very soon after they found work. Indeed of the 547 individuals whose final outcome is recorded as a full-time job, 112 (20 percent) left the Want2Work project as soon as they found a job, and so their final outcome was automatically a job. In such cases, we clearly cannot therefore say anything about the duration of the jobs that they found. In addition, there is a lot of missing information, such that for 30 percent of the participants who found work by the end of 2006, their final outcome by the end of 2007 is either not known or not recorded in the database.

73. Of the 870 individuals who obtained a job through Want2Work before the end of 2006, if we omit all individuals for whom the final outcome is not known and not recorded, and also omit all individuals who left the programme fewer than 9 months after obtaining a job, then we are left with 416 individuals for whom final outcome is known, and who remained observed by Want2Work for at least 9 months after finding a job. Of these, 387 (93 percent) were in some form of employment (almost all in full-time employment). Thus, the apparent success of Want2Work in getting people into jobs that last is observed, although there is clearly a worry that we have a 9-month-plus final outcome recorded for only 48% (416/870) of the sample who obtained jobs before the end of 2006. This apparent success could easily be reversed, if we had full information on those individuals who immediately left the programme once they found a job, or for whom a final outcome was not recorded.

74. Whilst acknowledging the problems with the job duration and final outcome data, one natural question is to ask how this 93 percent rate of remaining in work for Want2Work participants compares to the general population of originally inactive job-seekers. The QLFS data can again help us to answer this question. Recall that respondents to the survey are interviewed five times in five successive quarters. By construction, the control group we created was all those who were not in employment when first surveyed by the QLFS. Some will however have moved into employment by the time of their second interview, and it is these people who form our control group for the job duration analysis. Given that they are surveyed a further three times, this means that we observe them for a minimum of a further nine months, and we can therefore observe whether they remain in employment throughout this period.²⁰ We do not consider anyone who first reported moving into work in their third or subsequent interview, because there would not be a suitably long following period in which to observe whether they remain in work. A similar period is therefore used for both treatment and control groups, to observe whether individuals remain classified as employed. The measures differ in that the Want2Work participants are observed continuously, whilst the QLFS respondents are only observed at three month intervals. Potentially, the latter group could have been out of employment, and subsequently found a new job, between the points at which they are observed. The observed duration of employment for this group is therefore an upper bound for their true duration, which means that the Want2Work effect on job duration may be biased downwards, if true duration for control group members is shorter than observed in the QLFS.

²⁰ This is the reason that a nine month gap between finding a job and leaving the project was required for the Want2Work participants when observing whether they stay in employment, to ensure comparability between the Want2Work sample and the QLFS control group.

75. In the QLFS sample of out-of work respondents in their first interview, across all our five cohorts, 684 individuals have moved into work by the time of their second interview. Of these, 506 (74 percent) remain in a job for the succeeding three quarters that they are interviewed. This is clearly less than the 93 percent of Want2Work respondents who remain in work for at least nine months, and this difference is strongly statistically significant.

76. Table 2.11 reports the results of a probit analysis, investigating the probability of remaining in work for at least nine months, estimated for the combined Want2Work – QLFS sample. Given the raw data above, a positive Want2Work effect would be expected, and this is indeed observed. The estimated effect of Want2Work participants being 25 percentage points more likely to remain in employment is greater than the 19 percentage point difference in the raw data, suggesting that on average Want2Work participants had characteristics unfavourable to continuing employment. The estimated effects for these other characteristics are mostly statistically insignificant, which could be caused by the small sample size. A few statistically significant relationships emerge, such as middle-aged individuals are more likely to have a long duration job than both young and old individuals. Individuals with no qualifications are the least likely to still be in work nine months or more after finding a job. Finally, the likelihood of remaining in work is higher in districts with a higher unemployment rate. Presumably this is due to the greater fear of not finding another job persuading individuals to stay in the job they have, in higher unemployment areas.

77. We also ran a version of the probit equation in Table 2.11 for the Want2Work sample only, which allowed us to investigate for whom Want2Work worked best in terms of getting into long-lasting jobs. Unfortunately, due to the very small sample size, almost all estimated coefficients were statistically insignificant, the exceptions being a negative effect for males, and a positive effect of living in higher unemployment districts. Amongst the statistically insignificant results was a new variable that we introduced to indicate Want2Work participants in receipt of the Return to Work Credit. Such individuals were apparently no more likely to remain in their jobs than those who were not receiving this credit.

78. A second method of investigating job duration available to us is to use the data in the second postal survey. The sample for this survey was all individuals identified in the original Want2Work database as being in employment at the end of 2006. This was 804 people. The survey took place in February 2008, and asked whether the respondents were still in work, and if so whether the job was the same one that they had acquired through Want2Work. The response

rate to the survey was 16% (131/804). Given such a low response rate, it is important to check how representative the respondents were of all people who found jobs through Want2Work by the end of 2006. The respondents were on average older than the full surveyed sample (an average age of 41 compared to 35), better educated (45% having no qualifications, compared to 51%), less likely to be from an ethnic minority (6% compared to 12%), and less likely to have never worked or to have been out of work for a long time. Although the differences are not large, it has to be acknowledged that they are all working in favour of the respondents, and so the likelihood of staying in a job amongst the survey respondents may not be representative of this probability amongst all Want2Work participants who find a job.

79. Of the second survey respondents, 67% had worked in the previous week, with another 5% typically working but having been away that week. Consistent with the above results, there is therefore substantial persistence in the Want2Work employment effect, even after the Return to Work Credit has ended. Recalling that the respondents were surveyed in February 2008, and had been in work at the end of 2006, it will be a minimum of 13 months (and for most significantly longer) since they obtained their Want2Work jobs. Of course, this does not mean that they are in the same job, and may have been in a succession of temporary jobs. However, answers to a further question revealed that, of those with a job in February 2008, 73% were working in the same job that they obtained through Want2Work. Thus, although there is a question mark about the representativeness of the data, such a large figure suggests that Want2Work is successful in getting workers into long-term, permanent jobs.

80. A probit equation was estimated, to determine whether remaining in a job was related to any of the characteristics of the survey respondents. The results are displayed in Table 2.12. Given the small sample nature of the exercise (131 observations) the importance of the results should not be over-emphasised. They show that older individuals are more likely to have remained in work (contrary to the results using the Want2Work database and the QLFS above). There are strong education effects, such that those respondents with no qualifications are less likely to have remained in employment. The results on the Return to Work Credit receipt variable suggest that this benefit is positively related to remaining in employment, although the coefficient just fails to attain statistical significance at the 10% level.

81. Finally in this section, other questions on the second survey revealed the following information about the jobs being held at the time of the survey. Of those in work, 15% were self employed, with the largest employers (by sector) being retail, healthcare, and the public sector

(12% each). 56% of those working earned less than £10,000 a year, with only 3% earning above £20,000 per year. 8% of working respondents typically did so for fewer than 15 hours a week, with 36% working between 15-29 hours, 49% working between 30-44 hours, and 8% working 45 hours or more. 54% of individuals had received training through their current job.

2.6 Summary and Conclusion

82. This section has evaluated the success of the Want2Work programme in Wales, focussing on the likelihood of participants moving into employment following their involvement in the programme. The evaluation was performed by comparing the outcomes for Want2Work participants to those of 'similar' people in terms of their observable characteristics, with a long list of such control variables available to us. The evidence produced is convincing, and supportive of Want2Work. Using a range of estimation methods, different sub-samples, and different types of job, the Want2Work participants consistently come out as being more likely to move into employment, compared to individuals in the control group. The size of the effect varies according to the specification being considered, but is always statistically significant. Our preferred specification is the most conservative one; allowing Want2Work participants a maximum of 15 months to find a job (as this is the longest that we can observe individuals in the control group), and comparing them to out-of-work QLFS respondents who say that they actually want a job, the Want2Work participants are 4-7 percentage points more likely to move into employment. Given that only around 1 in 5 people across the two datasets obtained a job (or 1 in 3 people actually looking for work obtained a job), this Want2Work effect is sizeable, and suggests a favourable role for Want2Work. Further evidence suggests that Want2Work is particularly successful in terms of employment for individuals initially in receipt of Incapacity Benefit. In terms of the type of job accepted, the Want2Work effect is slightly weaker for obtaining full-time work than for obtaining any job in the case of former Incapacity Benefit claimants. Even in this case, however, the Want2Work effect compared to the control group is strongly positive. In terms of earnings, there is some evidence that Want2Work participants accept lower wage jobs than members of the control group, though this difference is not statistically significant. Finally, although the quality of the data tracking individuals over time is not high, with many individuals having missing data in the database or not responding to follow-up postal questionnaires, the information that is available suggests that a large majority of Want2Work participants who find work move into stable jobs that last for a significant period. Their likelihood of finding a long-lasting job appears significantly higher than that of individuals in the control group.

83. The Want2Work effect can be compared to other Active Labour Market Policies recently used in the UK. The most similar is Pathways to Work, described above in the introduction (paragraph 5). Pathways has been evaluated, for example by Adam *et al.* (2006), who collected data via a telephone survey from individuals who made an enquiry about IB in either pilot or selected non-pilot areas, in both cases both before and after the introduction of Pathways. They could therefore derive a difference-in-difference estimator, comparing the difference in the re-employment rates between pilot and non-pilot areas after the introduction of Pathways, to the same difference between areas before the introduction of Pathways. By observing the inter-area difference before the programme was introduced, then any unobserved differences between the regions can be controlled for. Their results showed that, amongst those beginning a claim for IB, Pathways increased the percentage in employment 10½ months later by an estimated 9.4 percentage points, from a base of just 22.5 percent.

84. This work was extended by Bewley *et al.* (2007), who considered a longer time period of eighteen months after the initial enquiry into receiving IB. Using a similar methodology to Adam *et al.* (2006) of surveys in pilot and non-pilot areas before and after programme introduction to derive a difference-in-difference estimator, Bewley *et al.* (2007) found that Pathways increased the probability of an initial IB claimant being in work eighteen months later by 7.4 percentage points, from a base of 29.7 percent in the absence of the policy. This effect and base re-employment rate are almost identical to the ones estimated above for Want2Work in our preferred specification. One difference, however, is that Want2Work is for all individuals regardless of the duration of current joblessness, whereas these results for Pathways are for new claimants only, who we know from the results presented above are more likely to find a job. However, a further report by Bewley *et al.* (2008) also considered the impact of Pathways on *existing* IB claimants. Their core result showed that if an existing claimant had a Work-Focussed Interview this reduced the probability of still being out of work by 3.5 percentage points eighteen months later, from 97.2 percent to 93.7 percent. Thus, the impact of Pathways for existing IB claimants is smaller than the impact of Want2Work estimated for all claimants.

85. A second active labour market scheme that has attracted a lot of attention is the New Deal, and in particular the New Deal for Young People (NDYP). This scheme was piloted in selected areas of the UK in January 1998 and rolled-out nationally in April 1998. NDYP is a compulsory scheme for young people aged 18-24 who have been out of work for 6 months. The scheme involves an initial ‘Gateway’ period of around 4 months, where job search help is provided by an advisor. If the participant fails to obtain a job in this period, they can spend up to one year in one

of four options; a period of education and training, a subsidised job, a job in the voluntary sector or work with an environmental task force. If a permanent job is still not obtained after participating in an option, a further ‘follow through’ period with an adviser is undertaken.

86. Again, a number of evaluations of NDYP have been undertaken. Blundell *et al.* (2004) conducted a difference-in-difference analysis, where the control group consisted of individuals with similar observed characteristics and living in the same area, but aged just over 24 and so not eligible for NDYP. They only studied the impact of the initial four month Gateway period, and found that participating in the Gateway increased male individuals’ prospects of having moved into employment four months later by 5 percentage points, against a base of 26 percent. De Giorgi (2005) added to these results by considering the probability of re-employment 18 months after beginning an unemployment spell, and so considered the impact of the period spent on an option, as well as the Gateway period considered by Blundell *et al.* (2004). He adopts a similar procedure to the latter paper, using a difference-in-difference approach with those individuals aged just over 24 and so not eligible for NDYP as the control group. His results show NDYP participation increased the male re-employment probability after eighteen months by 4.6 percentage points. The results of both of these studies for NDYP are therefore very similar to the estimated impact of Want2Work, falling towards the lower end of the estimated range of the Want2Work impact in our preferred specification (4-7 percentage points). It can therefore be concluded that Want2Work has been at least as effective in its labour market outcomes as other UK Active Labour Market Policies, and probably slightly more effective.

Section 2 Tables

Table 2.1: Labour Market Outcomes for the Treatment and Control Group

a) Employment Incidence (percent)

	Percentage that got a job	N
Want2Work	29.8%	6424
- IB only	29.0%	3836
- other benefits	25.1%	1367
- no benefits	37.8%	1221
QLFS	18.7%	8994
- IB only	4.4%	3027
- other benefits	21.9%	1495
- no benefits	26.6%	4611
QLFS seeking work	31.9%	3427
- IB only	8.3%	882
- other benefits	31.1%	909
- no benefits	43.8%	1689
DWP (all)	13.8%	2,231,841
DWP (IB only)	19.6%	697,470
DWP (Torfaen only)	15.0%	5017

b) Annuals Earnings (percent in each pay band)

Gross Annual Pay	Want2Work Participants	QLFS
<£10000	54.7%* [0.011]	61.8% [0.017]
£10000-14999	35.4%* [0.011]	16.7% [0.013]
£15000-19999	7.7% [0.006]	8.4% [0.010]
£20000-29999	1.7%* [0.003]	7.3% [0.009]
£30000+	0.5%* [0.002]	5.8% [0.008]
N ^a	1901	838

Note: Standard errors in square brackets.

* denotes different from the QLFS at the 5% level.

a In full time employment with earnings reported.

QLFS is the GB Quarterly Labour Force Survey

Table 2.2 Sample Means for the Want2Work participants and the QLFS

	Want2Work Participants (treated)		QLFS (control group)		QLFS – seeking work only (control group)	
Variable	Mean	Std. Dev.	Mean	Std. Dev.	Mean	Std. Dev.
Age 16-19	0.077	0.267	0.052***	0.223	0.081	0.272
Age 20-24	0.149	0.357	0.069***	0.253	0.088***	0.284
Age 25-29	0.145	0.352	0.075***	0.264	0.088***	0.284
Age 30-34	0.124	0.329	0.101***	0.301	0.110*	0.312
Age 35-39	0.137	0.344	0.121***	0.327	0.125*	0.331
Age 40-44	0.130	0.336	0.114***	0.318	0.126	0.332
Age 45-49	0.102	0.303	0.105	0.306	0.105	0.307
Age 50-54	0.073	0.261	0.118***	0.323	0.109***	0.312
Age 55-59	0.052	0.222	0.175***	0.380	0.115***	0.319
<i>Age 60 plus</i>	0.010	0.100	0.070***	0.254	0.052***	0.222
Highest Qualification: NQF5	0.041	0.197	0.090***	0.285	0.104***	0.305
Highest Qualification: NQF4	0.020	0.138	0.053***	0.224	0.050***	0.219
Highest Qualification: NQF3	0.093	0.290	0.160***	0.367	0.177***	0.381
Highest Qualification: NQF2	0.196	0.397	0.224***	0.417	0.244***	0.429
Highest Qualification: NQF1	0.154	0.361	0.137***	0.344	0.155	0.362
<i>No Qualifications</i>	0.497	0.500	0.337***	0.473	0.270***	0.444
Male	0.495	0.500	0.361***	0.480	0.453***	0.498
Illness: Cardio	0.025	0.157	0.117***	0.321	0.107***	0.309
Illness: Learning	0.017	0.128	0.033***	0.177	0.030***	0.172
Illness: Mental Health	0.250	0.433	0.085***	0.279	0.074***	0.261
Illness: musculoskeletal	0.192	0.394	0.198	0.398	0.185	0.388
Illness: Other	0.126	0.332	0.105***	0.307	0.095***	0.293
Illness: Respiratory	0.019	0.135	0.051	0.220	0.056***	0.230
<i>Illness: None</i>	0.371	0.483	0.411***	0.492	0.453***	0.498
Single Parent	0.211	0.408	0.159***	0.366	0.196*	0.397
Non-white	0.100	0.299	0.120***	0.325	0.112	0.316
Never worked	0.053	0.225	0.156***	0.362	0.125***	0.331
Last worked 0-6 months ago	0.209	0.406	0.103***	0.305	0.193***	0.395
Last worked 6-12 months ago	0.108	0.311	0.059***	0.236	0.088***	0.284
Last worked 12-24 months ago	0.118	0.323	0.085***	0.280	0.113	0.317
Last worked 2-5 years ago	0.257	0.437	0.168***	0.374	0.159***	0.366
Last worked 6-10 years ago	0.147	0.355	0.192***	0.394	0.162**	0.368
Last worked 11-15 years ago	0.071	0.257	0.111***	0.314	0.090***	0.286
Last worked 16-20 years ago	0.018	0.132	0.056***	0.231	0.037***	0.189
Last worked more than 20 years ago	0.018	0.132	0.068***	0.252	0.032***	0.177
Regional unemployment rate	0.059	0.021	0.049***	0.026	0.050***	0.026
Incapacity benefit in first period	0.598	0.490	0.342***	0.475	0.262***	0.440
Income Support in first period	0.192	0.393	0.095***	0.293	0.108***	0.311
Claiming other benefit in first period	0.019	0.138	0.078***	0.268	0.163***	0.370
No benefit in first period	0.190	0.393	0.502***	0.500	0.483***	0.500
Has disability	0.505	0.500	-	-	-	-
Welsh speaker	0.029	0.168	-	-	-	-
Ex offenders	0.047	0.211	-	-	-	-
Drug/drink mis-users	0.055	0.228	-	-	-	-
Number of observations	6424		8994		3427	

Note: QLFS is the GB Quarterly Labour Force Survey

Asterisks denote statistically different proportions from the treatment group where * is significant at 10%, ** is significant at 5% and *** is significant at the 1% level.

Variables that form the excluded categories in the estimated relationships are shown in italics.

Table 2.3 ‘Soft Outcomes’ of Want2Work Participants

Outcome	Percentage of Participants
In-work training	1.1%
Voluntary work	3.3%
Work-based learning for adults	1.3%
Other training	12.8%
Further Education	1.8%
Basic skills training	0.8%
Work Placement	0.5%
Community group involvement	0.5%
Work preparation	0.7%

Table 2.4 Employment Probit (Marginal Effects) - Want2Work Participants Only

	Employment	Employment
Age 16-19	-0.055	-0.055
Age 20-24	0.042	0.040
Age 25-29	0.044	0.043
Age 30-34	0.048	0.049
Age 35-39	0.057	0.057
Age 40-44	0.057	0.055
Age 45-49	0.039	0.037
Age 50-54	0.043	0.046
Age 55-59	-0.006	-0.004
Highest Qualification: NQF5	0.020	0.025
Highest Qualification: NQF4	0.045	0.043
Highest Qualification: NQF3	0.041**	0.041**
Highest Qualification: NQF2	0.009	0.011
Highest Qualification: NQF1	0.015	0.015
Male	-0.003	-0.006
Illness: Cardio	-0.000	0.000
Illness: Learning/blind/deaf etc	-0.073	-0.075
Illness: Mental Health	-0.011	-0.010
Illness: musculoskeletal	0.025	0.023
Illness: Other etc	-0.030	-0.029
Illness: Respiratory	-0.080*	-0.079*
Single parent	0.035*	0.033*
Non-white	0.061***	0.060***
Never worked	0.010	0.005
Last worked 6 months ago	0.248***	0.240***
Last worked 6-12 months ago	0.179***	0.174***
Last worked 12-24 months ago	0.125**	0.118**
Last worked 2-5 years ago	0.044	0.038
Last worked 6-10 years ago	0.025	0.018
Last worked 11-15 years ago	-0.013	-0.018
Last worked 16-20 years ago	-0.004	-0.009
Regional Unemployment rate	-0.333	-0.375
Incapacity type benefit in first period	-0.036	-0.034
Income support benefit in first period	-0.082***	-0.082***
Other benefit in first period	-0.101***	-0.105***
Disability	0.014	0.013
Welsh Speaker	0.016	0.016
Ex-offenders	-0.026	-0.029
Drug and Alcohol Mis-users:	-0.056**	-0.052**
Voluntary work		-0.029
Work-Based Learning for Adults		0.037
Other training		0.059***
Further Education		-0.125***
Basic skills training		-0.082
Work placement		0.135*
Community group		-0.106
Work preparation		-0.031
Observations	6424	6424

* significant at 1%, ** significant at 5%, *** significant at 1%

Table 2.5 Earnings Equations for the Want2Work Participants
Dependent Variable = Actual Value of Annual Earnings

	Interval Regression	Mid Points
Age 16-19	-2,211.333*	-1,777.456*
Age 20-24	-1,203.575	-1,151.024
Age 25-29	-955.622	-1,018.130
Age 30-34	-150.393	-237.975
Age 35-39	-409.165	-469.189
Age 40-44	-651.397	-797.468
Age 45-49	-496.170	-500.001
Age 50-54	-389.583	-553.362
Age 55-59	-29.641	-433.588
Highest Qualification: NQF5	1,291.143**	539.050
Highest Qualification: NQF4	-767.902	-542.760
Highest Qualification: NQF3	515.064	269.822
Highest Qualification: NQF2	712.082**	520.275**
Highest Qualification: NQF1	120.503	123.070
Male	2,940.563***	1,964.971***
Illness: Cardio	261.742	-40.441
Illness: Learning/blind/deaf etc	-997.330	-724.302
Illness: Mental Health	445.118	119.178
Illness: musculoskeletal	959.726*	491.271
Illness: Other etc	413.877	153.869
Illness: Respiratory	2,285.463**	1,453.626*
Single parent	-874.551**	-504.356*
Non-white	-106.527	-280.639
Never worked	1,064.473	173.021
Last worked 6 months ago	1,695.596	843.754
Last worked 6-12 months ago	1,190.806	511.677
Last worked 12-24 months ago	1,280.057	537.879
Last worked 2-5 years ago	530.857	101.825
Last worked 6-10 years ago	393.968	-89.119
Last worked 11-15 years ago	-1,729.413	-1,042.031
Last worked 16-20 years ago	-1,505.193	-742.749
Regional Unemployment rate	-2,202.207	-3,252.282
Incapacity type benefit in first period	97.815	171.430
Income support benefit in first period	-219.087	-137.851
Other benefit in first period	225.608	-194.788
Disability	-947.643***	-671.566**
Welsh Speaker	-101.536	-245.796
Ex-offenders	949.470	734.054
Drug and Alcohol Mis-users:	-277.254	-476.242
Permanent job	-143.196	35.200
Constant	7,681.517***	11,309.431***
Observations	1884	1884
R-squared		0.12

