HEALTH SELECT COMMITTEE SOCIAL CARE INQUIRY

Written Evidence[1] Submitted by

Professor Stephen Pudney, Francesca Zantomio
ESRC Research Centre on Micro-Social Change, Institute for Social and Economic Research, University of Essex

Professor Ruth Hancock[2], Dr Marcello Morciano
Health Economics Group, Faculty of Health, University of East Anglia

November 2009

Summary

Our evidence summarises emerging findings from our research on the role of cash benefits – Attendance Allowance (AA) and Disability Living Allowance (DLA) – in the support of older disabled people. It relates to people living in private households and excludes the care home population. The principal findings relevant to this inquiry are:

1. Claim behaviour for AA is strongly related to age, income and severity of disability. People with higher levels of age and disability, and lower levels of income, are more likely to make a claim for AA. Adjudication outcomes are, as expected, strongly related to disability.
2. Although not explicitly means-tested, AA/DLA payments display a degree of income targeting, since low-income people are more likely to have severe disability and are also more likely to make a claim. The degree of income-targeting is less than for Pension Credit, but still significant.
3. There is evidence of a large group of older people (at least 30% of the over-65s) who are not receiving AA but would be predicted to be successful, were they to make a claim.
4. Our analysis finds no evidence of significant numbers of older people receiving AA/DLA long-term without any accompanying health problem.
5. Receipt of AA/DLA and receipt of local authority social care services overlap only partially – there are many people who receive social care services who do not receive AA/DLA and vice versa.
6. A switch from a dual system of support (AA/DLA + local care services) to a unitary system providing only care services will greatly increase the uncertainty faced by potential applicants for support and the risk of uneven administration. Increased uncertainty poses a significant threat to take-up.

[1] This evidence updates and expands on evidence submitted by Stephen Pudney to the Work and Pensions Select Committee's recent Inquiry into Pensioner Poverty.

[2] Corresponding author: Ruth Hancock: r.hancock@uea.ac.uk

Introduction

1. The Social Care Green Paper (DH, 2009) suggests that as part of reforms to the long-term care funding system, consideration should be given to integrating some elements of disability benefits into the social care system. The idea of diverting (some of) the money spent on disability benefits into the social care system was first suggested in the 2006 King's Fund Review of Social Care (Wanless, 2006).

2. In 2008 we provided an initial critique of the Wanless suggestion (Berthoud and Hancock, 2008). Currently we are part way through a project funded by the Nuffield Foundation on the Role and Effectiveness of Disability Benefits for Older People. Much of the evidence submitted here arises from emerging findings from that project[3].

Background

3. The Green Paper puts forward a number of options for reforming the funding of social care. The front runner seems to be a 'partnership' system in which everyone assessed as needing formal care services, would get *some* proportion (e.g. a quarter or a third) of their care costs met by the state without a means test. The remainder of their care costs, and the hotel costs of care home fees, would remain subject to a means test of some sort. The Green Paper also says

> 'We think we should consider integrating some elements of disability benefits, for example Attendance Allowance, to create a new offer for individuals with care needs'. (p. 103)

and

> 'Whatever the outcome of the consultation, we want to ensure that the people receiving the benefits at the time of the reform would continue to receive an equivalent level of support and protection under a new and better care and support system' (p. 104).

4. Underpinning the Green Paper is analysis by Forder and Fernandez (2009) which is referred to in the Green Paper itself and in the Regulatory Impact Assessment (DH, 2009a). The latter provides some broad estimates of the costs of various