* significant at 1%, ** significant at 5%, *** significant at 1%

Table 2.6 Employment Probit (Marginal Effects) for the Combined Sample

	Not controlling for whether the QLFS control group are seeking work	Including a control for whether the QLFS control group are seeking work
Want2Work participants	0.113***	0.032***
Age 16-19	0.213***	0.174***
Age 20-24	0.224***	0.200***
Age 25-29	0.199***	0.177***
Age 30-34	0.218***	0.192***
Age 35-39	0.220***	0.198***
Age 40-44	0.242***	0.214***
Age 45-49	0.218***	0.196***
Age 50-54	0.185***	0.164***
Age 55-59	0.104***	0.101***
Highest Qualification: NQF5	0.138***	0.129***
Highest Qualification: NQF4	0.071***	0.069***
Highest Qualification: NQF3	0.063***	0.058***
Highest Qualification: NQF2	0.048***	0.045***
Highest Qualification: NQF1	0.031***	0.025**
Male	0.021***	0.006
Illness: Cardio	-0.047***	-0.051***
Illness: Learning/blind/deaf etc	-0.064***	-0.068***
Illness: Mental Health	-0.022*	-0.026**
Illness: musculoskeletal	-0.009	-0.014
Illness: Other etc	-0.045***	-0.047***
Illness: Respiratory	-0.034*	-0.039**
Single parent	0.062***	0.050***
Non-white	-0.027**	-0.026**
Never worked	0.098***	0.091***
Last worked 6 months ago	0.361***	0.309***
Last worked 6-12 months ago	0.267***	0.225***
Last worked 12-24 months ago	0.198***	0.160***
Last worked 2-5 years ago	0.107***	0.082***
Last worked 6-10 years ago	0.051**	0.032
Last worked 11-15 years ago	0.023	0.005
Last worked 16-20 years ago	-0.008	-0.016
Regional Unemployment rate	-0.395***	-0.456***
Incapacity type benefit in first period	-0.088***	-0.086***
Income support benefit in first period	-0.114***	-0.117***
Other benefit in first period	0.035**	-0.015
Seeking work		0.150***
Observations	13921	13921

* significant at 1%, ** significant at 5%, *** significant at 1%

Table 2.7 Earnings Equations for the Combined Sample
Dependent Variable = Actual Value of Annual Earnings

	Interval Regression	Mid Points
Want2work participants	-930.224**	-1,743.716***
Age 16-19	-4,009.636***	-2,968.906***
Age 20-24	-2,332.384*	-2,007.948*
Age 25-29	-1,911.769	-1,755.128*
Age 30-34	-771.608	-588.576
Age 35-39	-630.580	-555.412
Age 40-44	-840.800	-742.729
Age 45-49	-898.462	-622.851
Age 50-54	-361.144	-444.389
Age 55-59	-641.927	-1,022.360
Highest Qualification: NQF5	4,153.613***	3,697.962***
Highest Qualification: NQF4	-542.332	-520.810
Highest Qualification: NQF3	1,542.258***	897.610***
Highest Qualification: NQF2	792.532**	478.804*
Highest Qualification: NQF1	258.892	118.326
Male	4,544.851***	3,015.310***
Illness: Cardio	-1,053.857	-1,015.437
Illness: Learning/blind/deaf etc	-3,306.316**	-2,578.020***
Illness: Mental Health	-711.563	-774.190**
Illness: musculoskeletal	-303.207	-597.834
Illness: Other etc	-509.108	-538.269
Illness: Respiratory	-235.330	-873.071
Single parent	-1,240.139**	-610.545*
Non-white	-183.942	-442.814
Never worked	3,266.700**	1,226.821
Last worked 6 months ago	4,021.302***	2,084.489**
Last worked 6-12 months ago	3,173.472**	1,661.921*
Last worked 12-24 months ago	3,313.851**	1,509.262
Last worked 2-5 years ago	2,156.969	974.490
Last worked 6-10 years ago	1,772.258	637.291
Last worked 11-15 years ago	-942.574	-487.297
Last worked 16-20 years ago	676.618	375.005
Regional Unemployment rate	-2,808.945	-3,057.547
Incapacity type benefit in first period	-57.642	-13.241
Income support benefit in first period	-209.141	-34.978
Other benefit in first period	951.008	883.918
Permanent job	49.817	303.063
Constant	5,665.520***	11,853.656***
Observations	2363	2363
R-squared		0.18

* significant at 1%, ** significant at 5%, *** significant at 1%

Table 2.8 Propensity Score Estimates of the Want2Work Participation Effect on the Probability of Moving into Work, Compared to a Control Group of Job-Seekers in the QLFS

<i>Full Sample</i>			
	Propensity Score (one2one)	Propensity Score (Kernel)	N
Any job	0.053***	0.083***	9342
Permanent job	0.106***	0.104***	9249
Full-time job	0.070***	0.083***	9342
<i>On Want2Work scheme < 15 months</i>			
	Propensity Score (one2one)	Propensity Score (Kernel)	N
Any job	0.043**	0.073***	9342
Permanent job	0.067***	0.062***	9249
Full-time job	0.041***	0.041***	9342
<i>IB recipients only</i>			
	Propensity Score (one2one)	Propensity Score (Kernel)	N
Any job	0.141***	0.150***	4686
Permanent job	0.157***	0.159***	4678
Full-time job	0.098***	0.115***	4686
<i>IB recipients only and on Want2Work scheme < 15 months</i>			
	Propensity Score (one2one)	Propensity Score (Kernel)	N
Any job	0.125***	0.134***	4686
Permanent job	0.144***	0.146***	4678
Full-time job	0.089***	0.106***	4686

* significant at 1%, ** significant at 5%, *** significant at 1%

Table 2.9 Propensity Score Estimates of the Want2Work Participation Effect on Earnings

	Propensity Score (one2one)	Propensity Score (Kernel)	N
Full Sample	-1137.45	-649.51	2584
IB only	65.18	-1009.65	1135

* significant at 1%, ** significant at 5%; *** significant at 1%

Table 2.10 Tabulation of Final Outcomes for Want2Work Participants who found a Job before the End of 2006

Final Outcome	Frequency	Percent
Full-time job	547	62.9%
Part-time job	11	1.3%
Self-employment	8	0.9%
Further Education	2	0.2%
Return to benefits	24	2.8%
Other	18	2.1%
Not known	16	1.8%
No recorded final outcome	244	28.1%
Total	870	100%

Table 2.11: Probit (Marginal Effects) Investigating the Probability of Remaining in Work, Having Found a Job

	Still in employment
want2work participants	0.254***
Age 16-19	0.017
Age 20-24	0.020
Age 25-29	0.073
Age 30-34	0.107**
Age 35-39	0.128***
Age 40-44	0.056
Age 45-49	0.102**
Age 50-54	0.105**
Age 55-59	0.039
Highest Qualification: NQF5	0.048
Highest Qualification: NQF4	0.066
Highest Qualification: NQF3	0.033
Highest Qualification: NQF2	0.036
Highest Qualification: NQF1	0.074**
Male	-0.025
Illness: Cardio	-0.024
Illness: Learning/blind/deaf etc	-0.161
Illness: Mental Health	-0.130*
Illness: musculoskeletal	-0.091*
Illness: Other etc	-0.063
Illness: Respiratory	-0.066
Single parent	0.011
Non-white	-0.018
Never worked	0.057
Last worked 6 months ago	0.084
Last worked 6-12 months ago	0.000
Last worked 12-24 months ago	0.018
Last worked 2-5 years ago	-0.018
Last worked 6-10 years ago	0.044
Last worked 11-15 years ago	-0.118
Last worked 16-20 years ago	-0.075
Regional Unemployment rate	1.261***
Incapacity type benefit in first period	-0.025
Income support benefit in first period	-0.055
Other benefit in first period	-0.031
Observations	987

* significant at 1%, ** significant at 5%; *** significant at 1%

3. Health Outcomes and Other Results from the Postal Surveys

3.1 Introduction

87. This section of the Want2Work evaluation considers extra information on the health, satisfaction and related outcomes of the Want2Work participants. Additional quantitative information was provided by two self-completed postal surveys sent to Want2Work participants; the first in May 2007 and the second in February 2008. The first survey was particularly focused on respondents' health, their satisfaction with various aspects of their life and also on their opinions about Want2Work. The second survey asked follow-up questions on health, satisfaction with life and recent labour market experience. Unfortunately very little baseline health information was available in the Want2Work database, and this severely limits the causal inferences that can be made concerning health impacts. We have focused on descriptive analyses that might shed some light on potential causal relationships, while the qualitative work in the subsequent section will also help with this inference. Thus, we consider changes in self-reported health from the follow-up survey and relate these to labour market experience, but because of the selected nature of the sample of respondents we cannot infer causality from labour market experience to health change (for more detail see the methodology section below).

3.2 Survey and Data

88. Two postal questionnaires were designed to obtain information on health and labour market outcomes for Want2Work clients. The questionnaires are reproduced in Appendix 1 and 2. The first questionnaire was administered in May 2007; it consisted of a series of surrogate, attitudinal outcomes provided by Want2Work, health questions based on the British Household Panel Survey (BHPS) and the SF-6D health status measure (see below), followed by labour outcomes, childcare questions, life satisfaction questions, and general belief questions based on the BHPS.

89. Following concerns over the length of the initial draft of this questionnaire a piloting sample of 200 clients was identified across a range of Welsh regions. Sampling was conducted in January-March 2007 to test the response rate to this longer form questionnaire against a shorter questionnaire that removed all details on childcare and NHS contact. Removing those forms returned to sender, the response rate to the long-form questionnaire was 22% (20/92), as against 19% (18/95) in the short-form questionnaire. Following piloting, the long form questionnaire

was adopted with two sections modified (one simplified, one removed) in response to the higher rates of missing data in certain questions observed in the full version of the questionnaire.

90. The main survey was delayed, due to elections, until May 2007, with the reminder sent out in July. Respondents were entered into a draw for a total of £100 in Tesco vouchers (1x£50 and 2x£25). A total of 3265 individuals were surveyed in the main survey²¹. The 200 clients surveyed in the pilot were not re-sampled.

91. Following the reminder questionnaire, 540 valid responses were received, a response rate of 17% (540/3265) of the non-piloted Want2Work clients. (The response rate would be higher if 'returned-to-sender' questionnaires were removed from the 3265.) Whilst this rate is relatively low, it is likely to be acceptable given the educational and socioeconomic profile of the respondents.

92. The follow up survey was administered in February 2008 to those individuals identified as in employment at the end of 2006 (according to the Want2Work database); it contained questions on health, health change, overall life satisfaction and recent labour market and training experience. A total of 804 clients were surveyed, and 131 responses were received giving a response rate of 16% (a further 28 questionnaires were returned to sender). All the returned cases were usable, with one exception - one individual's data was complete but his stated occupation ("superhero") suggested that the data were unlikely to be reliable. In several other cases the duration of employment in Want2Work -based jobs was requested, but individuals appear to have provided the earliest instance of employment in their current job – up to 36 years previously.

3.2.1 The British Household Panel Survey

93. Many of the questions in the Want2Work surveys were designed to match those of the BHPS. The BHPS is a nationally representative longitudinal survey of individuals within private households²². It includes a rich set of socio-economic variables and in particular contains good information on the health status of respondents, including self assessed general health, specific health problems, GP and hospital visits and whether or not the respondent considers themselves

²¹ The original Want2Work database (documenting the programme to the end of 2006) comprised of 3466 individuals but this figure included one individual who was included twice within the database having left Want2Work in employment but subsequently re-registered three months later. This leaves a usable database of 3465 individuals.

²² For full details see the BHPS website at <http://www.iser.essex.ac.uk/ulsc/bhps/>

to be disabled. In addition in 2004 (and 1999) the BHPS included the Short Form 36 Health Survey, a detailed generic health status instrument (see below). The BHPS started in 1991 and 15 waves (to 2005) were available at the time of our analysis. The first wave achieved a sample of some 5,500 households, covering approximately 10,300 adults from 250 areas of Great Britain. Additional samples of 1,500 households in each of Scotland and Wales were added to the main sample in 1999, and in 2001 a sample of 2,000 households was added in Northern Ireland.

3.2.2 The Short Form 36 Health Survey and the SF-6D

94. The Short Form 36 Health Survey (SF-36) is a standardised questionnaire used to assess patient health across eight dimensions (Ware et al, 1993). It consists of items which present respondents with choices about their perception of their health. The physical functioning dimension, for example, has 10 items to which the patient can make one of three responses: 'limited a lot', 'limited a little' or 'not limited at all'. These responses are coded 1, 2 and 3 respectively and the ten coded responses summed to produce a score from 10 to 30. These raw dimension scores are transformed onto a 0 to 100 scale, which are *not* comparable across dimensions.

95. There is extensive evidence of the ability of these scores to describe the health differences between different patient groups and their ability to detect health changes in populations following intervention (Garratt et al, 1993). However, the method of scoring the SF-36 is not based on preferences. The simple scoring algorithm it uses assumes equal intervals between the response choices (e.g. the change from 'no limitation' to 'limited a little' is regarded as the same the change from 'limited a little' to 'limited a lot'). Furthermore, it assumes the items are of equal importance; for example, being limited in walking has the same importance as being limited in climbing flights of stairs. The evidence has confirmed these concerns with the scoring. Studies have found only low to moderate correlations between these type of measures and preference-based measures (Revicki and Kaplan, 1993). The absence of preference data makes it impossible to undertake any trade-offs between SF-36 dimensions, or between its dimensions and survival and/or cost.

96. A research team at the University of Sheffield in collaboration with Dr. Ware at Boston has estimated a preference-based single index measure of health from the SF-36 (Brazier, Roberts and Deverill, 2002). The index is estimated via a health state classification called the SF-6D derived from the SF-36 and is composed of six multi-level dimensions of health. It was

constructed from a sample of 11 items selected from the SF-36 to minimise the loss of descriptive information. A selection of states defined by the SF-6D has been valued by a representative sample of the UK general population using the ‘standard gamble’ valuation technique²³. Statistical models were estimated to predict single index scores for all health states defined by the SF-6D. The resultant algorithm generates a preference-based index (or utility index) on a continuous scale where one is full health and zero is for states equivalent to death.

97. We included the SF-6D in our first questionnaire (questions 6 to 11), firstly to give us a detailed generic health measure on a continuous scale that could be used in multivariate analysis, and secondly to enable a comparison with population norms for a matched sample from BHPS 2004. This will allow us to see how the Want2Work respondents compare with a representative group of economically inactive people in Wales.

3.3 Methodology

98. In the analysis of labour market outcomes above, the main analytical challenge was to establish an appropriate control group in order to estimate a counterfactual i.e. to estimate what would have happened to the individuals in question had they not participated in Want2Work. The analysis of health outcomes faces a more fundamental problem. We have only extremely limited baseline information on the health of the Want2Work participants (recorded in the database on first contact with Want2Work), and exploratory data analysis reveals that this baseline measure is not comparable to the data collected in our survey, or in the BHPS, thus we cannot investigate health changes as a result of participation in Want2Work.

99. For the analysis of labour market outcomes we know that the individuals were unemployed prior to contact with Want2Work, and we can trace whether or not they find a job after participating in the program. For the analysis of health outcomes we have only one baseline health measure, whether or not the individual has one of the following seven specific health problems:

- cardiovascular
- hearing, speech or visual
- learning difficulty

²³ ‘Standard gamble’ is a method for deriving preferences for different states of health. Respondents are asked to choose between a hypothetical health state and a gamble on alternatives, which are usually complete recovery or death. By varying the probabilities between the two alternatives until the respondent is indifferent between them, we can derive a preference (or value) for the health state.

- mental health
- musculoskeletal
- respiratory
- other

100. In our survey we also asked about specific health problems, but here (as is standard with this type of question), respondents were able to record more than one problem²⁴. As a result the prevalence of problems is much greater in the survey (and the BHPS matched sample) than in the Want2Work database (see Table 3.16) and thus we cannot use these data as an indicator of how health has changed between first contact with Want2Work and the time of the survey (May 2007). The prevalence of health problems found in our survey is very similar to that recorded in the BHPS matched sample (see Table 3.16).

101. It is important to stress the extent to which inference is constrained by the largely cross sectional nature of our health information. As we have no baseline health data for the Want2Work participants we cannot say with any certainty either how the Want2Work scheme or finding a job contributes to health *change*. If we find, for example, a significant positive correlation between the *level* of a respondent's health in mid 2007 and them getting a job, there are three possible reasons for this:

- (i) getting a job causes an improvement in health;
- (ii) people with better health are more likely to get jobs;
- (iii) effects that we do not observe (like the individual's level of motivation) are related both to the probability of getting a job and of having better health.

In reality it is likely that the results we obtain are a reflection of all three of these effects, but with only cross section data on health (measured at one point in time) we cannot distinguish between them.

102. In the absence of causal analysis we focus instead on descriptive analyses that might shed some light on potential causal relationships. Our aims were to assess:

- a) Representativeness of Want2Work sample respondents against the full Want2Work database;
- b) Client views of Want2Work;
- c) Client health and labour outcomes;
- d) The extent to which Want2Work participants differ from a representative sample of the economical inactive in Wales (selected from the BHPS).

²⁴ It is common for economically inactive individuals to have multiple health problems (Bacon, 2002).

103. In addition we use the second, follow-up survey to investigate health changes between May 2007 and February 2008 and relate this to labour market experience. We also consider changes in overall life satisfaction, again relating this to labour market experience. The most we can infer is whether or not health/life satisfaction changes and labour market experiences are associated; we cannot infer the direction of causality.

3.4 Results: First Want2Work Survey

3.4.1 Representativeness of Want2Work survey respondents

104. Table 3.1 compares the full Want2Work database with the 3265 individuals receiving the survey, and with the sample of those returning the survey. Two logistic regressions²⁵ were run predicting firstly inclusion on the final survey (i.e. non-removal at piloting) and predicting whether those receiving the Want2Work survey returned it. Given that responses to the questionnaire were voluntary, those who choose (or choose not) to respond to the questionnaire may differ.

105. The full dataset (n = 3465) and the sample receiving the final version of the questionnaire (n = 3265) are expected to be similar, since those receiving the pilot questionnaire were only stratified by location. No obvious differences exist between the first and second columns of Table 3.1. The logistic regression predicting inclusion in the final survey reveals whether the characteristics will differ between those received the pilot and the full Want2Work sample. The logistic regression does not reveal any significant differences at a 5% level except in the case of those holding NVQ Level 5 as their highest qualification. None of the 13 individuals in this group were piloted, and so all received a questionnaire in the main study. This difference is unlikely to be important.

106. The second and third columns of Table 3.1 highlight the differences in average characteristics between those receiving and responding to the questionnaire. To identify such differences we again used a logistic regression predicting whether or not an individual receiving the questionnaire would respond or not. This regression suggests differences based on the type

²⁵ Logistic regressions are used for models where the dependent variable (for instance, whether a person responded to a survey) falls into one of two cases (responded, didn't respond). Using the observed data on the dependent variable (whether each person responded or not), the model investigates how this depends on a series of independent variables (gender, age etc). The predicted values of a logistic regression are a function of the probability in falling into one case (e.g. of that person responding).

of illness, single parent/carer status, gender and age. Compared to those with no illnesses, those with illnesses other than those specifically named by Want2Work were more likely to respond to the questionnaire (23.3% vs 11.8%). Those who were single parents or had other sole care responsibilities were less likely to respond than those without such responsibility (11.8% vs 17.8%). Men were also significantly less likely to respond to the questionnaire than women (15.2% vs 17.8%). Finally, there was a general pattern in which the response rate tended to increase by age – those aged 16-29 had a response rate of 9.5%, compared to 15.9% for those aged 30-44 and 24.3% for those aged 45 and over.

107. We do not find any evidence that Welsh language speakers, those of non-white ethnicity, those with drink/drug problems, those with low qualifications, those with illness or disability (beyond the catchall “other illness” category) or criminal convictions were less likely to respond than their counterpart groups. It appears that the only notably disadvantaged group with a significantly lower response rate were single parents and others with sole care responsibilities. As such, the data from the survey should be considered largely reflective of the full Want2Work sample.

3.4.2 Client views of Want2Work

108. The Want2Work survey included questions considering surrogate outcomes on the success of Want2Work. Variables that **form the excluded categories in the estimated relationships are shown in italics.**

Table 3.2 reports the agreement with statements measured on a 7-point Likert scale from 1 (strongly disagree) to 7 (strongly agree). A neutral response on each question is given by a score of 4.00. Overall, Want2Work was supported in agreement to statements that “I received enough support to help me towards or back into work” (4.87) and “I saw the same people enough that I felt they understood my case well” (4.99).

109. The Want2Work advisors received relatively high support in comparison to both health professionals and Want2Work more generally. There was strong agreement that the advisors were “knowledgeable and supportive” (5.43), “friendly, available and accessible” (5.60), and effective (5.02).

110. The statement that “I received support from local GPs/nursing staff” was the only one answered negatively in aggregate, having scored an average of 3.55 points on the Likert scale²⁶. However, when Want2Work Health Professionals and other health professionals were considered together the responses were more positive. Here, all health professionals were seen to be knowledgeable and supportive (4.65), friendly, available and accessible (4.84) and effective in aiding clients towards work (4.40). Note that there are far more missing data in these later questions than in the first, negatively answered, question. If some respondents receive less contact from either local GPs or nursing staff or Want2Work Health Professionals, they may feel unable to comment on the more specific questions later. It appears, however, that there may be more support for Want2Work Health Professionals than for other NHS staff that clients came into contact with.

111. The questions considering client views about specific interventions (Table 3.3) typically involved a large amount of missing data, with fewer than half of the sample providing responses on most questions. Overall, a negative response was given to the specific interventions “Job Preparation Premium” (3.45), “Training” (3.46), “In work support or development” (3.46), and “volunteering opportunities” (3.60). Only the statement “I was really helped towards or back into work by extra funds provided by Want2Work” received a positive response (4.34). This may be due to the Return to Work Credit, which received a very high rating amongst those receiving it (87 of 540 respondents in the survey). Of these clients (Table 3.4), the mean rating given to the statement “I was really helped towards or back into work by the RTWC” was 6.16, and 75% stated that the opportunity of receiving this credit encouraged them to look for work.

3.4.3 Client health and labour market outcomes

112. The survey used a series of questions to assess health status, contact with the NHS, the interventions provided by Want2Work, and labour market outcomes. Overall, self-assessed health was relatively poor in the Want2Work sample (Table 3.5), with most answering that relative to other people their health was either Fair (31%) or Poor (24%). Only 9% of those in the sample judged their health to be excellent. Most of the respondents had had contact with GPs in the previous 3 months (79%), with the majority using a GP between one and five times

²⁶ Survey evidence from the Pathways to Work evaluation found that many people were reluctant to meet with their GPs if they felt they did not support their aspiration to return to work or questioned their illness.

(64%) (Table 3.6). 21% of clients used one of these contacts to ask for a sick note (100/478), with 6% requesting one more than three times in the past three months (Table 3.7).

113. Over the previous 3 months, 49% of respondents had had contact with hospitals or clinics as an outpatient or day case. 2% of the sample had had more than ten such contacts, with the majority receiving only one or two (Table 3.8). 68/515 respondents (13%) had had an accident that led to contact with an NHS doctor or hospital, with four of these clients having four or more such accidents (Table 3.9).

114. Table 3.10 presents a summary of the labour market outcomes for the Want2Work survey respondents. 25% of the sample had looked for paid work or government training in the previous four weeks, with a further 29% currently working and not looking for a job. The final 46% did not look for work, but the reasons for this are not given. One third of the sample (33%) had worked in the previous week either as an employee or self-employed, and the majority of these individuals believe that this job is permanent. Fewer than 10% of employees had seasonal work, fixed term contracts, temporary agency work, or casual work (each). Only 6% of those employed were uncertain whether or not their job was permanent.

115. Of those who did not work in the seven days prior to the survey, 92% did not have a job, with 6% away sick or injured and 2% away for some other reason.

116. Of those with children, 53% had access to an affordable form of childcare (71/134, Table 3.11). As 32% of the sample had children below 12 years of age, the availability of childcare may be an important predictor of labour market outcomes and may be a cause of significant ongoing unemployment.

117. A further nine outcomes considered life satisfaction, as a broader characterisation of wellbeing than health or labour market outcomes. As with the evaluation questions before, these figures are measured on a 7 point Likert scale (1 = Not Satisfied, 7 = Completely Satisfied). Unlike the earlier comparisons, there is no generally identifiable “neutral” point on this scale. Table 3.12 provides the results from these life satisfaction questions. Those having a spouse/partner were generally relatively satisfied with this aspect of their life, with an average score of 5.52. In order of mean response, accommodation received the next highest mark (4.54), followed by one’s job (where employed) (4.40), the amount of leisure time (3.66), and the way this time is spent (3.42). The least satisfactory elements of life for those here were household

income (3.11), social life (3.25) and health (3.41). Overall life satisfaction received a score of 3.74.

3.4.4 Predictors of labour market status

Health variables

118. Using only data from the Want2Work database (observed at the end of 2006)²⁷ and the first postal survey, we cannot look at *changes* in health, for the reasons outlined above to do with measurement of health in the database, though it is still possible to look at how health and labour market outcomes are related. We do this by considering health variables and job status variables within Want2Work and within the first survey (Table 3.13). 32% of clients within the main database achieved employment within the Want2Work period. The type of illness (e.g. cardiovascular, mental health, other) appears to be significantly related to job status within Want2Work ($p=0.002$), with the lowest employment rates amongst those with learning disabilities (0%) and respiratory disease (20%), and the highest rates amongst those with hearing/speech/visual problems (36%) and musculoskeletal illnesses (35%). This effect was not observed in the survey data ($p = 0.854$).

119. The Want2Work ‘disability’ variable takes a value of 1 wherever a designated health problem is identified, and is related to job outcomes through Want2Work ($p = 0.037$). This disability variable does not predict survey job status ($p = 0.921$), unlike answers to the self-assessed disability (the answer to the question “do you consider yourself to be a disabled person”) which is significantly related to job status in the survey ($p = 0.000$), with 27% of those having a job and 44% of those not having a job self-classifying themselves as disabled. This suggests that a self-assessed disability measure may be a better predictor of long-term employment than the measure currently included in the Want2Work database. The degree of self-assessed health (comparing one’s health to that of others) is also significantly related to job status in the survey ($p = 0.000$). It appears from the survey data that those who self-declare themselves in better health are more likely to have a job, although we cannot say why this is.

²⁷ As the first survey was conducted in May 2007, it could only be matched to the original version of the database supplied to us, covering Want2Work participants until the end of 2006. The results on labour market status in this section will therefore differ slightly to those described in Section 2 above, which used the final version of the Want2Work database, observed to the end of 2007.

Client views of Want2Work

120. The client views of Want2Work may also be significantly related to whether or not a person received employment. Note that the mechanism for this is uncertain, as it is unclear whether those finding work would be better disposed towards Want2Work (for example, as a form of hindsight bias), or whether those who received the best support were most likely to find work. Table 3.14 shows the relationships between client views and survey job status.

121. In the main views of Want2Work, it appears that employment is higher with agreement to the statement that “I received enough support to help me towards or back into work” ($p = 0.000$), and “I saw the same people enough that I felt they understood my case well” ($p = 0.001$). When considering Want2Work advisors, employment was higher amongst those who felt that “they were knowledgeable and supportive” ($p = 0.002$), “they were friendly, available and accessible” ($p = 0.036$), and “they were effective in helping me make progress towards or back into work” ($p = 0.000$). When considering Want2Work and other health professionals, the only significant relationship with survey job status was related to agreement with the statement that “they were effective in helping me make progress towards or back into work” ($p = 0.042$). Other possible attributes of medical staff (knowledge, supportiveness, friendliness, availability and accessibility) were not significantly related to survey job status.

122. There were some significant relationships between client views on these nine questions and the type of health conditions suffered by individuals. For example, in the case of anxiety, 23% of the sample strongly disagreed (1 or 2 out of 7) with the statement that Want2Work advisors were “effective in helping me make progress towards or back into work”, with 23% more neutral (3, 4, or 5), and 54% strongly agreeing (6 or 7 out of 7). The corresponding proportions were 14%, 27%, and 58% for those not recording anxiety as a problem ($p=0.037$). This suggests that those with anxiety-related health problems felt that the advisors were less effective than did those who did not, even though there were no significant differences in the perceptions of how knowledgeable/supportive, or friendly/available/accessible the Want2Work advisers were.

123. Of the small number ($n=13$) of people for whom epilepsy was a health problem, most appeared to have quite extreme views as to whether they had seen the same people enough to feel reassured that they understood their cases well, with 46% selecting strong disagreement to the statement (scoring 1 or 2 out of 7), 46% selecting strong agreement (6 or 7) and only 8% selecting having neutral views (3, 4, or 5). In comparison, those without epilepsy had proportions 18%, 27% and 55%.

124. The remaining three relationships between illness type and client views concern the health professionals. Those with heart problems (n= 66) had more negative views (30% strong disagreement, 24% neutral and 45% strong agreement) regarding the statement that the professionals were “friendly, available, and accessible” than those without heart problems (17%, 32% and 51%; $p=0.049$). Those with limb problems (n= 143) appeared to give less support (26% strong disagreement, 38% neutral and 36% strong agreement) to the statement that the health professionals had “helped them towards or back into work” than those without limb problems (28%, 26% and 46%; $p=0.045$). Finally, those with sight problems (n= 32) had more extreme views (34% strong disagreement, 9% neutral and 56% strong agreement) regarding the statement that the professionals were “knowledgeable and supportive” compared to those without sight problems (23%, 32% and 46%; $p=0.025$).

125. There were no significant differences in the views of the overall effectiveness of Want2Work, the main advisors, or the health advisors, between those suffering from “hearing”, “skin”, “chest”, “diabetes”, “alcohol”, “migraine”, “cancer”, or “stroke” conditions and those who did not.

Childcare

Table 3.15 considers those not gaining a job through Want2Work by the end of 2006, and investigates whether their job status at the time of the first survey (May 2007) is related to childcare issues. Having a child did not affect the ability of a person to find employment ($p = 0.742$). The availability of childcare might be expected to have a greater impact than simply having children, since those who perceive that they lack childcare may be less interested in and less able to take up employment. The survey asked those with children whether they had “an affordable way for them to be looked after while you work”, with the affordability not explicitly defined. 71 (53%) of the survey respondents with children felt they had access to affordable childcare, with 63 (47%) having no such access. 50 of the 63 with no access to affordable childcare gave no details as to what childcare options were available, with one person stating that they did not know options would be available for them. Those with childcare access through a current or former partner were most likely to state that childcare was affordable (92%), followed by access through other friends or family (81% affordable), and those with access to group based activities (77% affordable). However, availability or non-availability of “affordable” childcare did not significantly predict the chances of finding employment ($p = 0.258$). Those with no

access to affordable childcare had a 14% chance of gaining a job, against a 23% chance for those with access.

3.5 Results: Comparison of Outcomes for Want2Work Participants and BHPS Respondents

127. In order to see how the Want2Work participants compare with people who have a similar labour market history and circumstances we used the British Household Panel Survey (BHPS) to provide a matched control group. We used the three most recent waves of the BHPS (2003 to 2005). These years were chosen to be as close as possible to Want2Work (January 2005 for the baseline and May 2007 for our survey) and also because the SF-36 is only available for the BHPS in 2004²⁸. The matched sample consists of adults (aged 16 to 65 years) who were economically inactive in 2003²⁹; these individuals are then surveyed in 2004 and 2005 and we can observe whether or not they get a job, along with a number of other outcomes relating to job characteristics, health and satisfaction with various life domains. These samples may differ in the desire to seek employment; those who enter Want2Work may have a greater desire to enter or re-enter employment than an otherwise similar out of work group.

128. The BHPS classifies respondents as belonging to one of 20 different regions in the UK, of which Wales is one³⁰. Our primary BHPS match sample consists of people who were resident in Wales; there are 419 individuals in 2003 and 347 in 2005, due to sample attrition.

3.5.1 Bivariate analysis

Demographic characteristics

129. Table 3.16 compares sample characteristics for the Want2Work survey, the BHPS Wales sample and the BHPS sample for the UK as a whole. To provide an appropriate comparison for the Want2Work survey, the characteristics (apart from health problems) are measured at baseline on first contact with Want2Work (recorded in the Want2Work database); health problems are measured from our survey in May 2007 because the Want2Work database health problems data

²⁸ The SF-36 was also included in the BHPS in 1999 but this is too early for a comparison with Want2Work.

²⁹ Economically inactive includes people of working age who classify themselves as *unemployed*, or *long term sick and disabled*. Those in full-time education, on maternity leave or defining themselves as retired are excluded.

³⁰ A more detailed geographical breakdown is not readily available. In addition smaller areas would have insufficient sample sizes to make meaningful comparisons.

were not comparable (see above). For the BHPS the characteristics are measured in 2003 when all respondents are economically inactive.

130. Looking first at the BHPS Wales sample versus the Want2Work survey:

- there are fewer people in their 30s and 40s and more aged over 55 in the BHPS (however the mean age in both cases is 41);
- the BHPS sample appears to have a higher level of education; more people in the BHPS have a highest educational qualification of NQF4 and above, and far fewer have a highest qualification of NQF1;
- there is a lower proportion of males, non-whites and people with a language problem³¹ in the BHPS sample, but a much higher proportion of Welsh speakers³²;
- health problems seems to be distributed comparably, apart from mental health problems which are more prevalent in the Want2Work survey sample;
- more people in the BHPS sample have been unemployed for more than 5 years, but far fewer are on Incapacity Benefit (IB).

131. Most of these comparisons are similar when comparing the Want2Work survey respondents to the UK. On balance the BHPS Wales sample is a better match for the Want2Work survey respondents than the BHPS UK sample. There are four exceptions: (i) proportion aged 30-34; (ii) proportion with highest qualification at NQF3; (iii) proportion unemployed more than 5 years; (iv) proportion of Welsh speakers.

132. These statistics show that while the Want2Work survey respondents and BHPS Wales samples are quite similar there are differences, and we should keep these in mind when we look at the health differences reported in Table 3.18. In particular, the much larger proportion of Want2Work respondents on IB is a key difference between the two samples so in separate analyses we treat IB claimants as a distinct group. It is also important to note that the observable differences between the BHPS Wales and Want2Work samples are controlled for in the multivariate regression analysis (see below).

³¹ The language problems variable may not be comparable. The BHPS variable denotes whether the interviewer thought the respondent had language problems that may have affected the interview, whereas the Want2Work variables denotes whether the respondent requires training in English or Welsh as a second language.

³² This is to be expected because the BHPS sample covers all of Wales whereas the Want2Work scheme only covers the south of the country.

Job search and job characteristics

133. Table 3.17 compares job search behaviour and job characteristics (for those who gained employment) for the BHPS sample in 2005 and the Want2Work sample at the time of our first survey. At this time just under half of the survey respondents had been with Want2Work for 6 to 12 months and 10% for more than two years. A higher proportion of Want2Work survey respondents had gained employment than the BHPS sample. 146 of our 538 survey respondents (27%) had got a job compared to 20% for the BHPS. In addition, of those Want2Work respondents not in employment, more had actively looked for a job in the past 7 days than the BHPS sample. Of those who found employment there is no significant difference between the two samples in terms of job tenure, salary or the proportion in self-employment. Fewer of the Want2Work sample are working less than 9 hours per week and more are working 16 to 29, but similar proportions are in full-time work (over 30 hours per week).

Health outcomes

134. Table 3.18 and Table 3.19 compare health outcomes and life satisfaction for the Want2Work survey respondents and the BHPS sample. Again these samples should be comparable since for Want2Work the data come from our survey (June 2007) and for the BHPS they are from 2005; at this stage some respondents (in both samples) are in work and some are not. Table 3.18 looks at mean outcomes. The overwhelming evidence is that the Want2Work survey respondents have worse subjective health and lower life satisfaction than the BHPS sample, this is despite a very similar prevalence of specific health problems (apart from mental health problems), as reported in Table 3.16. Want2Work respondents have significantly higher scores (meaning worse disability) on five of the six SF-6D dimensions, and the mean SF-6D index is ten percentage points lower at 0.64 compared to 0.74. Histograms for the SF-6D index are shown in Figures 3.1 and 3.2, and the poorer health of the Want2Work respondents is clearly seen. In addition to the SF-6D index the Want2Work respondents seem to be less satisfied with almost all of the life domains, the only exceptions being *home* and *partner*, where the differences are not statistically significant.

135. Given that most of the variables reported in Table 3.18 are discrete, Table 3.19 looks at proportions. Here we consider the proportion of people who consider themselves *disabled*, the proportion in *good* and *excellent* self-assessed health, and the proportions who are *very*

*satisfied*³³ with the various life domains. A much higher proportion of Want2Work respondents consider themselves *disabled* (39% v. 25%) and a much lower proportion have *good* or *excellent* health (29% vs 52%). Want2Work respondents are less likely to be very satisfied with the life domains, apart from *home*, *partner* and *job*.

136. In an effort to investigate whether getting a job makes any difference to these outcomes, the results reported in Table 3.20 are disaggregated by employment status. The upper panel looks at those not in work and the lower panel considers only those who found a job. These results show that the differences between the Want2Work sample and the BHPS do not disappear when we control for employment status. For both groups the Want2Work sample have worse health status and are less satisfied. One implication of this is that Want2Work participants are in work with worse health status than the average economically inactive person from the BHPS who has subsequently found work.

137. It is clear from the results in Table 3.20 that (for both the BHPS and Want2Work samples) those in work have better health and better life satisfaction than those not in work, and we investigate this further in the multivariate analysis below. But what is also apparent is that the difference in health status is greater for the BHPS than for Want2Work. For example, for Want2Work the SD-6D index is 0.05 higher for those in work (0.62 v. 0.67), whereas for the BHPS this difference is 0.09 (0.72 v 0.81). Of the BHPS sample in work only 7% consider themselves disabled compared to 30% who are not in work. Whereas for the Want2Work sample in employment 36% consider themselves disabled, which is only marginally lower than the proportion of those not in work (40%). This is an interesting result suggesting that employment status may not do much to affect a Want2Work respondent's view of their own health status.

138. Table 3.21 repeats the comparison but distinguishes between those Want2Work and BHPS respondents who were claiming IB and those who were not (at baseline for Want2Work and in wave 13 for the BHPS). For those not claiming IB the significantly worse health of the Want2Work respondents remains a key factor. Want2Work respondents do significantly worse on 4 of the 6 SF-6D dimensions and have a lower overall index value (0.69 vs 0.77) and lower self-assessed health. They are also significantly less satisfied with 6 of the 9 life domains including overall life satisfaction.

³³ Very satisfied is defined as response 6 or 7 on the 7 point satisfaction scale.

139. Of those on IB, the Want2Work respondents do worse on 5 of the 6 SF-6D dimensions, but the overall mean index value is very similar for Want2Work and BHPS (0.60 vs 0.59), while self-assessed health is also very similar. Want2Work IB claimants are more satisfied with their health than BHPS claimants but they are less satisfied with 4 of the 9 life domains. The overall life satisfaction score is lower for the Want2Work group but the difference is not significant at 5%. These results suggest that in terms of health and life satisfaction outcomes the two groups of incapacity benefit claimants are more similar than the BHPS and Want2Work samples as a whole.

3.5.2 Multivariate analysis: Comparing Want2Work Survey Respondents with the BHPS

Pooled Analysis

140. The bivariate analysis reported above suggests that the Want2Work respondents have worse health and life satisfaction than a matched BHPS sample, whether or not they are in employment. It also suggests that the health differences between those in work and not in work may be greater for the BHPS than for Want2Work; and that the two groups of IB claimants may be more similar (in terms of health outcomes) than the samples as a whole. However, while the Want2Work survey respondents and the BHPS sample are similar they are not a perfect match and there are observable differences between the two groups as reported in Table 3.16. In particular a respondent in the Want2Work sample is less likely to be well educated, a Welsh speaker and unemployed for more than 5 years; and more likely to be male, non-white, be on IB and have a mental health problem or language problem. Note that with the exception of mental health problems, the prevalence of other specific health problems (including problems with drugs or alcohol) do appear to be the similar in the two samples.

141. All of these factors are expected to influence health, so in order to control for observable differences between the Want2Work survey respondents and the BHPS sample we use multivariate regression analysis to investigate the determinants of health outcomes. The first analysis involves pooling the BHPS sample from 2005 ($n = 347$) and the Want2Work survey respondents ($n = 538$). A dummy variable is included to denote respondents in the Want2Work sample. This will allow us to test whether health outcomes are significantly different for the Want2Work respondents after controlling for observable differences such as age, sex, race and education.

142. Table 3.22 reports the results of a number of models where the dependent variable in each case is the SF-6D health index (0 = health states equivalent to death, 1 = full health). Model (1) is a basic model controlling for age, sex, race, language, caring status and education; it does not distinguish between the two samples. The SF-6D index largely deteriorates with age (although there may be some improvement for the over 60s), having a language problem is positively correlated with the index³⁴, as is education. As model (2) shows, many of these effects disappear once we control for specific health problems; now only the effects of language problems and the highest level of education remain, but all the health problems (except cardiovascular) have a significant negative effect on the health index. The explanatory power of the model increases from 0.16 to 0.47 when specific health problems are included. In an effort to control for reporting heterogeneity, model (3) also includes whether or not the individual considers themselves to be a disabled person; this is significant and negative and has little effect on the existing coefficients. Adding self-reported disability increases the explanatory power from 0.47 to 0.54. Model (3) therefore forms the baseline for comparison of the Want2Work and BHPS samples.

143. Model (4) includes a dummy variable to distinguish between the Want2Work and BHPS samples and this is not significant, suggesting that when we control for the full set of observable characteristics (including specific health problems) the Want2Work sample do not have significantly worse health than the BHPS sample. It is worth pointing out here that even when specific health problems and disability status are not controlled for, we still find no significant difference in the SF-6D index between Want2Work respondents and the BHPS (model not reported here). Model (5) adds a dummy variable denoting whether or not the individual gets a job. This variable is significant and shows that people who get a job have better health than those who do not (in further analysis below we also investigate whether this effect differs for the two groups). The size of the effect is quite small; those with a job have an SF-6D index 0.022 points higher on average than those who do not. This is approximately one-third of the health benefit attributed to having educational qualifications at NQF5 compared to having no qualifications. Model (6) considers job search behaviour and shows that those who looked for work within the last 7 days have better health than those who did not. The health benefit associated with active job search (an SF-6D index 0.046 higher on average) is larger than that for getting a job.

144. In addition to the models reported here we also estimated similar models including variables for working hours, job tenure, unemployment duration, whether or not the Want2Work sample

³⁴ We cannot rule out the fact that this may be due to a misunderstanding of the questions.

received a Return to Work Credit, and whether or not they received any intervention from Want2Work; none of these variables had a significant effect on health outcomes.

Pooled analysis for Incapacity Benefit claimants

145. Repeating the analysis of Table 3.22 but only for those Want2Work and BHPS respondents who are claiming IB produces very similar results (not reported here). Again there is no difference in the SF-6D health index between the two groups once the observable characteristics are controlled for. Those who get a job and/or look for a job have better health than those who do not. These effects are larger than for the sample as whole. Getting a job is associated with a health benefit (on the SF-6D index) of 0.039 (half of that attributed to NQF5), and again the effect of looking for a job is larger at 0.060. Working hours, job tenure and unemployment duration have no effect, but for the IB claimant sample (unlike the whole sample) both the *Return to Work Credit* and the ‘any intervention’ variable have a significantly positive association with health. Again we must stress that this may not be a causal relationship, and it may be that those Want2Work respondents with better health are more likely to receive these interventions.

Pooled analysis for alternative health outcomes

146. In order to test the robustness of our findings to alternative health outcome measures we have estimated similar models to those reported in Table 3.22 but for three alternative outcomes: self-assessed health, health satisfaction and life satisfaction. These are discrete ordinal dependent variables, the first is measured on a 5-point scale and the last two on a 7-point scale, hence ordered probit regression is used to estimate the models. To save space we do not reproduce the results here but simply report on them. We discuss only the key variables here since the results for the conditioning variables are very similar to those reported in Table 3.22.