[3] The work was supported by the Nuffield Foundation, a charitable trust established by Lord Nuffield. Its widest charitable objective is 'the advancement of social well-being'. The Foundation has long had an interest in social welfare and has supported this project to stimulate public discussion and policy development. Support from the ESRC through the Research Centre on Micro-social Change (MiSoC) at the University of Essex is also acknowledged. The British Household Panel Survey data were originally collected by MiSoC (now incorporated within the Institute for Social and Economic Research) and made available through the UK Data Archive. Data from the English Longitudinal Study of Ageing (ELSA), made available through the UK Data Archive, were developed by researchers based at University College London, the Institute for Fiscal Studies and the National Centre for Social Research. Material from the Family Resources Survey, made available from the Office for National Statistics via the UK Data Archive, has been used with permission. All responsibility for data analysis and interpretation, and views expressed, rests with the authors.

options (including the partnership option) for 'bringing new money' into the care and support system. These costs are

> 'based on a system where Attendance Allowance had been drawn into care and support to create a new and better system ..' (DH, 2009a, p. 37)

5. The way in which AA is assumed to have been drawn into the care and support system is not clear. There is no mention of drawing in DLA although a recent ministerial statement rules out the possibility of DLA being withdrawn for people aged under 65.[4]

6. The rationale for diverting resources spent on disability benefits into the care system seems to be that these benefits are less well targeted than social care, although neither the Green Paper nor the 2006 Wanless report offers evidence on the targeting of social care services. Some analysis is presented in Forder and Fernandez (2009), which questions the targeting of AA and DLA, concluding that a relatively large number of people, despite having no limitations in activities of daily living, receive AA (p. 12) and that 'very wealthy people still show a significant propensity to claim [AA]' (p. 13). They analyse data from the English Longitudinal Study on Ageing (ELSA) and the British Household Panel Survey (BHPS), although we have not found precise details of their analysis in the public domain.

Aims of our research

7. Berthoud and Hancock (2008) undertook an initial analysis of the Family Resources Survey (FRS) which showed disability benefits to be received mainly by people whose incomes, before these disability benefits, are in the lower parts of the income distribution.

8. Our current research concerns people aged 65 and over and so focuses mainly on Attendance Allowance (AA), although some of what follows refers also to DLA paid to people aged 65 and over[5]. We aim to answer the following questions:
   - How does the AA system work in practice in terms of the achieved pattern of delivery of benefit to potential claimants?
   - Does the chance of success of a claim for AA depend as strongly on measured disability as we would expect (i.e. how effective is the assessment process)? Is the probability of receiving AA for people with no disabilities really as high as has sometimes been suggested?

[4] Speech by Secretary of State for Health, Andy Burnham, to the National Children and Adult Services conference, 22nd October 2009 (http://www.dh.gov.uk/en/News/Speeches/DH_107455).

[5] Of the 2.4m people aged 65+ receiving either AA or DLA in February 2009, 0.8m (i.e. a third) received DLA (statistics obtained using the DWP tabulator tool, available at http://83.244.183.180/100pc/dla/tabtool_dla.html.

- What are the influences on claim behaviour? In particular, what are the personal characteristics and circumstances that distinguish AA recipients from potential beneficiaries who do not claim?
- Are many potentially successful AA claims not pursued by the potential claimants?
- Although AA is not means tested, is there evidence that lower income people are more likely to claim than higher income people with similar disability levels? Does the nature of claimant behaviour mean that the AA system in fact mimics the effects of means-testing?
- Are there arguments in favour of having two separate systems – disability benefits and social care services – particularly as both entail uncertainty in outcomes?

Our research uses household survey data, so is confined to people living in private households. It excludes older people living in care homes.

9. Behavioural theories which regard benefit claims as a form of "rational" decision-making behaviour predict that:
   (i) People with higher income will be less likely to claim AA;
   (ii) People with more severe disability will be more likely to claim AA *unless*
   - disability makes it much more difficult to negotiate the claims process and/or:
   - disability reduces the individual's capacity to benefit from additional cash income (e.g. because of the difficulty of managing the process of buying care).

   Point (i) means that the flat-rate non-means-tested AA system may mimic a means-tested benefit to some degree. Point (ii) means that, should we find claim behaviour to be unaffected by the severity of disability, it would suggest a problem of poor targeting of AA, in the sense that disability in itself makes the process of claiming and using the benefit more difficult.