147. Membership of the Want2Work sample makes no difference to any of the health outcomes; i.e. once we control for the full set of observable characteristics, Want2Work respondents do not have significantly different self-assessed health, health satisfaction or life satisfaction than the economically-inactive matched BHPS sample in Wales. For all three measures getting a job is positively associated with good outcomes. Looking for a job has the same effect on self-assessed health and health satisfaction but is not associated with life satisfaction. The same is true for

working hours and job tenure. The Return to Work Credit and whether or not the respondent received any Want2Work intervention are positively associated with good outcomes.

148. Thus the results for the alternative health outcome variables seem to confirm those for the SF-6D, although there is some evidence that life satisfaction (which we can think of as the broadest measure of wellbeing) is not as closely related to labour market experience or Want2Work interventions as the other two.

Multivariate analysis on separate Want2Work and BHPS samples

149. The models reported above restrict the effect of the explanatory variables to be the same for the Want2Work and BHPS samples, allowing only an intercept shift dependent on sample membership. It is possible that the effects of getting a job, job search etc will be different for the Want2Work and BHPS samples and we allow for this possibility in the models reported in Table 3.23.

150. In Table 3.23 we report three models for each of the samples. Models (1a) and (1b) contain the core demographic variables, health problems and disability status, and models (2a), (2b), (3a) and (3b) include dummy variables for getting a job and looking for job. The t-tests reported in the column following each pair of models, show that in almost every case the coefficient estimates differ significantly between the two samples. Comparing models (1a) and (1b), age has no effect on the health index in either sample; sex and race are significant in the BHPS model, with males having better health and non-whites worse health, but these effects are not apparent for the Want2Work group. The effect of being a lone parent or a carer is positive for the Want2Work group but negative for the BHPS sample. The positive relationship is contrary to expectations and may be explained by the under-representation of this group in our sample compared to the Want2Work population. High educational qualifications have a positive effect on health for Want2Work but not for the BHPS. All the specific health problems are important for the Want2Work group but only mental health and musculoskeletal problems are significant for the BHPS. The disability variable is important for both groups but the effect is smaller for Want2Work. In models (2a) and (2b) we see that the effect of getting a job is positive and significant at $p < 0.10$ for the Want2Work group but not for the BHPS. Similarly in models (3a) and (3b) the positive effect of looking for job is highly significant for Want2Work but not for the BHPS. The size of the effects is smaller than in the pooled model, suggesting here that getting a job is associated with an Sf-6D index 0.023 points higher, while looking for a job is associated

with an extra 0.046 points. In results not reported here we also investigated the effects of job hours, job tenure and unemployment duration but these variables had no relationship with the health outcomes for either sample.

151. Repeating the analysis for Want2Work and BHPS respondents who are claiming IB (results not reported here) again shows that getting a job and looking for a job are positively associated with health for the Want2Work sample but not for the BHPS. The size of the effects is larger for IB claimants than for the sample as a whole.

152. To test the robustness of these results to the health outcome measure we estimated similar models using the three alternative outcome measures: self-assessed health, health satisfaction and life satisfaction. These do not provide much additional information but they do confirm that the effects of getting a job and looking for a job are larger for the Want2Work sample than for the BHPS.

3.6 Results: Health, components of Want2Work and opinions on Want2Work

153. In Table 3.24 we investigate whether various Want2Work interventions³⁵ are correlated with the SF-6D health index, and also whether respondents' opinions about the Want2Work service are correlated with the health outcome. Column (1) shows results for the Want2Work sample as a whole and column (2) only for those who are claiming IB. The upper panel of Table 3.24 reports the results for interventions. For the whole sample, the only intervention that had any significant effect on the SF-6D is whether the participant took part in any *health or fitness related activity*. This finding should be treated with caution, as those able to safely take part in health or fitness activities may be in better health than those who are not. For the IB claimant sample, receipt of a discretionary payment and the 'any intervention' dummy are also significantly associated with health.

154. The first set of questions on our survey asked for respondents' opinions on various aspects of the Want2Work programme and the lower panel of Table 3.24 looks at how these opinions are correlated with the SF-6D health index. As Section 3.4.2 showed, most of these ratings were positive. For both samples thinking you received enough support to get you back into or help you towards work is positively associated with health. In general having a positive opinion about the

³⁵ Only those interventions received by at least 10 people are investigated.

advisors also has a positive effect. Opinion on the knowledge and support of the health professionals is negatively related to health. For the sample as whole only the opinion of the job preparation premium is significant but for the IB claimants the opinion about extra funds and the return to work credit were also positively associated with health.

3.7 Results: Follow-up survey, employment and health changes

155. The second, follow-up survey in February 2008 asked questions regarding health status and current employment status to those identified within the Want2Work database as being in work at the end of 2006. A total of 130 respondents returned data that could be analysed, of which six stated that they did not find work within Want2Work. Of the 148 individuals providing usable data in the first (2007) Want2Work survey who also obtained a job by the end of 2006, 71 also provided data in the 2008 follow-up survey (previous respondents' response rate 48%, versus 9% for previous non-responders).

Health and life satisfaction data

156. Both Want2Work surveys asked individuals questions relating to their own health and life satisfaction. Consistency in these figures (in conjunction with health change data) suggests test re-test reliability. Health data were summarised by identifying "excellent" and "good" health, and life satisfaction data were summarised by identifying individuals with satisfaction of 4 or above (out of 7). Health improvements were summarised by identifying those with "much better" or "somewhat better" health compared to 12 months ago, and by comparing the summary variables at each point in time. In these summary variables, 40% of individuals reported having good health, 43% reported having better health than in the previous year, and 73% were moderately or highly satisfied with their life.

157. As expected, significant associations were found for responses to the 5-item health questions ($p = 0.001$; Fisher exact) and the 7-item life satisfaction questions ($p = 0.005$; Fisher exact) over time. In a binary logistic regression, current health ("excellent/good", vs. not) was found to be positively associated to past health ("excellent/good", vs. not; $p = 0.011$) and perceived health changes ("somewhat better" or "much better", vs. not; $p = 0.001$).

158. The 5-item perceived health change question (“Compared to 12 months ago, how would you rate your health in general now”) was not significantly associated to either prior health ($p = 0.639$) or prior life satisfaction ($p = 0.146$). Using the summarised (binary) variables, a logistic regression found no significant association between health changes and either prior health ($p = 0.922$) or prior life satisfaction (mid/high vs low; $p = 0.083$). Whether a person perceives an improvement in their health appears to be associated with differences in health (logistic regression $p = 0.006$ & $p = 0.467$). Overall, health status appears to be related between periods and consistent with perceived health changes. The health questions used appear to have empirical validity.

Employment and health

159. If employment improves health, then we would expect to see an association between perceived health changes and employment. This question was examined using all those who provided follow-up data, with a binary logistic regression run against dummy variables: for all employment, self-employment (as an additional factor), yearly income, hours worked, and covariates (gender, age (below 40 or above), Want2Work disability, Want2Work mental health illness, Want2Work musculoskeletal illness, single parent or other carers, drug or alcohol problem, and IB receipt).

160. Table 3.25 presents the results of the (binary) logistic regression of health, health changes and life satisfaction against the factors listed above. Health status appears to be better amongst those with a job ($p = 0.012$) and this is the only significant factor. For reasons outlined previously, this does not necessarily suggest that job status increases health, and at best only reveals an associative relationship between the variables. The modified model including previous job survey status (2nd column) is insignificant and is ignored.

161. The chance of perceiving health improvements appears to be higher amongst those working longer hours ($p = 0.018$), with such changes significantly less likely amongst men and those (mainly) suffering from musculoskeletal illnesses (3rd Column of Table 3.25). Previous job survey status is insignificant when included (4th Column), and the gender effect disappears in the subgroup responding to both surveys. Possibly surprisingly, continuous employment has little impact on health changes.

162. Life satisfaction appears to be higher amongst those with greater income ($p = 0.030$) and those with disability ($p = 0.002$), but lower amongst alcohol and drug misusers ($p = 0.028$) and those with musculoskeletal illnesses ($p = 0.075$) (5th Column, Table 3.25). Previous job survey status is once more insignificant when included (6th Column).

163. Taking firm-based employees earning below £15,000 per year, we can say that those working 8 or fewer hours a week (since $-0.450 + 8 \times 0.053 = -0.026$) are less likely to report positive health changes than a similar unemployed person, whilst those working 9 or more hours a week are more likely to report positive health changes than a similar unemployed person (since $-0.450 + 9 \times 0.053 = 0.027$). For those who are self-employed, this cut-off would be at 16.9 hours. Of the employees providing data on hours worked, only 4% (4/97) typically worked fewer than 9 hours. It appears that those working were more likely to report health improvements than those who were not.

164. Overall, the follow-up survey could be interpreted to give weak support to the idea that working may improve health, although this is subject to several caveats: this is an associative finding; our sample is small (130 with complete data) with evidence of large selection bias.

3.8 Summary

165. The raw data reported here shows that a higher proportion of Want2Work survey respondents got a job than in the matched BHPS sample, and a higher proportion were actively looking for work. These findings add weight to those of Section 2 where the relevant comparison was the Labour Force Survey. In addition our survey has shown that, of those who found employment, there is no significant difference between Want2Work and the BHPS in terms of job tenure, salary, or the proportion of respondents in full-time work or self-employment.

166. The raw data also show that the Want2Work survey respondents have worse subjective health and lower life satisfaction than the BHPS sample, but when we control for observable characteristics this difference disappears. This finding is true whether or not we control for specific health problems and disability status. Want2Work respondents have similar specific health problems to the BHPS sample, although one difference is that the Want2Work sample has a higher prevalence of mental health problems.

167. Getting a job and actively looking for a job are both associated with a positive health benefit, and job search has the larger effect. If we estimate models separately for the Want2Work respondents and the BHPS, it appears that these positive benefits only accrue to the Want2Work respondents. But it is important to stress that the lack of baseline health information makes it impossible to infer causality from these results. It could be that those with better health are more likely to look for, and get, a job, and also given the voluntary nature of Want2Work those with better health may be more likely to participate in the programme.

168. The follow-up survey gave some support to the argument that increasing the number of hours worked is associated with health improvements but this finding should be interpreted with caution. For example, we would expect those losing a job through ill-health to record both unemployment and no health improvement, which would also explain the health gains between those who do and do not work.

169. The Want2Work and follow-up survey found no evidence that continuous employment improves health, as would be expected if working encourages health effects over time. If employment improves health, then it appears to do so only so long as a person remains employed (the follow-up sample were all recorded as employed on Want2Work) and does not appear to be cumulative over time.

170. Client views of Want2Work are generally positive, with the exception of the support from local GPs and nursing staff, which has an average rating below 4. The Return to Work Credit was highly rated by respondents and there is evidence that this rating (and that of the job preparation premium) is positively associated with health.

Section 3 Tables

Table 3.1: Background Characteristics of the Want2Work Question Sample and Respondents, alongside the Full Database

	Want2Work: Full database	Want2Work: Questionnaire Sample	Want2Work: Questionnaire Respondents
<i>Age 16-19</i>	0.0312	0.0306	0.0185
Age 20-24	0.1253	0.1228	0.0667
Age 25-29	0.1417	0.1433	0.0852
Age 30-34	0.1241	0.1247	0.1185
Age 35-39	0.1368	0.1366	0.1333
Age 40-44	0.1400	0.1421	0.1370
Age 45-49	0.1238	0.1216	0.1593
Age 50-54	0.0895	0.0904	0.1444
Age 55-59	0.0606	0.0609	0.0907
Age 60 plus	0.0271	0.0270	0.0463
Highest Qualification: Degree	0.0320	0.0324	0.0370
Highest Qualification: NQF5	0.0038	0.0040	0.0056
Highest Qualification: NQF4	0.0219	0.0224	0.0315
Highest Qualification: NQF3	0.0817	0.0827	0.1111
Highest Qualification: NQF2	0.1703	0.1678	0.1815
Highest Qualification: NQF1	0.1452	0.1455	0.1481
<i>No Qualifications</i>	0.5452	0.5452	0.4852
Male	0.4788	0.4790	0.4407
<i>Illness: None</i>	0.3177	0.3188	0.2278
Illness: Cardio	0.0332	0.0343	0.0481
Illness: Hearing/Speech/Visual	0.0118	0.0119	0.0130
Illness: Learning	0.0058	0.0058	0.0037
Illness: Mental Health	0.2797	0.2775	0.2833
Illness: Musculoskeletal	0.2271	0.2273	0.2500
Illness: Respiratory	0.0182	0.0181	0.0241
Illness: Other	0.1065	0.1063	0.1500
Single Parent	0.2211	0.2199	0.1574
Non-white	0.0889	0.0894	0.0630
Unemployed 0-6 months	0.1890	0.1917	0.1574
Unemployed 6-12 months	0.1025	0.1017	0.0981
Unemployed 12-24 months	0.1227	0.1225	0.1259
Unemployed 2-5 years	0.2949	0.2977	0.3111
Unemployed 6-10 years	0.1622	0.1608	0.1667
Unemployed 11-15 years	0.0857	0.0833	0.0870
Unemployed more than 16 years	0.0430	0.0423	0.0537
Has disability	0.5763	0.5758	0.6537
Welsh speaker	0.0251	0.0257	0.0352
Ex offenders	0.0442	0.0444	0.0370
Drug/drink mis-users	0.0540	0.0548	0.0444
N	3465	3265	540

Variables that form the excluded categories in the estimated relationships are shown in italics.

Table 3.2: About Want2Work

Statement (1 = Strongly disagree, 7 = Strongly agree)	N	Mean response	Standard deviation
<u>About the general experience of W2W</u>			
"I received enough support to help me towards or back into work."	482	4.87	2.12
"I received support from local GPs/nursing staff."	398	3.55	2.31
"I saw the same people enough that I felt they understood my case well."	480	4.99	2.17
<u>About your W2W Advisors:</u>			
"They were knowledgeable and supportive."	478	5.43	1.96
"They were friendly, available and accessible."	502	5.60	1.91
"They were effective in helping me make progress towards or back into work."	481	5.02	2.22
<u>About your W2W Health Professional and other health professionals:</u>			
"They were knowledgeable and supportive."	346	4.65	2.26
"They were friendly, available and accessible."	358	4.84	2.16
"They were effective in helping me make progress towards or back into work."	342	4.40	2.30

Table 3.3: Effect of different forms of help

Statement (1 = Strongly disagree, 7 = Strongly agree)	N	Mean response	Standard deviation
I was really helped towards or back into work by ...			
Extra funds provided by W2W.	323	4.34	2.59
Job Preparation Premium.	240	3.45	2.533
Training. (Was it quick? Was it right?)	263	3.46	2.53
Volunteering opportunities	252	3.60	2.45
In work support or development.	246	3.46	2.39

Table 3.4: Return to Work Credit (only those with rtwc = 1, = 330 of 3265)

Statement	N	Mean response	Standard deviation
I was really helped towards or back into work by the Return To Work Credit. (1 = Strongly disagree, 7 = Strongly agree)	87	6.16	1.67
		Yes	No
Did the opportunity of receiving return to work credit encourage you to look for work (1 = yes, 2 = no)	82	61	21

Table 3.5: “Compared to people of your own age, would you say that your health has on the whole been ...”

	N	%
Excellent	45	8.6%
Good	104	19.8%
Fair	161	30.6%
Poor	127	24.1%
Very Poor	81	15.4%
Don't know	8	1.5%

Table 3.6: NHS Contact: GP contact

	N	%
None	111	20.9%
One or two	194	36.6%
Three to five	143	27.0%
Six to ten	49	9.2%
More than ten	19	3.6%
Don't know	1	0.2%

Table 3.7: NHS Contact: GPs contacted for sicknotes

	N	%
Never	378	79.1%
Once or twice	71	14.9%
Three to five times	17	3.6%
More than five	12	2.5%

Table 3.8: NHS Contact: hospital/clinic contacts (outpatient and day patient)

	N	%
None	256	48.5%
One or two	167	31.6%
Three to five	69	13.1%
Six to ten	16	3.0%
More than ten	9	1.7%
Don't know	11	2.1%

Table 3.9: NHS Contact: accidents leading to doctor/hospital contacts

	N	%
Yes	68	13.2%
How often?		
One	41	60.3%
Two	14	20.6%
Three	9	13.2%
Four or more	4	5.9%

Table 3.10: Labour Outcomes

	N	%
Looked for paid work/government training in the last four weeks?		
Yes	125	25.1%
No, I am currently working and not looking for work	145	29.2%
No, but for a different reason	227	45.7%
Worked in the last week (employee or self-employed)		
Yes	168	33.0%
No	341	67.0%
If working: is it a permanent job?		
Yes	133	61.0%
No, it is seasonal work	8	3.7%
No, it is a fixed term contract	18	8.3%
No, it is temporary agency work	11	5.0%
No, it is casual	8	3.7%
No, for some other reason	26	11.9%
Don't know	14	6.4%
If not working last week, do you have a job?		
Yes, but I was sick or injured	20	6.4%
Yes, but I was away for some other reason	5	1.6%
No, I did not have a job	288	92.0%

Table 3.11: Childcare

	N	%
Do you have any children below 12 years of age?		
Yes	164	32.0%
No	348	68.0%
If you have children, then do you have an affordable way for them to be looked after while you work?		
Yes	71	53.0%
No	63	47.0%

Table 3.12: Life satisfaction

Statement (1 = Not satisfied, 7 = Completely satisfied)	N	Mean response	Standard deviation
Your health	510	3.41	1.98
The income of your household	472	3.11	1.83
Your house/flat	443	4.54	2.02
Your husband/wife/partner	260	5.52	2.07
Your job (if employed)	215	4.40	2.12
Your social life	475	3.25	1.91
The amount of leisure time you have	458	3.66	1.98
The way you spend your leisure time	462	3.42	1.96
Your life overall	499	3.74	2.00

Table 3.13: Labour market outcomes by health status in Want2Work database and first survey

	Job Status in Want2Work database			Job Status in Want2Work survey		
	No Job (n=2223)	Job (n=1042)	Sig	No Job (n=283)	Job (n=186)	Sig
W2W “Disability”	1308	572	0.037	187	122	0.921
Self-assessed disability				125	51	0.000
Self-assessed health						0.000
Excellent				20	20	
Good				44	47	
Fair				75	65	
Poor				76	38	
Very Poor				56	11	
Don’t Know				4	3	
Nature of illness:			0.002			0.854
Cardiovascular	81	31		12	12	
Hearing/speech/visual	25	14		5	2	
Learning disability	19	0		1	1	
Mental health	633	273		78	52	
Muscularskelateral	483	259		68	51	
Other	248	99		46	26	
Respiratory	47	12		8	3	

Table 3. 14: Employment at survey by client views of Want2Work

	No Job	Job	Sig
Evaluation of W2W			
1.1 "I received enough support to help me towards or back into work."			0.000
Strong Disagreement (1-2)	56 (22.7%)	25 (14.0%)	
Neutral/mild agreement or disagreement (3-5)	101 (40.9%)	42 (23.6%)	
Strong Agreement (6-7)	90 (36.4%)	111 (62.4%)	
1.2 "I received support from local GPs/nursing staff"			0.106
Strong Disagreement (1-2)	77 (37.4%)	71 (48.3%)	
Neutral/mild agreement or disagreement (3-5)	73 (35.4%)	40 (27.2%)	
Strong Agreement (6-7)	56 (27.2%)	36 (24.5%)	
1.3 "I saw the same people enough that I felt they understood my case well"			0.001
Strong Disagreement (1-2)	57 (23.6%)	24 (13.6%)	
Neutral/mild agreement or disagreement (3-5)	74 (30.6%)	38 (21.6%)	
Strong Agreement (6-7)	111 (45.9%)	114 (64.8%)	
2.1 "They were knowledgeable and supportive"			0.002
Strong Disagreement (1-2)	34 (13.7%)	12 (7.0%)	
Neutral/mild agreement or disagreement (3-5)	79 (31.9%)	37 (21.5%)	
Strong Agreement (6-7)	135 (54.4%)	123 (71.5%)	
2.2 "They were friendly, available and accessible"			0.036
Strong Disagreement (1-2)	34 (13.0%)	15 (8.3%)	
Neutral/mild agreement or disagreement (3-5)	61 (23.3%)	30 (16.6%)	
Strong Agreement (6-7)	167 (63.7%)	136 (75.1%)	
2.3 "They were effective in helping me make progress towards or back into work"			0.000
Strong Disagreement (1-2)	60 (24.2%)	20 (11.4%)	
Neutral/mild agreement or disagreement (3-5)	71 (28.6%)	38 (21.6%)	
Strong Agreement (6-7)	117 (47.2%)	118 (67.0%)	
3.1 "They were knowledgeable and supportive"			0.337
Strong Disagreement (1-2)	42 (23.6%)	28 (22.4%)	
Neutral/mild agreement or disagreement (3-5)	59 (33.1%)	33 (26.4%)	
Strong Agreement (6-7)	77 (43.3%)	64 (51.2%)	
3.2 "They were friendly, available and accessible"			0.151
Strong Disagreement (1-2)	37 (20.0%)	26 (20.2%)	
Neutral/mild agreement or disagreement (3-5)	64 (34.6%)	32 (24.8%)	
Strong Agreement (6-7)	84 (45.4%)	71 (55.0%)	
3.3 "They were effective in helping me make progress towards or back into work"			0.042
Strong Disagreement (1-2)	52 (30.2%)	30 (23.4%)	
Neutral/mild agreement or disagreement (3-5)	59 (34.3%)	34 (26.6%)	
Strong Agreement (6-7)	61 (35.5%)	64 (50.0%)	

Table 3.15: Working at the time of the first survey, by childcare status, for those who had not gained a job by the end of 2006

Survey Status	No Job (N = 230)	Job (N = 54)	Sig
Children:			
No	154	39	0.742
Yes	69	15	
Affordable childcare:			
No	37	6	0.258
Yes	20	6	

Table 3.16: Comparing Socio-demographic characteristics (Want2Work Survey v BHPS)

	W2W Database	W2W survey	BHPS Wales	Test¹	BHPS UK	Test¹
Age 16-19		1.85	5.25	-1.46	4.53	-2.85
Age 20-24		6.67	9.07	-0.79	8.81	-1.61
Age 25-29		8.52	9.07	-0.27	8.72	-0.15
Age 30-34		11.85	7.88	2.22	11.42	0.28
Age 35-39		13.33	11.69	0.95	13.03	0.19
Age 40-44		13.7	11.69	0.78	11.77	1.23
Age 45-49		15.93	10.5	3.73	9.37	4.45
Age 50-54		14.44	14.56	-0.07	12.6	1.14
Age 55-59		9.07	12.65	-2.15	12.55	-2.24
Age 60 plus		4.63	7.24	-2.03	7.19	-2.14
Highest Qualification: > NQF5		3.7	0	6.74	1.27	3.89
Highest Qualification: NQF5		0.56	5.88	-4.90	5.09	-4.70
Highest Qualification: NQF4		3.15	3.74	-0.61	4.01	-0.93
Highest Qualification: NQF3		11.11	16.04	-2.83	13.76	-1.63
Highest Qualification: NQF2		18.15	22.19	-1.78	24.98	-3.35
Highest Qualification: NQF1		14.81	5.61	7.16	7.21	5.64
No Qualifications		48.52	46.52	0.71	43.69	2.03
Male		44.07	37.47	2.64	31.78	5.41
Illness: None	31.88	22.78	26.01	-1.34	28.99	-2.89
Illness: Cardio	3.43	19.14	18.75	0.19	18.83	0.17
Illness: Hearing/Speech/Visual	1.19	13.75	14.9	-0.72	11.33	1.57
Illness: Mental Health	27.75	47.77	29.36	8.07	25.46	10.19
Illness: Musculoskeletal	22.73	43.68	42.07	0.62	35.38	3.59
Illness: Respiratory	1.81	20.07	21.88	-0.88	19.89	0.09
Illness: Other	11.21	42.38	43.03	-0.24	39.95	1.03
Single Parent/carer		15.74	15.27	0.24	18.7	-1.60
Non-white		6.3	1.19	5.69	3.44	3.05
Unemployed 0-12 months		25.46	25.35	0.05	23.21	1.11
Unemployed 12-24 months		12.64	10.16	1.42	13.8	-0.71
Unemployed 2-5 years		31.23	28.25	1.24	28.63	1.19
Unemployed more than 5 years		30.67	36.24	-2.17	34.36	-1.63
Welsh speaker		3.52	14.56	-13.96	2.66	1.08
Drug/drink mis-users		4.46	4.09	0.48	2.5	2.45
Language problem		4.65	0.79	6.85	1.34	4.97
Incapacity benefit		60.5	28.84	14.98	21.27	18.10
N		540	419		2294	

¹ Test of equality of proportions. As a rule of thumb values greater than ± 2.00 are significant at 5%.

Table 3.17: Job search, job characteristics and NHS Utilisation – BHPS v Want2Work

	W2W			BHPS			
	n	P		n	P		Test ¹
Got a job	538	0.2714		346	0.1994		2.44
Looked for a job	394	0.3173		347	0.2161		3.10
In permanent job	146	0.8699		69	0.8841		-0.29
Commute by public transport	146	0.1575		69	0.0869		1.41
Self employed	146	0.089		69	0.1159		-0.62
<i>Working hours:</i>							
0-8	146	0.0137		69	0.1014		-3.00
9-15	146	0.0822		69	0.1304		-1.11
16-29	146	0.3904		69	0.1884		2.95
30 plus	146	0.5205		69	0.5072		0.18
<i>Salary (£000):</i>							
< 10	146	0.60274		69	0.6332		-0.43
10 - 15	146	0.3288		69	0.2464		1.23
15 -20	146	0.0479		69	0.1014		-1.48
20 - 30	146	0.0137		69	0.0290		-0.77

¹ Test of equality of proportions. As a rule of thumb values greater than ± 2.00 are significant at 5%.

Table 3.18: Differences in health outcomes and life satisfaction – means

	W2W Survey					BHPS Matched sample					
	n	mean	s.d.	min	max	n	mean	s.d.	min	max	t-test ²
SF-6D ¹ :											
Physical functioning	481	3.09	1.60	1	6	319	2.43	1.45	1	6	6.08
Role limitation	480	2.44	1.16	1	4	312	2.07	1.28	1	4	4.11
Social; functioning	497	2.95	1.36	1	6	310	2.20	1.40	1	5	7.48
Pain	469	3.26	1.79	1	6	312	2.96	1.76	1	6	2.34
Mental health	500	2.97	1.17	1	5	312	2.51	1.23	1	5	5.23
Vitality	508	3.29	1.14	1	5	312	3.27	1.20	1	5	0.32
Overall index	408	0.64	0.17	0.30	1	307	0.74	0.16	0.35	1	-8.11
Self-assessed health	516	2.82	1.18	1	5	346	3.36	1.11	1	5	-6.86
Satisfaction:											
Health	508	3.41	1.98	1	7	336	3.98	1.89	1	7	-4.19
Income	470	3.11	1.83	1	7	336	4.62	1.65	1	7	-12.25
Home	442	4.54	2.02	1	7	336	4.80	1.90	1	7	-1.84
Partner	258	5.53	2.06	1	7	227	5.93	1.54	1	7	-2.41
Job	214	4.42	2.11	1	7	93	4.71	1.69	1	7	-1.29
Social life	473	3.25	1.91	1	7	337	4.34	1.78	1	7	-8.33
Amount leisure time	456	3.66	1.98	1	7	336	4.43	1.80	1	7	-5.71
Use of leisure time	461	3.43	1.96	1	7	336	4.36	1.78	1	7	-7.00
Overall life	497	3.74	2.01	1	7	336	4.62	1.65	1	7	-6.93

1. The SF-6D dimensions increase in disability, the other variables increase in health

2. t-test for equality of means. Appropriate tests for discrete variables give results that are substantively the same. As a rule of thumb values greater than ± 2.00 are significant at 5%.

Table 3.19: Differences in health outcomes and life satisfaction -proportions.

	W2W Survey		BHPS Matched sample		
	n	P	n	P	Test ¹
Considers self disabled	538	0.39	346	0.25	4.30
Self-assessed health (good or excellent)	516	0.29	347	0.52	-6.85
<i>Completely satisfied (6 or 7):</i>					
health	508	0.17	336	0.24	-2.38
income	470	0.12	337	0.20	-3.15
home	442	0.38	336	0.42	-1.06
partner	258	0.68	227	0.72	-0.91
job	146	0.36	69	0.38	-0.34
social life	473	0.15	337	0.27	-4.29
amount leisure time	456	0.22	336	0.31	-2.88
use of leisure time	461	0.19	336	0.29	-3.42
overall life	497	0.23	336	0.36	-4.11

1. Test for equality of proportions. As a rule of thumb values greater than ± 2.00 are significant at 5%.

Table 3.20: Differences in health and satisfaction outcomes, in work v. not in work.

Not in work							
	W2W			BHPS			Test²
SF-6D ¹ :	n	Mean	Std. Dev.	n	Mean	Std. Dev.	
Physical functioning	347	3.1412	1.5674	253	2.4625	1.4651	5.44
Role limitation	348	2.4540	1.1666	245	2.0776	1.2635	3.69
Social; functioning	362	2.9696	1.3792	243	2.2263	1.4062	6.42
Pain	333	3.3604	1.8142	245	3.0163	1.7764	2.28
Mental health	360	3.0278	1.1892	245	2.5388	1.2362	4.85
Vitality	366	3.3197	1.1746	245	3.2571	1.2059	0.63
SF-6D index	288	0.6221	0.1744	243	0.7165	0.1584	-6.53
Self-assessed health	374	2.7246	1.2194	277	3.2094	1.1162	-5.27
Satisfaction:							
Health	365	3.2301	1.9756	267	3.7266	1.8988	-3.19
Income	333	2.9760	1.8184	269	3.7844	1.7572	-5.53
Home	316	4.4684	2.0491	267	4.8352	1.9260	-2.23
Partner	180	5.2722	2.1966	183	5.9672	1.5367	-3.49
Social life	337	3.0178	1.9333	268	4.2425	1.8188	-8.00
Amount of leisure time	322	3.5217	1.9987	267	4.4382	1.8716	-5.74
Use of leisure time	328	3.2835	1.9882	267	4.2584	1.8528	-6.18
Overall life	357	3.4958	2.0301	267	4.4981	1.7066	-6.69
Considers self disabled	392	40.05		277	29.96		2.80
In Work	W2W			BHPS			
SF-6D ¹ :							
Physical functioning	134	2.9552	1.6628	65	2.3077	1.4023	2.87
Role limitation	132	2.3864	1.1435	66	2.0455	1.3293	1.78
Social; functioning	135	2.9037	1.3151	66	2.1364	1.3687	3.78
Pain	136	3.0074	1.6931	66	2.7576	1.7102	0.98
Mental health	140	2.8143	1.0901	66	2.4394	1.2169	2.13
Vitality	142	3.2254	1.0478	66	3.3182	1.2046	-0.54
SF-6D index	120	0.6706	0.1595	63	0.8092	0.1234	-6.51
Self-assessed health	142	3.0704	1.0221	69	3.9710	0.8397	-6.79
Satisfaction: health	143	3.8741	1.9315	68	4.9265	1.4794	-4.36
Satisfaction: income	137	3.4307	1.8383	67	4.2537	1.5408	-3.36
Satisfaction: home	126	4.7222	1.9458	68	4.6324	1.7864	0.32
Satisfaction: partner	78	6.1410	1.5435	43	5.7674	1.5711	1.26
Satisfaction: job	98	4.8571	1.9636	68	5.0441	1.3761	-0.72
Satisfaction: social life	136	3.8309	1.7408	68	4.7059	1.5555	-3.64
Satisfaction: amount of leisure time	134	3.9851	1.8918	68	4.3676	1.5053	-1.56
Satisfaction: use of leisure time	133	3.7744	1.8366	68	4.7059	1.4042	-4.00
Satisfaction: overall life	140	4.3571	1.8115	68	5.0735	1.2966	-3.26
Considers self disabled	146	36.3		69	7.25		4.48

1. The SF-6D dimensions increase in disability, the other variables increase in health

2. Test of equality of proportions. As a rule of thumb values greater than ± 2.00 are significant at 5%.

Table 3.21: Differences in health and satisfaction outcomes, IB claimants v non-IB claimants

Not on IB												
	W2 W						BHPS					
Variable	n	Mean	Std. Dev.	Min	Max		n	Mean	Std. Dev.	Min	Max	T- test ²
SF-6D ¹ :												
Physical functioning	186	3.17	1.63	1	6		241	2.41	1.43	1	6	4.98
Role limitation	182	2.38	1.18	1	4		237	2.03	1.27	1	4	2.92
Social functioning	192	2.84	1.35	1	6		235	2.17	1.40	1	5	5.02
Pain	177	3.08	1.76	1	6		237	2.92	1.79	1	6	0.93
Mental heath	191	2.91	1.17	1	5		237	2.45	1.19	1	5	3.98
Vitality	197	3.23	1.17	1	5		237	3.23	1.20	1	5	0.05
SF-6D index	148	0.69	0.18	0.301	1		246	0.77	0.14	0.37	1	-4.38
Self-assessed health	202	3.20	1.24	1	5		261	3.56	1.07	1	5	-3.30
Satisfaction with:												
Health	194	3.91	2.14	1	7		256	4.23	1.85	1	7	-1.63
Income	178	3.04	1.85	1	7		257	4.03	1.73	1	7	-5.66
Home	164	4.48	2.08	1	7		257	4.84	1.87	1	7	-1.78
Partner	96	5.18	2.21	1	7		180	5.78	1.60	1	7	-2.38
Job	80	4.41	2.19	1	7		85	4.67	1.71	1	7	-0.84
Social life	183	3.44	1.98	1	7		257	4.49	1.69	1	7	-5.86
Amount leisure time	180	3.68	2.01	1	7		256	4.51	1.73	1	7	-4.51
Use leisure time	180	3.57	2.00	1	7		256	4.44	1.72	1	7	-4.74
Life overall	193	4.02	2.01	1	7		256	4.76	1.56	1	7	-4.22
on IB												
SF-6D ¹ :												
Physical functioning	295	3.04	1.57	1	6		59	2.29	1.39	1	6	3.71
Role limitation	298	2.47	1.15	1	4		57	2.04	1.27	1	4	2.39
Social functioning	305	3.02	1.36	1	5		57	2.16	1.32	1	5	4.52
Pain	292	3.36	1.79	1	6		57	2.84	1.65	1	6	2.15
Mental heath	309	3.01	1.16	1	5		57	2.49	1.27	1	5	2.85
Vitality	311	3.33	1.12	1	5		57	3.19	1.19	1	5	0.81
SF-6D index	260	0.60	0.16	0.301	1		59	0.59	0.13	0.354	0.894	0.50
Self-assessed health	314	2.58	1.07	1	5		63	2.51	0.93	1	5	0.52
Satisfaction with												
Health	314	3.10	1.81	1	7		60	2.67	1.54	1	7	1.95
Income	292	3.15	1.83	1	7		61	3.11	1.59	1	7	0.16
Home	278	4.58	1.99	1	7		59	4.53	2.07	1	7	0.17
Partner	162	5.75	1.94	1	7		41	6.59	1.05	3	7	-3.75
Job	290	3.13	1.87	1	7		61	3.77	1.94	1	7	-2.35
Social life	276	3.64	1.96	1	7		61	4.28	2.07	1	7	-2.19
Amount leisure time	281	3.33	1.93	1	7		61	4.11	2.07	1	7	-2.70
Use leisure time	304	3.56	1.99	1	7		61	4.02	1.92	1	7	-1.69

1. The SF-6D dimensions increase in disability, the other variables increase in health

2. Test of equality of means. As a rule of thumb values greater than ± 2.00 are significant at 5%.

Table 3.22: OLS Models, Correlates of the Sf-6D Health Index (Want2Work and BHPS Pool).

Variables	(1)	(2)	(3)	(4)	(5)	(6)
Age 20-24	-0.113**	-0.027	-0.039	-0.040	-0.042	-0.027
Age 25-29	-0.106**	-0.012	-0.019	-0.019	-0.019	-0.017
Age 30-34	-0.107**	-0.019	-0.018	-0.019	-0.021	-0.025
Age 35-39	-0.144***	-0.041	-0.041	-0.041	-0.042	-0.043
Age 40-44	-0.151***	-0.022	-0.029	-0.029	-0.030	-0.038
Age 45-49	-0.178***	-0.047	-0.048	-0.048	-0.050	-0.047
Age 50-54	-0.208***	-0.051	-0.040	-0.040	-0.041	-0.041
Age 55-59	-0.204***	-0.029	-0.028	-0.028	-0.028	-0.032
Age 60+	-0.176***	-0.013	-0.007	-0.006	-0.005	-0.003
Male	-0.020	-0.005	0.009	0.010	0.008	0.006
Non-white	0.011	-0.004	-0.025	-0.024	-0.021	-0.055**
Welsh speaker	-0.042*	-0.022	-0.024	-0.025	-0.021	-0.024
Language problem	0.049***	0.029***	0.024***	0.010	0.014	0.009
Single parent/carer	0.025	0.009	0.005	0.006	0.007	-0.002
NQF1	0.043**	0.035**	0.021	0.021	0.019	0.016
NQF2	0.025	0.025**	0.021*	0.021*	0.021*	0.021*
NQF3	0.023	0.020	0.011	0.011	0.009	0.014
NQF4	0.037	0.003	0.002	0.001	0.003	-0.004
NQF5	0.090**	0.089***	0.079***	0.081***	0.079***	0.084**
<i>Health problems</i>						
Cardio		-0.018	-0.011	-0.011	-0.011	-0.005
Hearing, speech, visual		-0.037**	-0.035**	-0.035**	-0.037***	-0.046***
Mental health		-0.109***	-0.097***	-0.097***	-0.095***	-0.091***
Musculoskeletal		-0.131***	-0.096***	-0.096***	-0.096***	-0.081***
Respiratory		-0.052***	-0.039***	-0.039***	-0.039***	-0.033***
Other		-0.039***	-0.032***	-0.032***	-0.031***	-0.031***
Considers self disabled			-0.112***	-0.113***	-0.111***	-0.107***
Want2Work				-0.028	-0.023	-0.057
Got a job					0.022**	
Looked for work last week						0.038***
N	699	699	699	699	699	583
Adjusted R ²	0.163	0.465	0.536	0.536	0.538	0.569

* significant at 10%, ** significant at 5%, *** significant at 1%,

Table 3.23: OLS Regression Models, Correlates of the Sf-6D Health Index (Want2Work and BHPS separate models).

Variables	W2W (1a)	BHPS (1b)	t-test ¹	W2W (2a)	BHPS (2b)	t-test ¹	W2W (3a)	BHPS (3b)	t-test ¹
Age 20-24	-0.077	-0.025	11.727	-0.077	-0.027	11.429	0.052	-0.028	5.119
Age 25-29	-0.068	0.041	25.518	-0.067	0.040	25.117	-0.069	0.038	23.441
Age 30-34	-0.046	-0.004	10.104	-0.049	-0.005	10.747	-0.055	-0.005	11.070
Age 35-39	-0.079	-0.014	15.631	-0.08	-0.015	15.628	-0.082	-0.015	14.996
Age 40-44	-0.061	0.006	16.209	-0.062	0.005	16.085	-0.081	0.005	18.948
Age 45-49	-0.064	-0.050	3.495	-0.066	-0.050	3.729	-0.060	-0.051	1.991
Age 50-54	-0.056	-0.039	4.003	-0.059	-0.037	5.077	-0.059	-0.037	4.896
Age 55-59	-0.065	0.002	15.711	-0.065	0.003	15.912	-0.077	0.003	17.347
Age 60+	-0.030	0.008	8.708	-0.029	0.009	8.573	-0.021	0.010	6.425
Male	0.007	0.030	20.159	0.004	0.029*	21.692	0.001	0.028*	22.538
Non-white	0.002	-0.102**	-35.115	0.005	-0.098**	-34.306	-0.040	-0.097**	-18.246
Welsh speaker	-0.034	-0.005	14.074	-0.028	-0.003	12.208	-0.033	-0.002	14.324
Language problem	-0.008	0.080	25.959	-0.005	0.082	25.319	-0.017	0.086	29.237
Single parent/carer	0.037	-0.037**	-54.517	0.036**	-0.035**	-52.402	0.028	-0.034**	-42.012
NQF1	0.024	0.018	-3.586	0.023	0.017	-3.072	0.015	0.017	0.985
NQF2	0.027	0.004	-17.552	0.027	0.003	-18.169	0.031	0.003	-19.948
NQF3	-0.002	0.027	18.301	-0.004	0.026	18.890	0.000	0.026	15.104
NQF4	0.016	-0.025	-18.913	0.022	-0.026	-21.905	0.006	-0.027	-14.435
NQF5	0.104***	0.019	-24.482	0.102***	0.021	-23.408	0.122***	0.021	-26.010
<i>Health problems</i>									
Cardio	-0.014	-0.012	1.523	-0.014	-0.012	1.805	-0.003	-0.012	-5.790
Hearing, speech, visual	-0.040**	-0.020	12.729	-0.042**	-0.021	13.101	-0.053**	-0.021	18.573
Mental health	-0.106***	-0.09***	13.756	-0.104***	-0.088***	13.036	-0.101***	-0.087***	10.960
Musculoskeletal	-0.108***	-0.082***	22.136	-0.109***	-0.081***	22.862	-0.087***	-0.082***	3.867
Respiratory	-0.035**	-0.027	6.078	-0.034**	-0.027	5.558	-0.022	-0.027	-3.996
Other	-0.048***	-0.010	35.657	-0.046***	-0.009	34.630	-0.054***	-0.008	40.202
Disability	-0.107***	-0.133***	-20.067	-0.106***	-0.132***	-19.587	-0.101***	-0.13***	-21.095
Got a job				0.023*	0.015	-6.576			
Looked for work last week							0.046***	0.022	-18.716
N	408	291		408	291		292	291	
Adjusted R ²	0.507	0.4941		0.5093	0.4936		0.5021	0.4955	

* significant at 10%, ** significant at 5%, *** significant at 1%. 1. t-test for equality of means. Tests for discrete variables give results that are substantively the same. As a rule of thumb values greater than ± 2.00 are significant at 5%.

Table 3.24: Components of Want2Work and Opinions on the Programme

Dependent Variable is SF-6D index	(1)	(2)
Variables	Whole sample	IB claimants
<i>W2W interventions</i>		
Return to work credit	0.008	0.036
Discretionary payment	0.021	0.035*
Voluntary work	-0.010	-0.125
Referred to nddp	0.018	0.051
Health/fitness activity	0.053***	0.061**
Motivation/confidence building	-0.034	-0.039
Referred to in team health professional	0.003	0.023
Self employment support	0.044	0.034
Any intervention	0.014	0.030*
<i>Opinions on W2W:</i>		
<i>General Experience</i>		
Received enough support to help me towards or back into work	0.024*	0.031*
Received support from local GPs/nursing staff	-0.021	-0.026
Saw the same people enough I felt they understood my case well	0.015	0.024
<i>Advisors</i>		
Knowledgeable and supportive	0.023*	0.034**
Friendly, available and accessible	0.012	0.029*
Effective in helping me make progress towards or back into work	0.03**	0.036**
<i>Health professionals</i>		
Knowledgeable and supportive	-0.025*	-0.036**
Friendly, available and accessible	-0.013	-0.016
Effective in helping me make progress towards or back into work	0.006	0.002
<i>Helped back into work or towards work by:</i>		
Extra funds	0.021	0.030*
Return to work credit	0.021	0.039**
Job preparation premium	0.029*	0.046**
Training	0.009	0.009
Volunteering opportunities	0.022	0.029
In work support or development	0.024	0.035

* significant at 10%, ** significant at 5%, *** significant at 1%,

Notes:

The table reports coefficients estimated separately from models that also included all the variables reported in column (3) of Table 3.22. These coefficients are not reported here to ease exposition; the effects of the unreported variables are much the same as those reported in Table 3.22.

Table 3.25: Health status, health changes and life satisfaction in the follow-up survey

Dependent variable	Health status		Health changes		Life satisfaction	
	Question 1: Chance of “good” / “excellent” health		Question 2: Chance of “somewhat better” or “much better”.		Question 3: Chance of moderate to high “life satisfaction”	
In follow-up						
Any job at follow-up	2.008 **	1.870	-0.450	-0.453	-0.615	-5.780 **
Self-employed	-0.202	-0.773	0.447	0.248	0.705	2.485 *
Income above £15,000	0.608	-0.753	-0.050	-0.064	2.066 **	2.663 *
Hours worked per week	0.000	-0.007	0.053 **	0.069 *	0.001	0.049
Covariates (from W2W dbase)						
Aged under 40	0.016	-0.003	0.006	-0.031	-0.021	0.004
Disability	0.545	1.982 *	-0.019	1.549	2.095 ***	4.063 **
Mental health illness	0.437	-0.255	-0.130	0.195	-0.466	-1.087
Musculoskeletal	-0.558	-1.098	-1.174 *	-1.654 *	-1.214 **	-2.978 **
Male	-0.544	-1.110	-1.488 ***	-0.862	-0.480	-3.015 **
Single parent/other caring responsibility	0.877	1.964 *	-0.310	-2.300	-0.083	0.081
Drug and Alcohol Misuser	-1.729	-0.184	-0.191	-0.034	-1.993	-4.116 *
Incapacity Benefit	-0.784	0.343	1.022	0.366	-1.079	-1.607
Job at previous survey		-0.081		-0.306		2.214
Constant	-2.402 **	-2.380	-1.048	-0.031	2.318 **	3.349
Model fit and significance						
Correct predictions						
Actual 1.00s	54.9	68.0	58.2	77.4	95.8	95.7
Actual 0.00s	81.0	89.5	76.0	81.3	29.4	58.5
Model significance, N	0.001, 130	0.212, 63	0.011, 130	0.032, 63	0.045, 130	0.005, 63

* significant at 10%, ** significant at 5%, *** significant at 1%,

Figure 3.1: SF-6D index, Want2Work Survey Respondents

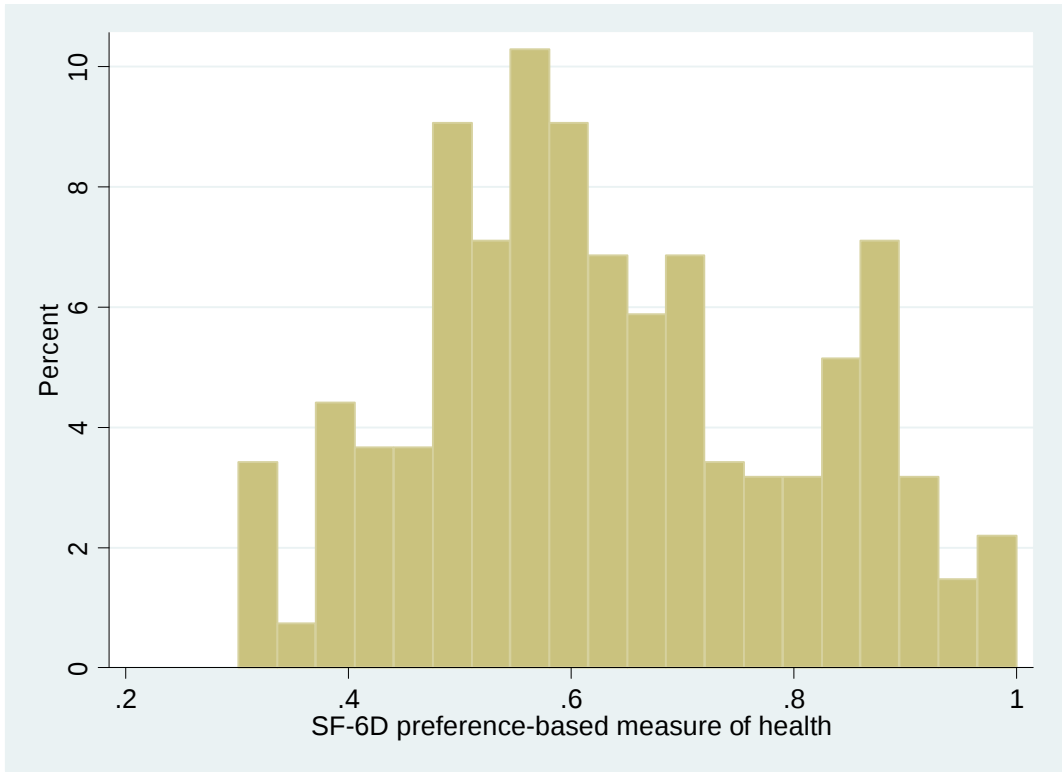
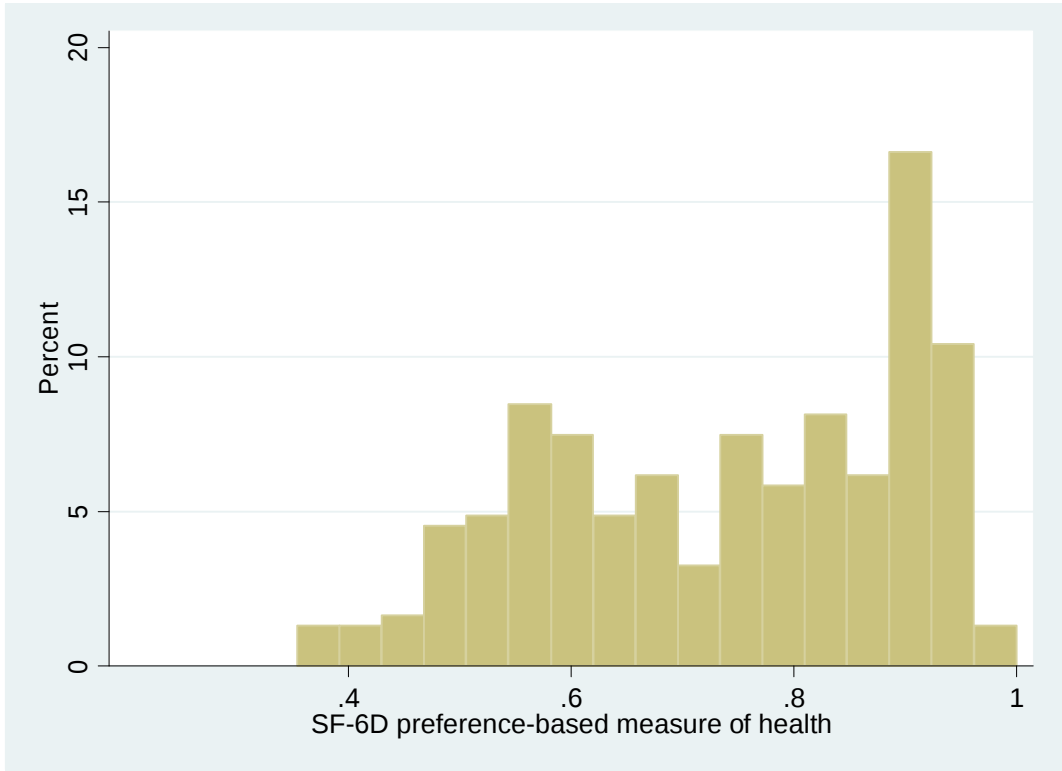


Figure 3.2: SF-6D index, BHPS Wales



Appendix 3.1: The First Questionnaire Survey

Thank you for filling in this questionnaire. It asks questions about your experiences with Want2Work, your health and contact with the NHS, and your current activities. Please tick the box (or boxes) that best answers each question.

About Want2Work

1. These questions ask about your experiences with Want2Work. Please tick the number that you feel best describes how much you disagree or agree with the following statements about the programme: (If a question is not relevant to you, please leave it blank.)

1 = Strongly disagree.

7 = Strongly agree.

	Strongly disagree						Strongly agree
	1	2	3	4	5	6	7
About your general experience of Want2Work:							
I received enough support to help me towards or back into work.							
I received support from local GPs/nursing staff.							
I saw the same people enough that I felt they understood my case well.							
About your Want2Work advisors:							
a. They were knowledgeable and supportive.							
b. They were friendly, available and accessible.							
c. They were effective in helping me make progress towards or back into work.							
About your Want2Work Health Professional and other health professionals:							
a. They were knowledgeable and supportive.							
b. They were friendly, available and accessible.							
c. They were effective in helping me make progress towards or back into work.							
I was really helped towards or back into work by ...							
a. Extra funds provided by Want2Work.							
b. Return To Work Credit. (£60, £40, £20 payments)							
c. Job Preparation Premium.							
d. Training. (Was it quick? Was it right?)							
e. Volunteering opportunities.							
f. In work support or development.							

2. Did the **opportunity of receiving** Return to Work Credit encourage you to look for work?

c Yes

c No

About your health

3. Do you consider yourself to be a disabled person?

c Yes c No

4. Please think back over the last 12 months about how your health has been. Compared to people of your own age, would you say that your health has on the whole been ...

c Excellent
c Good
c Fair
c Poor
c Very Poor

OR c Don't know

5. Looking at the following list, please tick any of the health problems or disabilities that you have.

c Problems or disability connected with: arms, legs, hands, feet, back, or neck
(including arthritis and rheumatism)
c Difficulty in seeing (other than needing glasses to read normal size print)
c Difficulty in hearing
c Skin conditions/allergies
c Chest/breathing problems, asthma, bronchitis
c Heart/high blood pressure or blood circulation problems
c Diabetes
c Anxiety, depression or bad nerves, psychiatric problems
c Alcohol or drug related problems
c Epilepsy
c Migraine or frequent headaches
c Cancer
c Stroke
c Other health problems

If "Other health problems", please give details

In the following questions, please tick the box that best applies to your health in the past month.

6. In the past month, would you say that:

c Your health does not limit you in vigorous activities
c Your health limits you a little in vigorous activities
c Your health limits you a little in moderate activities
c Your health limits you a lot in moderate activities
c Your health limits you a little in bathing and dressing
c Your health limits you a lot in bathing and dressing

7. In the past month, would you say that:

- c You have no problems with your work or other regular daily activities as a result of your physical health or any emotional problems
- c You are limited in the kind of work or other activities as a result of your physical health
- c You accomplish less than you would like as a result of emotional problems
- c You are limited in the kind of work or other activities as a result of your physical health and accomplish less than you would like as a result of emotional problems

8. In the past month, would you say that:

- c Your health limits your social activities none of the time
- c Your health limits your social activities a little of the time
- c Your health limits your social activities some of the time
- c Your health limits your social activities most of the time
- c Your health limits your social activities all of the time

9. In the past month, would you say that:

- c You have no pain
- c You have pain but it does not interfere with your normal work (both outside the home and housework)
- c You have pain that interferes with your normal work (both outside the home and housework) a little bit
- c You have pain that interferes with your normal work (both outside the home and housework) moderately
- c You have pain that interferes with your normal work (both outside the home and housework) quite a bit
- c You have pain that interferes with your normal work (both outside the home and housework) extremely

10. In the past month, would you say that:

- c You feel tense or downhearted and low none of the time
- c You feel tense or downhearted and low a little of the time
- c You feel tense or downhearted and low some of the time
- c You feel tense or downhearted and low most of the time
- c You feel tense or downhearted and low all of the time

11. In the past month, would you say that:

- c You have a lot of energy all of the time
- c You have a lot of energy most of the time
- c You have a lot of energy some of the time
- c You have a lot of energy a little of the time
- c You have a lot of energy none of the time

About your contact with the NHS

12. In the last 3 months, approximately how many times have you talked to, or visited a GP or family doctor about your own health? Please do not include any visits to a hospital.

- c None
- c One or two
- c Three to five
- c Six to ten
- c More than ten

OR c Don't know

13. On these occasions, approximately how often did you see a doctor only about a sick note?

- c Never
- c Once or twice
- c Three to five times
- c More than five

14. In the last 3 months, approximately how many times have you attended a hospital or clinic as an out-patient or day patient? Please do not include visits to accident and emergency.

- c None
- c One or two
- c Three to five
- c Six to ten
- c More than ten

OR c Don't know

15. In the last 3 months, have you had any kind of accident as a result of which you saw a doctor or went to hospital?

- c Yes
- c No

If you **have**, then how many times?

- c One
- c Two
- c Three
- c Four or more

Questions about working and childcare

16. Have you looked for any kind of paid work or government training scheme in the last four weeks?

- c Yes
- c No, I am currently working and not looking for work
- c No, but for a different reason

17. Did you do any work last week - that is in the seven days ending last Sunday - either as an employee or self employed?

- c Yes
- c No

18. If you **did** work last week, then is this job permanent (leaving aside your personal intentions and circumstances)?

- c Yes
- c No, it is seasonal work
- c No, it is a fixed term contract
- c No, it is temporary agency work
- c No, it is casual
- c No, for some other reason

OR c Don't know

19. If you **didn't** work last week, then did you have a job that you were away from last week?

- c Yes, but I was sick or injured
- c Yes, but I was away for some other reason
- c No, I did not have a job

20. Do you have any children below 12 years of age?

- c Yes
- c No

21. If you **have** children, then do you have an affordable way for them to be looked after while you work?

- c Yes
- c No

Please give details of the types of childcare available to you:

Other questions about you and your beliefs

22. Here are some questions about how you feel about your life. If a question does not apply to you, please leave it blank. Please tick the number that you feel best describes how dissatisfied or satisfied you are with the following aspects of your current situation:

1 = Not satisfied at all

7 = Completely satisfied

	Not satisfied at all					Completely Satisfied	
	1	2	3	4	5	6	7
Your health							
The income of your household							
Your house/flat							
Your husband/wife/partner							
Your job (if employed)							
Your social life							
The amount of leisure time you have							
The way you spend your leisure time							
Your life overall							

Appendix 3.2: The Follow-Up Questionnaire Survey

1. Please think back over the last 12 months about how your health has been. Compared to people of your own age, would you say that your health has on the whole been ...

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Very Poor

2. Compared to 12 months ago, how would you rate your health in general now?

- ☐ Much better
- ☐ Somewhat better
- ☐ About the same
- ☐ Somewhat worse
- ☐ Much worse

3. On a scale of 1 (not satisfied) to 7 (completely satisfied), what number best describes how you feel about your life overall?

Not satisfied at all			Completely Satisfied			
1	2	3	4	5	6	7

4. Did you do any work last week - that is in the seven days ending last Sunday - either as an employee or self employed?

- ☐ Yes
- ☐ No

5. If you **did not** work last week, then did you have a job that you were away from last week?

- ☐ Yes, I was sick or injured
- ☐ Yes, I was away for some other reason
- ☐ No, I did not have a job

6. If you **did not** work last week, when did you leave the job that you obtained through Want2Work? _____

If you answered '**No**' to both questions 4 and 5, then you do not need to answer any of the remaining questions. Please send us your questionnaire in the envelope provided.

If you **did** work last week, or were absent from a job you still hold, please answer the questions below about this work.

7. In the work that you are doing, are you an employee who works for a firm, or are you self-employed?

- ☐ Employee at a firm
- ☐ Self-employed

8. What is your job? Please describe what you do, or write in your job title.

9. Thinking about the job that you do, in which of the following sectors do you work?

- | | |
|--|--|
| ☐ animal care / farming | ☐ banking / finance |
| ☐ call centres | ☐ cleaning |
| ☐ construction | ☐ engineering |
| ☐ hair and beauty | ☐ healthcare |
| ☐ hotels and catering | ☐ insurance |
| ☐ leisure and tourism | ☐ manufacturing |
| ☐ public sector | ☐ retail / shops |
| ☐ security | ☐ transport |
| ☐ other | |

10. How long have you been doing this same job?

___ years ___ months

11. Is this job the same job with the same employer that you first found when you were participating in Want2Work?

- ☐ Yes (please go to Q13) ☐ No (please go to Q12)

12. When did you leave the job that you obtained through Want2Work?

13. How many hours per week do you usually spend working in this job?

_____ hours per week

14. How much do you earn in this job per year?

- | | |
|---|---|
| ☐ less than £10,000 | ☐ £10,000 to £14,999 |
| ☐ £15,000 to £19,999 | ☐ £20,000 to £29,999 |
| ☐ £30,000 or more | |

15. Have you been involved in any training through this job?

- ☐ Yes, at my place of work
☐ Yes, away from my place of work
☐ No

4. The Qualitative Evaluation

4.1 Introduction

171. What makes this study different from previous evaluations is the focus on the Health Advisor role and how that interacts with the role of the Personal Advisor and with the clients. This chapter describes the findings from interviews with the health care professionals attached to the pilot project, personal advisors and a number of clients including a small focus group. We were interviewing clients and personal advisors within the same time frame and this proved useful to bring some additional questions to the personal advisors interviews to help shed light on some client statements. We have not, nor did we ever, intend to interview all the personal advisors attached to the Want2Work programme.

172. A change to our planned contacts with the client group has resulted in more individual interviews. We also undertook a focus group which we had anticipated as being difficult to accomplish as this client group are often difficult to interact with. We may have only managed to keep contact with the most stable long term residents in the older age group who do not have the range of problems which may be more common in younger age groups.

4.2 Methods

4.2.1 The Interviews

173. The use of interviews to elicit explanations for behaviours and attitudes which are not easily captured by quantitative methods or to provide additional explanation to qualitative data is well established in health services research. (O’Cathain 2006) Indeed the combining of quantitative and qualitative methods has been perceived as giving added value to evaluative studies in health care. (O’Cathain 2006, O’Cathain 2004).

174. The interviews involving the health professionals and the Personal Advisors occurred in their place of work, including their new employment. We had anticipated that we may have needed to

undertake more telephone interviews with this group but that proved largely unnecessary. Some interviews were difficult to conduct as there was no private or quiet place to go. This does raise questions about privacy issues for the clients who may have wished to explore personal details. We are aware that the administrative offices were not the same as the places where staff met with clients. None of the interviews lasted more than an hour; all were taped and transcribed verbatim.

4.2.2 The Sample

175. Prior to the start of the study we agreed with the Want2Work programme the people who we wanted to interview as primary informants. We selected a purposive sample of individuals, by which we mean that we selected key informants who we thought would best contribute to our understanding and assist with the interpretation of the quantitative results. These were supplemented by recruiting some informants as part of a convenience sample.

176. We went on to interview all four health care professionals, two managers, nine Personal Advisors and eleven clients plus five attendees at a focus group. Additional information was given by administrative staff who explained the paperwork and background to how the pilot worked.

177. The health care workers seconded to the Want2Work programme were at various stages in their involvement period. Two had already finished work with the project and had returned to their previous employment (or taken up a new post). These four participants have contributed their experience of the pilot programme to the study. The Personal Advisors brought a different perspective.

178. We met with some members of the management team and two of the health professionals early on which allowed us to establish the working relationships and gave an entry point to approach specific individuals.

179. We had initially thought that using managers as an introduction may have been restricting if used exclusively. However, we also recruited by approaching individuals suggested by co-workers. We were aware that in close knit communities where everyone knows everyone else it is important that participants feel that they can be critical without being identified. In our experience, colleagues

will sometimes be able to identify which member of staff made particular comments. We had encountered this previously in health care settings where one individual was undertaking a new role and was easily identifiable. We were able to reassure participants that their interviews were confidential and we would not use quotes that could easily be attributed to specific individuals in the report and any subsequent publication.

4.2.3 The Questions

The Personal Advisors (PA)

180. We developed the topic guide prior to undertaking the interviews. We used semi-structured interviews which allowed us to explore in more depth by using supplementary questions and by allowing participants the opportunity to raise issues not covered by the topic guide.

181. We asked specifically about the informant's experience of the scheme. We started the interviews by getting the informants to tell us a bit about their background and experience prior to taking up their post with Want2Work.

182. We asked about the role of the health professional and how they felt their role 'fitted' in with this. Part of the exploration of the data included looking at this issue in relation to the background and experience of the PA.

183. We wanted to know how useful/helpful it was having the health professional in the team and we invited illustrations to demonstrate the times when the health professional has been important to the input with the client. As part of the same range of questions we also wanted to know if having the health professional as back up gave the PA more confidence to explore health issues with the clients. Other questions explored in this theme were what sort of information, advice and support has been provided to the users of the pilot's services? Not all informants were able to identify health related examples.

184. We asked how the informant would have evaluated the programme as often those most closely involved will have valuable insights into specific issues which may ultimately prove to be a key factor in how the scheme functions. Sometimes solutions as well as problems can emerge.

185. We wanted to know what, in their opinion, worked well and what less well. As part of the supplementary questions we asked about the links that had been established between the Want2Work team and local health services.

186. The question of the level of demand for health information and advice from the clients was addressed in the interviews with health professionals, the PAs and with Want2Work participants. We will compare the answers, to determine whether perceptions were similar on all sides.

187. We also wanted to know if there were any unexpected benefits of having a health component in the Want2Work project which was asked at the end of the interviews. We included this in the interviews with the clients but only if they had contact with the health professional.

The Health Professionals

188. We asked how the new role functioned alongside the more defined existing personal advisor role. We wanted to gauge the level of demand for health advice and the health professional's input from the clients and other team members. We had to tread carefully as there is a fine line between giving general examples of the kind of client seen, and very specific client related information. We have a number of examples of the kind of advice and help given which we have disguised heavily for the final report.

189. The health professionals are from different backgrounds and experience and from our early meetings with the teams this was raised as an issue. We were interested to see whether this was borne out with the experience of the teams as a whole and whether this had any impact on the functioning of the team.

190. The main responsibility for contacting the local health care teams fell to the health care professionals so we were particularly interested in them as key informants in this area. We asked about the efforts in bringing local GPs etc on board, contacts with other health care teams and inputs from the voluntary sector.

191. The health professionals were largely functioning without 'normal' roles and settings. This was an interesting issue for us in the research team. We wanted to know how they had settled in and

established a role within the teams used to working with this client group specifically. As this was a pilot project we wanted to know if the health professionals would be interested in pursuing a career change should such a post become established. The proliferation of nursing roles specifically in recent years has led to a number of changes in the way in which careers are perceived. Some nursing roles are seen as a diversion leading to a dead end in career terms and would not allow for a return to a more conventional role at the same level or grade. Job satisfaction and career prospects of our four informants in relation to their experiences as part of this pilot are also presented.

The Clients

192. We had initially planned to only conduct a focus group with the programme users. However, as the project has evolved we realised that some of the participants may have issues of confidentiality and a focus group may not be the best setting to get at the experiences of the service users. We have instead as mentioned above embarked on a number of individual interviews with the clients. We held a final focus group to discuss the results and allow for feedback from the clients concerning our analysis of the individual interviews and our conclusions. Focus groups in particular can help us identify the shared experiences and to highlight other experience that was not the norm. Both examples contribute to our overall understanding of the programme.

193. We sent out permission to be contacted slips and an invitation to participate with the postal survey, and a significant number of individuals responded to say they were interested in taking part. We wrote out again to a small sample of individuals who had returned their contact details and asked them to telephone and leave a message with their telephone number and a convenient time for the researcher to contact them. We conducted our interviews by telephone. This was a convenience sample but we also identified specific individuals from the dataset as part of a purposive sample and contacted them inviting them to take part. This was largely unsuccessful as we had response from only one individual. We had hoped through this way to be able to contact younger people and those who had contact with the health professional. At one stage none of the clients contacted were aware that the role existed and they did not access health advice.

194. Our initial belief had been that we were less likely to make contact with people not in employment but this has not proven to be accurate. The response was mixed with those in work, those who were still not in work and those who had been in work but were no longer working all involved. We invited fifteen individuals as part of a mixed group of participants, those in work and

those not, to take part. We arranged to undertake this in the Port Talbot area in the hotel very close to the Want2Work offices as it would be known to the participants. If we had a good response we planned to have two groups but on the day 5 people came to take part.

195. We asked where the clients had obtained the information about the Want2Work programme. What had motivated them to participate? We have asked about their views on the availability of information and advice on health and related issues. We wanted to know if they had seen the health professional and what kind of advice was available from them. We wanted to know if they accessed any training courses and whether that had contributed to their taking up employment. If they were not in employment we asked about specific barriers preventing them taking a job. We asked a number of questions relating to the impact of the Want2Work programme on the individual and the extended family group.

4.2.4 The Analysis

196. The transcripts were analysed using the framework approach developed by Ritchie and Spencer (1993). This approach was developed specifically for use in applied policy research, which is often constrained by time and the need to answer specific policy issues. In addition “the data collection tends to be more structured than would be the norm for much other qualitative research and the analytical process tends to be more explicit and more strongly informed by a priori reasoning.” (Pope, et al, 2000)

197. The transcripts have been read and re-read to familiarise the researcher with the content and to identify emergent themes from the manuscripts. They are examined to look for connections between the themes and ordered into key themes and sub themes which are inter-related. The data collected were very rich in detail and we have selected the themes and presented the data which we have considered to be most relevant to the experience of the pilot project and that have the most relevance to funding bodies.

198. As we were interested in capturing what worked well in the pilot project and what was less successful we asked specific questions about the whole process, from initial contact with the client to the moving on, either into employment or other activities.

From the very first interview it became apparent that teams had a great deal of flexibility in the way in which they functioned. Communicating with clients was central to the functioning of the pilot project and we developed this as a broad theme with initial contact being a sub-theme.

199. The local partner organisations' experiences of Want2Work will through necessity be interpreted through the filter of the Want2Work staff.

4.3 The Results

4.3.1 Making initial contact

200. Publicising the pilot project was left to the four individual pilot sites. There was a common model in as much as the project was seeking to engage with those on Incapacity Benefit who by definition would be more likely to have contacts with health care professionals in some capacity or other.

201. To facilitate good relations and initiate communication, local general practitioners were contacted via practice managers. Before the Want2Work health care professionals were in post the managers had initiated contact. What was surprising was the difficulty that seems fairly universal, apart from a few notable exceptions, that GPs were happy to listen to the presentations etc made by the various teams in their areas, but their response was tepid.

202. Firstly we hear from a manager who made the initial contact with the practices in their local area prior to the health care professional (HCP) taking up the post:

the health centre which has 2 surgeries in, I went down there prior to X coming on, met with the practice manager, met with one group of doctors who were not particularly encouraging but they did allow us to put some leaflets out there, talk to a couple people and we were for a while having a surgery down there so every Monday we were actually having a couple of advisors going down there, really just meeting people who were going through to the surgery, giving them our information to be able to... it wasn't... I didn't expect to get anything from the clients, what I wanted was to show that we were prepared to work in the surgery so that if the practice nurses or the health visitors or anyone had anyone that they thought could have our help, we would be on the site for

them, maybe just getting us in their thoughts more. It didn't really work out. We were there every Monday for 6/7 months but in the end we just had to withdraw it because it really wasn't giving us any feedback at all. (Manager)

203. Although there were some good working relationships that came through from the contacts built up at the local health centres it was, however, surprisingly universal that there was lack of interest from GPs.

204. The interviewer questioned this informant about how the Want2Work team had gone about publicising the project and attracting clients through the door. The emphasis on the health professional and other health benefits from this project made it important to have close contacts with GP practices. The illustrations below are not untypical:

I had assumedwas that you'd be getting referrals in from GP surgeries, from people who'd been on long-term incapacity benefit. (Int)

That was the idea, yeah. But GPs are so unfriendly. (PA)

And I think we're based in a surgery now and we haven't had one referral in 6 months, 7 months, 8 months. And they were just incredibly hard to talk to...the presentation we did over there, they said "it's no good." Because they don't want it I suppose, GPs run their own show and this is just one of those things. (PA)

Some of the GPs, yeah. I probably got into four different practices where I spoke to the GP practice manager. I think I spoke to three lots of GPs and the reception was pretty good, in so much that they would listen but as to referrals after, I think they actually made one referral from X (outside the area) so it didn't count. GPs were very receptive but, as I say, they didn't actually refer anyone. (HA)

205. A lot of this lack of involvement was interpreted by the health care professionals as the GPs being very busy individuals who see the patient for a specific problem with a limited time to deal with it. To probe further into other issues like their employment status was just not seen as a high priority for GPs. Although the disappointment was expressed above it was seen as probably inevitable. The advisors were less sympathetic.

4.3.2 Marketing the Project

206. The ingenuity and entrepreneurial skills have been amply demonstrated by the teams in the way in which they approached their marketing and reaching out to new clients. This advisor tells us about one approach to marketing which involved visiting the local prison. There are a number of clients who have just the kind of long term health issues which contribute to their unemployability on release from prison. It seems an obvious connection to make but these relationships between the prison and social services were not made before this advisor pursued this idea:

And I go to the prison once a month and do a resettlement fair there, something that's been going on for years and years and years but we've had never heard of and see then we meet not just clients, well actually through the prisoners, but organisations, that we don't seem to get to hear of. There seems to be little groups of organisations that stick together and we don't sort of mix with other people. Now through going to the prison, we've met quite a few really useful organisations for us and obviously their clients have benefited as well. (PA)

207. Marketing was not without its problems and it was seen as a drawback for others:

We've done events and I was marketing coordinator...and we spent, I don't know, a couple of thousand. We had a marquee and we had a lady in to cook food, it was cooking on a budget, it was free food, free snacks and everything and then we had all different health advisors, having blood pressure done, all these different things and I think we had about 30 / 40 people through the door – it was hardly anything really. (PA)

208. There were no easy answers to engage with the hard to reach elements. People were written to and invited to attend for advice and review. This invitation could be ignored and some people were written to up to three times. However, we know from the focus group that people found it threatening and the kind of people who didn't ignore the letter were individuals who were unlikely to be able to take up employment. One lady who attended the focus group had to get her sister to take time of work to come with her to the interview because she was so anxious and afraid to lose her benefits. This had a positive impact on her life in that she completed a cooking course and she had gained so much confidence from this that she was thinking about volunteering in the community.

209. Being part of the community seems essential as some of the views expressed below show:

I think the bedding your team down in a community. Rather than expecting people to come to you, you've got to go to them. I've learnt a great deal about marketing and I think you've got to get under the skin of the community that you're in and the time that will take will vary according to that community and it's taught me a lot about how to do that which I will relish taking back to the NHS. (HA)

Yes, it's a shopping area, so people that are passing, and because we've been left so long now, we are word of mouth. We've got quite a few families. I've got one family where I think I've got five, maybe six of the family enrolled. About three of them are in work now, but you know, their nieces, nephew, aunties, sisters etc. from only one person. (PA)

Some time you're going to meet these people again. Based in the community, you're not going to meet these people in formal Job Centres... (PA)

I think another thing the community is absolutely sick of is that you go in there for two or three years and then you disappear. I think they're absolutely sick to death of that. They think what's the point? (PA)

4.3.3 Joined up thinking

210. A finding which surprised us was the existing provision which encompassed all aspects of advice and benefits for clients. An important finding was how no-one seemed to have a full picture or understanding of this before the pilot project. Knowledge seems to have been shared in a piecemeal way and was entirely dependent on the contacts of individual advisors or health care professionals. The pilot project has made a major contribution to capturing this information and sharing it which benefited clients. For example one health professional noted that she now had *...an appreciation of the skills that they have (Job Centre Plus staff) and the knowledge that they have and the expertise that they have, and how in the Health Service we know very little about that and we know very little about how to tap into that resource and how to do it in a positive way for our patients, our customers. Virtually everybody that is in contact with secondary services like mental health services, most of those people are not in the labour market. There are a lot of reasons for that, which I won't go into now, there's a lot of research that's gone into it but they will be*

customers of Job Centre Plus because they have to be, because that's the only way they get any money...(HA)

211. The lasting effects of this kind of contact have also been highlighted:

And it's simple things like, whereas at one point in my career I would have referred somebody for a social worker, knowing what I know now, I'd be saying, "You can do this a lot quicker if you go to Job Centre Plus. You don't need a social worker." (HA)

4.3.4 The Role of the Health Professional

212. During the course of the interviews the question of what sort of person should have the role of health care professional was asked. As expected there were a number of different views, ranging from those who wanted a very hands-on approach and others who valued a more removed role where they would be responsible for co-ordinating and commissioning interventions for clients. Undoubtedly the latter allows for more clients to benefit. We present some of the findings below:

I think that anybody who had a decent knowledge of the health service and where things sit and how you get in there or who you might ring or how you look at it, who you get advice from – anybody I think with that knowledge, not necessarily somebody who would be regarded as a clinician could do the job effectively. (HA)

Yes. It wasn't just the training, (provided by the project and also HCP) but it was someone you could ask a question of. Sometimes you don't know if someone needs help and often the person themselves doesn't know they need help. If they're down and monosyllabic, does she need help? It was nice to be able to talk to X about that and maybe X coming along to one of our interviews without necessarily introducing herself as a mental health expert, but as a health worker, and just sitting in, and then being able to judge whether this person would need some extra help. (PA)

..X is very good because she can also give [other?] advice and if she doesn't know it herself, she'll look it up and get some more information for you so that's... and can ask people that you wouldn't be able to ask and look in places we wouldn't know to look and has brought I think more information about what help is out there already that we probably wouldn't have thought of or

known about so that's made a big difference to us. I don't know about with the other teamsSo, yeah, I definitely think that having a health professional involved has made a big difference. (PA)

When in the past you've said "Oh I can't help you, sorry" and now you can. And the facilities we've got access to like X and the mental health and other organisations, some you probably wouldn't have heard of in the Job Centre. You may have heard of but you wouldn't have been able to refer to them. And to have her on site, it's just a really good resource to have. (PA)

I don't know whether in the new project we need somebody with total mental health background, but I really think we need somebody with a health background there. (PA)

Because we'd have liked a health advisor whether or not it was actually a health professional or in various cases whether it was more concerned that she was with health policy, much, much earlier. There's lots of good things that have come out of actually having a health professional in the team (PA)

213. Being able to speak the same language as the local health care providers was seen across all the teams. The local mental health teams in particular had been difficult to deal with as they were unwilling to discuss referrals etc with non clinical team members. It is difficult to assess now that contact has been made and the advisors were able to talk directly to the mental health teams whether this would continue to be as positive without the clinical input in the team. One of the managers summed up the initial problems which were sorted by having their health advisor make the contacts: *..it was very difficult for me to walk through those doors. Whereas somebody coming in with the clinical experience in terms of being a mental health nurse with some years experience, it became a bit easier for her to speak in a different language I think and to be able to empathise with the targets and priorities of other organisations in comparison to our own and look to integrate common links in terms of customer groups and moving people forward (Manager)*

214. Having an individual who would be able to talk with the local health care professionals and have the contacts and the knowledge to have an impact on a larger number of clients, rather than one individual running counselling courses and giving hands-on care in what could be an area of ever increasing demand, was favoured by this manager:

I'm not sure whether or not it is a health professional. I think it is somebody who is a manager in health, who has the ability to interact with primary and secondary care providers and speak in the same language, to go in and do some negotiation and partnership work but behind that it's the pot of money in terms of provision based support, to find out where there are either current provisions or gaps and look to support those gaps with our own provision (Manager).

215. This view was also supported by these informants:

I see it as what it was described as which is a professional health advisor. If somebody needs a health intervention, then I would see it as my role to advise on or support them to access that health intervention. (HA)

I had to really work hard at trying to sell the public health kind of concept of health, rather talking of some medical model of dealing with health and well-being. So I turned it round to try and make it more about public health... (HA)

4.3.5 Mental Health Issues

216. The issue of mental health problems has been a consistent theme throughout the whole of the project. It has come up in various different contexts from unmet health needs to the area that caused greatest anxiety among the advisors as the condition they felt least confident about giving advice. We have reported on this under other themes and headings but we have also given it a main theme on it's own as it was often cited as an example or expressed as an anxiety by Personal Advisors:

I would say not the vast majority because the vast majority have a good health condition and are happy with the way things are going, but we have referred quite a few people to expert patient and they want help, especially with mental health, it's not so much referring them for more 'health' help, but referring them to maybe a leisure course where they are doing painting or photography, getting out of the house and starting to mix with people. Building that up, whatever it is, in small steps to get them back doing something, and that is a help to people who have got depression and anxiety. That seems to help them a lot. You see the change in them.(PA)

217. This type of client was very familiar to other teams:

And a rough estimate, I would say probably for every 5 people I was signing up, one of them would need X's (HCP) help in terms of confidence building or I can give examples. A lady up X, she barely went outside the door. She'd only come to the door because she thought her money was going to be stopped. And it took 2 years, and X was heavily involved there, of getting her into classrooms, small classrooms of women and she's working now. She's been working for coming up to 12 months and she's a completely different person from the time she came in. (PA)

I think especially because mental health is such a huge issue and I'd say it's the biggest proportion of our customers are on sick with some sort of mental health, whether its anxiety, stress, depression, I mean they're all connected but it's under mental health. I think it does give you a bit more confidence in dealing with it because if X's there you can say to her "If I suggest this to this person, is that going too far for them? Or can you see them to see how far down the road you think they are and am I pushing them too much? Am I not pushing them enough?" Because to be put on sick with stress, there's extremes of it. (PA)

218. Having Health Advisors on the team with a mental health background was very popular with the Personal Advisors although it did not appear to take very long for them to be more confident dealing with this themselves. Not all the health advisors had a clinical background in mental health and they acknowledged that they had to deal with their own anxieties on not being 'expert' in everything. Although there appears to be an almost endemic problem with mild to moderate anxiety and depression in some communities, those with serious mental health conditions are more likely to be known to the mental health teams and have their condition managed.

4.3.6 Voluntary Contact

219. A main theme that emerged from this work was the commitment to the voluntary nature of the project. As part of the questioning about the marketing of the project and how they were finding their client base, a little bit of the importance of the voluntary nature of the Want2Work project emerged. There is sometimes ambivalence expressed about the voluntary nature of the scheme but an interesting line of analysis is looking at how it appears that the interviewees were almost rehearsing the arguments for and against and were often at pains to point out that other projects

elsewhere had a different philosophy. The quote below illustrates how there is a feeling that this client group are hard to get to, hard to engage with and if you push too hard you can lose them:

Because, I know it's voluntary and it was this marketing a little bit that I wasn't sure where the voluntary bit... at what stage in the process that people actually got to know but it's that you go out and find your clients. (Int)

Yes, that's right. We tell them it's voluntary from the start as part of the initial interview and there's no pretence that they have to stay with us or they have to be committed to doing the project for a certain length of time.engaging them so they can stick with the project and that's what we do. If they stick with the commitment, and they see the support that we offer, it does encourage them. (PA)

220. Asked about other government initiatives this advisor explained the difference between what they were doing as part of the pilot project and what other agencies did:

... level where they're not dealing with the beneficiaries that we have whereas in certain areas, say if you were in a recruitment company and you had targets to reach, the people come to you and they're work-ready, whereas our beneficiaries are not work-ready and each one is an individual and they have such complex problems ...I like to think we can get them into work but realistically it's just not going to happen in certain circumstances. (PA)

221. All of those interviewed stressed the difficulties in engaging with this type of client as some of them were third or fourth generation of benefit claimants:

It's... I don't know how to describe it. It is an area where, it's a different type of culture and it is very much second, third, maybe fourth generation of benefit claimants. (PA)

222. These clients are being contacted cold and asked to come voluntarily to discuss ways of getting into work. It could almost be seen that an individual from such a family or community who made contact could be ridiculed and be seen as deviant by wanting to work at all.

223. One informant told us about an encounter with a client after the tape was turned off. The person concerned had been approached with a leaflet in the GP surgery and had been quite aggressive and verbally abusive. The advisor had calmed the situation down and offered a review of benefits as an opening. In the end the client after a lot of support and input moved into employment. It was hard to imagine a compulsory encounter would have broken down the barriers.

224. The difference between the approach from the Job Centre and that of the pilot project is highlighted below:

I think anyone walking into the Job Centre, it's an immediate barrier, it's officialdom, paperwork, and they think 'they're going to make me do something I don't want to do.' No matter how nice you are then, however you try to help, I think that's how they see it, that you're only there to stop their benefits or make them do something they don't want to do. Whereas because this is voluntary and it's friendlier and the environment is a bit more open, they do give us more trust perhaps and perhaps a bit more respect in what we're telling them. (PA)

4.3.7 Making a Difference

225. The purpose of the pilot project was to bring back into economic activity some of the growing number of individuals who are claiming Incapacity Benefit. The success of the project by necessity is to be measured on the number of claimants who get back into employment. However, as we noted above, these are a particularly difficult group to reach and motivate. The quote from the PA below helps to illustrate that they are not the same people who come through the doors of the Job Centre:

Yeah. I think the very fact that the people we're targeting aren't people who a Job Centre would normally meet makes it a bit more successful to start with. The fact that the long-term sick don't become employed, people who wouldn't go to the Job Centre normally, we interview and actually market it for them. We actually engage with them and we've actually got the process to get them into work. (PA)

226. The PAs, although committed to encouraging their clients, are also realistic on their behalf. The interviews conducted with the clients do bring to the fore the issue of unrealistic expectations. Being able to work with clients to help them move forward in their lives and perhaps be more active in their communities by volunteering or undertaking some activity other than paid employment is important:

I mean she's been unemployed for 20 years, has multiple health problems, physical and mental. She wants to do something, she wants to achieve something and she is. I think through our support, she can do voluntary work, little bit at a time, start slowly, voluntary work, maybe some exercise and it's

working. It's getting to the point now where she's thinking of applying for jobs. But actually she still has the health conditions which she can't overcome and never will, they'll be with her for life. (PA)

227. This advisor gave another example of what can be achieved but there is often considerable input from the team and the health care professional:

Came through the door, extremely overweight, crying her eyes out, buckets of tears in fact. And if you could see the woman now, she's now working in Mind – Mind mental health organisation- she's actually on the reception there, she's doing all the incoming calls, she deals with people. We've also paid for her to do a taxi license, so she does that as an additional income. A completely different person but then, again, that all started from the initial referral X (HCP) getting involved, do this, do that, that kind of stuff, an awful lot of work which you can't really explain in 2 seconds flat but just simple support- being there week after week after week and a completely different person. (PA)

228. The theme of pushing the client too far too fast is further illustrated by this quote from a PA. Knowing the clients and having time to spend with them is emerging as being part of the success in helping to motivate and engage the client:

...I think it's down to setting goals which you can achieve and not make them too unrealistic. Push them on a little bit but not push them so far that they're going to fail. Give them a little bit of confidence and then that builds confidence. ... we can't promise the world but we will achieve something. (PA)

229. Making a difference to families especially when a father found employment changes attitudes. This advisor shows how this changes lives in families where no one had worked:

People have said, fathers especially, "I've got a son, 2, 3 years old, I'd like to see him as a brickie." And that's really good to see. (PA)

4.3.8 The Quality of Employment

230. The type of jobs that were available to clients who had been in contact with the Want2Work project was raised as an issue. There was a feeling that most people were going into fairly low level employment at the lower end of the income bracket, though it was noted that there were some

exceptions where clients had been helped into employment suitable for their level of education and abilities:

... not just basic IT stuff, we've paid for people to go on really technical stuff. Not based on them just having a dream to do it, obviously them having the relevant qualifications and experience and also knowing that there are jobs available. I think that's probably one of the best things about this project. (HA)

231. It should be acknowledged that for some clients who left school with no qualifications and who have never worked, undertaking training and getting any job is a major achievement. The quantitative study showed that younger people and those who had not been unemployed for long periods of time were more likely to find work. Small targeted projects like the one in Merthyr which liaised with local employers to help them select employees for a new retail outlet have proved very successful for some clients:

We've actually, instead of just sending them on a retail course, worked with the new companies like New Look, Debenhams outfit, and we geared a course for them with a guaranteed interview at the end of it. So we didn't actually put the course on, but we helped arrange it with X... So they put on the course specifically for those shops and I think out of the twelve people put up for the New Look one, ten of them got jobs. So it was very successful. Other people put up who didn't get jobs in those shops have gone into retail work (e.g. Asda), which has been quite successful. (PA)

232. Similarly, specific training for a local hospital trust was organised, which was successful at placing groups of clients into employment. These jobs were aimed at care assistant level. The courses covered some of the basics that employers would have had to provide new starters with, such as health and safety updates etc. These updated skills made the clients more likely to be successful at interview. The hospital trust now contacted the team when they were planning to recruit new staff allowing them to prepare to place people more directly.

233. The quality of the training that it was possible to offer was universally praised as being one of the most positive benefits to the clients from the programme. The illustration below is fairly typical of the endorsement from the advisors. It is also indicative of the kinds of employment that clients have taken up. One of the most popular requests for training that the advisors reported seemed to be for forklift truck driving. Almost everyone mentioned it as being very popular with clients!

The one-off training has been a definite boon that we can draw funding down for customers to do a variety of training, from, we've beauticians to HCB drivers, personal track safety to rail tracks, plumbers, you know all sorts, a huge variety of training that these people wouldn't have been able to access through normal... without us being there. And it doesn't, it's not a 100 percent successful, people, as I say, people will let you down but I say that the greater percentage do get a lot from it and even if they don't go into what they trained for, the fact that somebody has shown them the option to do something and taken it seriously and helped them with it, even if they don't go into that application straight away, that they seem to go into something else instead and perhaps follow that on afterwards. (PA)

234. It is easier to look for a job with better prospects if you are already in employment. This first example is given by an advisor and the second from a client:

He started work when he finished the training, a bit of a low paid job for what he was doing but it was a step in. He's now working for X. He's on £26,000 a year and couldn't be happier, looking to buy his own place and just a real, a real nice success story and I think, I knew, if he hadn't have been here, he'd never have done that, he'd still be on sick, doing a bit on the side, because that's obviously how he was getting by. We know that it's made a big difference to him and he's determined to see his kids now, who are 18 / 19 I suppose, doing something else, doing something with their lives and not tending to just wasting it forever. (PA)

I went back to work on a part-time basis, it was so strange how it came about because I had a couple of interviews, they got back in touch with me and offered me permanent part time work in the shop as a shop assistant, so I took that, had the help from Want2work, they give you a clothing allowance, anything, and if you were working in an office and you needed a chair or whatever and they were marvellous they were really helpful. Anyway I started on a part-time basis and really enjoyed it, and I was offered some training then to go into dispensing. To tell you the truth I didn't feel all that confident, I would never have thought that I would have been able to that, so anyway I started the training, it's X Pharmacy I work for, (employer) pays for you to do the course work, it's been quite a struggle, so I actually started it over a year ago and I am on the last course now which is another year and I actually qualify then I become a qualified dispensing assistant. (Client)

235. This lady had not worked for a number of years and still has the health problems that originally made her go on the sick indeed she has other health problems and needs surgery. The interesting

point is that she made the contact having seen the poster at the GPs surgery and contacted the team herself. Obviously she was motivated to do so but some of the examples from the advisors and the clients have shown that this group although motivated are often unrealistic about what they can achieve. However, in this case it seems that having the external outlet of an interesting job and study has put her health condition into the background and allowed her to cope.

4.3.9 The Barriers for Clients

236. We wanted to know what the perceived barriers were among the professionals and clients to taking up the opportunities available from the pilot project. Getting the right experience is important for clients. The example of the new open cast mine at Merthyr was given. There had been considerable interest from local people in undertaking the appropriate training to operate specific machinery but the employers were quite clear that they were not interested in taking people with the certificate they wanted a minimum of 6 months experience as well. This was seen as creating a ‘catch 22’ situation for clients:

We’ve found we’ve got a lot of people asking if we’ve got open cast training starting up shortly. So lots of people have been coming in asking for licenses and by talking to the company, they don’t want people who have just got their license, they want people who have got experience as well, six months experience. So there was no point putting people on these courses, getting them their license just for them to fail again. That’s not good for them, and it’s a waste of money for us. There’s no point in doing that. (PA)

237. An additional problem with this employer was that they appeared to have received about 600 or 700 applications for a small number of jobs. There was no way that the pilot scheme could help place clients in jobs with this company.

238. The clients also had similar experiences and one in particular felt that this was something that needed to be addressed before the pilot project could be truly successful. Overcoming the barriers of ‘got the certificate, but not the experience’ is particularly challenging. This interviewee expressed the problem of combining the need to get experience and not working too many hours to lose benefit:

And as I said, you've got to work to get your hours on your log book. I'm just referring to myself now on the plant side of things. But a cook, or a vehicle mechanic or whatever obviously has to have hands-on experience of these things. But you've got constraints on the Government side of things, saying you can't work more than this. So how can you... (Client)

239. Another client was trying to set herself up as a yoga teacher and needed to have mats etc but she found the system complicated about how she could claim her expenses:

Yeah. It was a bit complicated in that initially I was told that I had to bring in prices for the items I needed and they would give me the money. When I did that I was told that I needed invoices for everything, so it got a bit more complicated. I had to spend the money first to get it back on more things. A couple of things were handled down the phone or through myself to 'Want2Work,' but it was different to what was initially settled (Client)

240. The interviews also identified the problem of child care as a barrier to taking up training before getting as far as entering employment:

And childcare with lone parents is enormous. Even just for training, it's impossible. One girl recently was so excited, she got a place in college to do beauty therapy. Her friend said when she finished the course in a years time she could rent a room of hers in her hairdressing salon and she could set up herself doing make-up and stuff. And she was so excited, so thrilled. And then she couldn't get any childcare. The nursery in the college was full and X and places like that only do short-term training. They don't do it for a year. So she couldn't do it, so she's back with us. And she could have done it then in the evenings, but then you can't get childcare in the evenings. So you know, I tried everything to get childcare for her, and it's just not out there for that. Even if I could get someone in for her for evening work, for evening training, there isn't childcare out there for people to do evening courses. (PA)

241. The problem of childcare was further expanded by this interviewee. We think that although this was not as prominent in the quantitative results as we had thought it is worth exploring what this Personal Advisor has experienced in the day to day work with clients. It was felt the problems of finding good affordable childcare limited the kinds of employment that they were seeking. In particular this advisor felt that a lot of women were looking for a job which they could do in school hours and be there for the children the rest of the time:

Even people who are not lone parents, you know, with children on Incapacity Benefit, and you see what kind of ..can I get from ten till two, and you think, 'you know, the world would shut down if they all had that job, and you've got to say to them realistically that the chances of them getting a job that's ten till two, Monday to Friday, are very slim. (PA)

242. One of the health care professionals targeted parents with young children specifically to work with in an innovative way as demonstrated below:

I did that because we were having a lot of clients in who were parents with young children and they weren't warming to the project because they wanted to do something but they had that young child who they felt they couldn't leave at the time but the aim was that eventually they would want to go back to work or on do some sort of training so it was just looking for activities for them really where they could bring their babies with them and boost their confidence, doing something they don't have to do with their child. I've done before (swimming instruction) that so.. just one session a week where they brought their babies to the pool. It was confidence building for the parents and then from then on we'd signpost them into language and play courses, practice they could do with their child and then clients would come back and see the advisors and then they would signpost them onto other training or they would actually job search for them whilst they were doing that. So, in a way, keeping the link going. (HA)

243. Parents with young children are a difficult group and they are often targeted. Availability of appropriate child care and issues of affordability can be a problem for clients. Engaging with individuals in more creative ways like this may reach parents in a non threatening way which could achieve better results than a traditional approach. An outcome of this swimming programme was for one of the mums to undertake training to become a registered childminder. This confidence building exercise is easy to overlook but it could have had additional benefits in improving parenting skills and communication between mums and babies. The professional background of the health care professional and her additional skills brought a very different approach from that normally encountered by clients at a traditional job centre.

244. As part of this theme we also found examples of the barriers to staying in employment which one advisor illustrated well for us:

It's not like "Oh great, you've got a job (unclear)." So that's the bit you can sort out yourself. They'll often come back in sort of 3 months later "I got this from the Council, what do I do with it?" And for us it's something quite easy to do because we know who we need to ring, we're used to dealing with forms, but for them it's a major headache and it can be like "Oh God, I can't cope with all this, I'm going to pack in work." And I think it's very easy because they have a different way of looking at things to start with and it takes time. (PA)

245. The idea here is of the client who has been unemployed for a long time, this is what they know and understand and the world of work, and the bureaucracy that goes with it is alien to them. Allowing people to have a period of adjustment seems to be important. This does put additional strain on the resources of the advisors who are having to continue to give support until the world of work becomes that norm rather than living on benefits. There are unfortunately no rules which will help the advisors know which people will continue to need support, what kind and for how long. It does illustrate that just placing people in work is not enough. If you want to keep them there you have to do more.

4.3.10 What Makes it Different - What is Important?

246. There is a great deal of rich information reflecting how everyone involved with the pilot project had a number of similar points to make. One advisor illustrated below picked up on the personal view that the staff who put themselves forward to take part in the pilot were central to the success of the project. The explanation was that personality of the staff mattered too, including their attitude to their clients and their willingness to embrace a new way of working with clients. There was consistent reflection of the difference between the way in which a Job Centre processes clients and the more individual approach essential to the working of the pilot project. Other interviewees made more oblique reference to the importance of the individual PAs and this was usually couched more in terms of the difference between working in a traditional Job Centre setting and that of the pilot project. There are links to literature from other professional groups like nursing where the individual taking on the role is central to how well it works:

Probably the skills of the Personal Advisor. It's really, really vital and I think without the people that are on board this project, it wouldn't work. It's the willingness of the people to give the time and effort to do the work. It's not as structured as the Job Centre and you've got to be really

committed to this sort of work and not be afraid to take on a challenge. You can't walk away from it.
(PA)

247. Moving people on and helping to make a difference to lives is what motivates advisors, although some people will never be able to become economically active. That there can be other meaningful improvements in people's lives was an important finding.

4.3.11 Unmet Health Needs

248. The whole area concerned with unmet health needs has emerged as an issue. The quantitative study found that individuals had less contact than expected with local health services. Both the health advisors and the PAs identified this as a major area of concern. A number of people are not in work due to a health condition, about which the advisor understands little and is unable to help manage the condition because of their lack of knowledge. We feel that this may be a major finding:

What I did notice, and I think (the other HCPs) will back me up on this, is that, there's a massive gap in the services for the clients who fall into that area where they're not severely mentally ill, they're not severe enough for psychiatric referral; they may or may not be treated by the GP for mild / moderate depression, anxiety, yet there wasn't much service for that client group and they're the ones who drifted along for a long time really without having any intervention and I felt those clients were being let down and you think oh they can be easily treated and easily managed and that wasn't happening so a lot of the clients I saw were of that nature and sometimes it's just getting them to see their GP to ask for some medication and to see about somebody just listening for a few weeks and if needed maybe to go for some counselling. And I think those clients were, in the area, let down and I don't think it's just this area, I think it's nationwide. (HA)

249. The illustration above is concerned with mental health but the same can apply to other conditions like diabetes as demonstrated below:

It's been really useful having X in her role... because ok, she's not a doctor or anything but she knows the right people to refer on to. We have people, I've got some beneficiaries that are diabetic and they're not managing their health condition and it's useful to know what they need to do....
(PA)

250. The negative connotations associated with some health problems alongside the lack of knowledge and support has left some of the client group unable to see what they can do and focus only on what restricts them:

We had one man who's lived with epilepsy for many years, and he's always been advised to say, 'I can't do this, I can't do that.' He now goes every fortnight to an epilepsy group, and he's now looking for work, because that group has given him knowledge and insight into what somebody with epilepsy actually can do. That's a real positive. (HA)

251. The teams have noted that unmet health needs come in various forms as we have shown. This lack of contact with local health services has been identified across the programme:

So there's a lot of people out there who are never seen (by a GP). It's even just finding out that they've been living with a health condition for years, and they know nothing about it, just by signposting them.... (HA)

252. We also came across problems with the clients who had drug and alcohol problems which were undiagnosed and little help available to these individuals. They are obviously not in any position to take advantage of help getting back into employment without considerable input from a multidisciplinary team. This was highlighted by several of our informants. This area is potentially so large that beyond commenting here we have not reported further as we are unable to demonstrate that the teams were equipped to do anything other than refer to the local drug and alcohol services.

253. This also connects with the other benefits of making contact with the Want2Work team. We wanted to know if there were any unexpected benefits from the project and towards the end of the interview this PA revealed the example illustrated below:

I think the unexpected thing is how much better they feel about themselves and about awareness takes a back-seat when you initially start meeting with them it's all they can talk about. It's central in their lives. What doctor they're at, what tablets they're taking. When they get up, when they go to sleep, everything. It's the centre of their universe.... and it's surprising to see how slowly they start talking about other things and it's not so important. It doesn't mean the illness or the condition has gone away, but they have other things to think about.

That is surprising, that even though they've got maybe even quite a severe condition, how over time, and the more things they get involved in, and the more things they do, the less that seems to be

important. Even though they're still coming in, and on some people's faces you can see that they are in pain, but it's not the be-all and end-all anymore. So that's been quite unexpected. (PA)

4.3.12 The Clients

254. The interviews and focus group with the clients although important to carry out was less rewarding in terms of data gathering. We found very quickly that clients were not telling us anything new about their experiences. This may have been due to the individuals who were willing to speak to us. There was always a possibility that those whom we most wanted to reach are those that the programme was not reaching either. We sent invitations to over 120 people who had ticked the box indicating that they would be prepared to be contacted but the response was disappointing.

255. The focus group was unfortunately dominated by one individual who, due to her health condition, was slightly disinhibited and this was off putting for the other participants. However, valuable corroboration from the interviews of the advisors was gained.

256. Beyond reporting that some clients had unrealistic expectations of what could be achieved on their behalf we have not detailed this particularly.

4.4 Discussion

257. There is an overwhelming view that the programme has been a success. The examples shown above are very typical and summarise what we heard from those with whom we had contact. They provide a background to some of the quantitative results. The richness of the data allowed us to present themes that were relevant to the quantitative work and provide a fuller picture of the project for the funders.

258. What would be lost if the programme ceased to be funded? As we have shown above there was considerable feeling from the community that this was just another directive that starts up and is then withdrawn just as people are getting used to it. This was also expressed by the Personal Advisors. The loss of momentum and expertise in a complex area would be difficult to recreate in another setting.

259. The overwhelming feeling conveyed by the interviews from all participants was the massive good will generated. There was a genuine feeling of excitement which we hope has been conveyed above at being able to offer the kinds of preparation that clients needed to move their lives on and take up meaningful employment. The Personal Advisors were very grateful to be given the opportunity to work with clients in new supportive environments and the clients responded by seeing what they were taking part in as an opportunity to change their lives. Even those who did not have particularly positive outcomes appreciated the work of the team.

260. The consideration that the voluntary nature of the scheme was central to its success is somewhat at odds with current government thinking. This view was upheld by both the professionals and the client group. Indeed the example of the anger felt by some hard to reach clients can be dispelled by the professionalism of the staff who emphasise the help they can give and the interest they have in clients as individuals shows what can be done.

261. It is recognised that an undertaking like the pilot project is not a money saving exercise to save on benefits. To properly support clients who present with multiple problems, not least unmet health needs, requires skill and dedication from highly experienced staff.

262. The issues raised concerning mental health problems were largely expected given the nature of the client group. However, the work of the health care professionals helped to put these problems into perspective. The reassurance given to the advisors in handling and dealing with clients is something that could be part of a wider programme.

263. The personal stories reflecting the successes which can be celebrated by the teams and the clients they helped are too numerous to detail. The project has had a profound effect on the lives of a considerable number of individuals. Some of these people will not have moved on into employment but they may have been able to give back to their community by volunteering.

264. Points for discussion remain, such as whether the health care professional should adapt to a more commissioning role, and whether the person in the role of health care professional actually needs to be a qualified nurse or equivalent practitioner. As we have shown, the number of clients with mental health problems and other related problems with addiction etc can be well served by a team that has an understanding of the issues and close links with the specialist practitioners in the

local area. It is arguable that clients would be better served by prompt identification and referral rather than looking to provide specialist care in house. The pilot project has shown that it takes time to forge those links but once established are invaluable.

265. We know that Personal Advisors on their own found it difficult to communicate effectively in the early days with the mental health teams and that having someone on the team who ‘spoke the same language’ facilitated the open dialogue which improves the care available to clients.

266. The health care professionals came from different background and experience and those without mental health experience worried that they would not be competent in that area. Those with more experience in mental health were more concerned that they lacked other expertise. The diversity of the team allowed for sharing of experience and ideas. Those seconded to the project have had very positive experiences and would consider working with such a scheme if it were to be rolled out nationally.

267. The interview data regarding this point from those with experience of the pilot is mixed. It is interesting to remember that even those with the most hands-on role also provided support and training to staff which reduced the number of cases that would be referred for an intervention from the health care professional. The majority of participants would appear to wish to opt for an individual with experience of commissioning but combining expert knowledge. The cascading of skills and knowledge gave a boost to the Personal Advisors allowing them to carry out their role with compassion and confidence.

268. As with all new roles, thought should be given to career pathways and professional development for those employed in whatever capacity. It is possible to envisage how this would enhance the career prospects for Personal Advisors but the experience may not work in the same way for other professional groups like nurses. This could perhaps be overcome by emphasising the public health role of any post that would be created.

269. Finally, in terms of future research recommendations, the teams had hopes that the new training programme for GPs being developed by a team from Cardiff University would help to bring about positive change in the way clients could be referred by practices. Future research should be aimed

at capturing the views of professionals from an NHS perspective. Ethical constraints from the beginning prevented us from contacting GPs to understand their perspective.

270. Although we have reported on some feedback from employers taking clients who had been part of the pilot project we did not undertake interviews as we only had one contact name and we felt that this would not necessarily add to our understanding of the process in a way that was applicable to other employers. Any future research could consider input from employers as a focus for improving and directing the opportunities for clients.

5. Conclusions

271. This report has undertaken a thorough review of the Want2Work pilot programme in Wales. A mixture of quantitative and qualitative analysis has been undertaken, to consider both the processes and the outcomes of the programme.

272. The first piece of quantitative analysis examined the labour market outcomes for those involved in Want2Work. Given that the ultimate aim of the programme was to move people, primarily those on Incapacity Benefits, into work, then its success in this regard should form a key part of the evaluation. The analysis in Section 2 of this report revealed that Want2Work has been successful in this respect. In particular, compared to a control group of out-of-work individuals who are looking for work, with the same observed characteristics, medical and labour market histories, and living in areas with the same economic conditions, individuals involved in Want2Work are 4-7 percentage points more likely to move into employment, depending on the estimation methodology used. We argue that this is a large effect, given the low probability (around 20%) of obtaining work observed across the sample as a whole. The impact of Want2Work on finding work is considerably larger (around 13 percentage points) when only individuals in receipt of Incapacity Benefits are considered in the treatment and control groups. Given the focus of Want2Work on such individuals, the attention paid to health issues and the involvement of health care professionals in the programme, this result might have been hoped for or expected, but is pleasing to observe nonetheless. In terms of the quality of jobs obtained by Want2Work participants, there is some limited evidence that they are more likely to accept lower paying jobs, and less likely to obtain a full-time job, compared to job-gainers in the control group, though the differences are small and typically not statistically significant.

273. An important aspect of the labour market outcomes evaluation is how long the jobs obtained by Want2Work participants last. If the jobs are merely short-lived, before the individuals return to benefits, then the impact of the programme would be much smaller. Unfortunately the evidence here is less robust, relying as it does on tracking people over time to observe any changes, and therefore suffering from attrition. We made use of information from the official Want2Work database that follows individuals for up to one year after they obtain work, and from our own follow-up postal survey which questioned individuals after a longer period in work had elapsed (at

least 14 months, and often longer). Both of these sources suffered from repeat observations not being available for a large number of people. All we can report, therefore, is that *for those who were tracked in the Want2Work database, or who responded to the follow-up survey*, jobs appeared to be long-lasting, with a majority still working in their original Want2Work jobs. Furthermore, compared to individuals in the control group who found work, Want2Work participants *on whom we had repeat information* stayed in work significantly longer. In summary, therefore, Want2Work has been very successful in terms of its primary labour market aims of getting people into work, and in particular some sort of permanent work.

274. The second focus of the quantitative analysis was health issues, as analysed primarily in Section 3. The analysis here was restricted in that no comparable indicator of health was obtained at the time that individuals became involved in Want2Work, and so we could not say whether involvement in Want2Work *caused* any changes in their health. The results show that Want2Work participants have on average worse health than the control group, but that this can mainly be explained by differences in their characteristics. Therefore Want2Work is dealing with people whose characteristics produce more serious health problems than those found amongst the general out-of-work population (even when the latter are restricted to Incapacity Benefit claimants only), which makes its employment successes described above more impressive.

275. As expected, those individuals who move into work have better health, though of course without the baseline health information, we cannot say whether this is a beneficial effect of moving into work, or whether those who are already healthier are the ones who are more likely to find work. Interestingly, this statistically significant positive relationship is only observed in the Want2Work sample, suggesting that the health gap between the employed and not-employed is larger for that group. One interpretation of such a result is that Want2Work, with its emphasis on health and its involvement of health care professionals, does more to improve the health of the clients that it moves into employment. Once again, however, with simple cross-section data, we cannot rule out alternative possibilities, such as that Want2Work focussed more on those individuals already in the best health and tried to get them into work first, creating a larger health differential between those in and out of work amongst its participants.

276. It was hoped that the second postal survey would provide more information on the causal impact of Want2Work in general, and moving into work in particular, on participants' health, by

providing a second measure of health at a different point in time. Unfortunately, due to the small sample size and large attrition problem on the second survey, robust evidence was unlikely to be found. The results that did emerge could find no effect of previously finding a job on current health status, nor any effect of being in work on changes in health over the previous year. The only result suggesting health benefits of being in work was one that showed a greater improvement in health over the previous year amongst those working longer hours. Overall, however, it has to be concluded that we have found no conclusive evidence either way to answer the question whether a movement into employment through Want2Work improves one's health.

277. The final part of the evaluation was the qualitative research, to determine participants' opinions of Want2Work. This was facilitated both by some of the questions on the first postal questionnaire, and also by the formal interviews that we undertook. The postal questionnaires were completed only by clients, and so were restricted to the views of that group. These views about the Want2Work scheme, and the individuals involved such as Personal Advisors and health care professionals, were positive in the large majority of cases. The only group of individuals involved who were viewed negatively by significant numbers of clients were GPs and/or nursing staff.

278. Moving on to the interviews with those involved with delivering Want2Work, again most views expressed were positive. Various characteristics of the programme were identified that have been key to its success. For example, the voluntary nature of Want2Work was mentioned by numerous Personal Advisors as an important aspect, since it allowed the scheme to be portrayed as an attempt to help those who want such help, rather than something forced on individuals by officialdom. In support of the clients' positive views of their Personal Advisors and health care professionals, the latter two consider the individual attention that they provide being key to the success of Want2Work. The ability to get to know individual clients, and so understand their problems and their abilities, makes finding suitable employment for them more likely. The involvement of the health care professionals seems also to have been valued, in terms of having a link up with the health profession, and in terms of gaining a better understanding of the problems faced by clients and how they can better be helped.

279. In terms of issues identified to be resolved, one is the quality of employment obtained by Want2Work participants, with some fears that only low level jobs were being obtained. The general feeling was that the training component of Want2Work is a very important determinant of helping

people into more fulfilling jobs. Other barriers to obtaining suitable work remain, however, and have to be addressed, such as a lack of recent or relevant work experience, and childcare issues.

280. Overall, then, the quantitative and qualitative evidence both point in the same direction of the Want2Work pilot being a successful programme that has largely achieved its goals. Whilst some of the individuals involved undoubtedly would have found work anyway, the evidence suggests that individuals are more likely to obtain employment through Want2Work than in the absence of the programme. These jobs appear to be long-lasting, at least over the timeframe considered, and those in work are healthier than those out of work, though the latter may not be a causal relationship. The programme is well thought of by everyone involved, and the innovative aspects, such as the inclusion of health care professionals, appear vindicated by results and participants' opinions.

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