10. Research on this issue is difficult since no large-scale data source tells us everything we need to know. Sources like the ELSA, the BHPS and the FRS tell us about receipt of AA, but not about unsuccessful claims or unpursued potential awards. The DWP's administrative records also tell us nothing about unpursued potential awards and they contain no information on factors like income, which are not required on the AA application form.

11. Our research uses two new approaches. First it combines FRS and administrative data to distinguish the separate roles of individual claim behaviour and the DWP assessment process. Secondly, it applies a statistical method[6] which allows us to

[6] Latent variable structural equation modelling.

uncover the underlying level of disability, on a continuous spectrum, that results in difficulties with activities etc. which respondents report in surveys. It exploits all the available measures of disability in the surveys. We can then examine how AA receipt is related to this underlying level of disability and to other personal characteristics, including income. We have applied this method to ELSA, the BHPS and FRS to see whether the results are consistent across these three sources.

12. Uncertainties are inherent in assessments of eligibility for disability benefits and for care services. Two different assessors processing the same application in the same circumstances may often – quite reasonably – reach different conclusions about eligibility for benefits or care. We therefore offer a preliminary and illustrative assessment of the consequences of these uncertainties in a single system of assessment for care services rather than the separate systems we now have for disability benefits and care services.

Emerging findings on claiming and being awarded Attendance Allowance

Our main findings, presented in detail in a technical paper (Pudney 2009), are the following:

Finding 1. The probability of an AA claim being upheld is strongly related to the claimant's severity of disability (expressed in terms of the number and nature of activities that are affected by impairments), so that eligibility adjudications do seem to be responsive to care needs.

Finding 2. Despite its formal design as a non-means-tested, largely flat-rate, benefit, AA is essentially self-means-tested in the sense that people who could be seen as having greater general need (i.e. older and with lower incomes) have higher probabilities of claiming AA, for any given level of disability.

Finding 3. Claim behaviour is strongly influenced by the severity of disability. We predict a much higher probability that a claim for AA will be made by people who are severely affected by disability. This tends to support the view that targeting is reasonably good in the sense that there are not large numbers of frivolous claims, and the 'hassle' of making a claim and the difficulty of using additional cash income effectively do not become overwhelming for higher-disability groups. This is, however, only a statistical statement about average behaviour for groups of people – there will still exist many particular individuals who suffer because they are put off from claiming by the hassle involved, or by worries about using a cash allowance to pay for care.

Finding 4. Targeting appears to be some way short of the picture suggested by the rules of the AA system. There is evidence of a large group of potential AA awards which are not made, because no claim is put forward. At least a third of over-65s in the household population who are not receiving disability benefit would be predicted to be successful if they were to make a claim. This

is a striking finding which is supported by the fact that, of AA/DLA non-recipients in the FRS, 37% report the existence of disability resulting in difficulties in at least one area of life. Even among those so disabled as to be receiving care day and night, fewer than 60% are recorded by the survey as receiving AA. Similar, or even lower, rates of AA receipt are observed for care recipients in ELSA and the BHPS. The debate on reform of disability benefits and the care system appears to have neglected the question of the extent to which the system deters potentially eligible claimants from coming forward. We have found no research into how many people who would be judged entitled to state supported social care, fail to come forward for it.

Emerging findings on how AA/DLA receipt is related to disability and income

A forthcoming discussion paper (Morciano et al., forthcoming) describes out analysis in detail. Emerging findings are:

Finding 5. Because high-income people have a lower propensity to claim AA and a lower incidence of severe disability, there is a degree of targeting of AA towards low-income people – although this is less pronounced than for the explicitly means-tested Pension Credit system. For example, around 25% of people in the bottom fifth of the distribution of original equivalent income[7] receive AA, compared with just over 50% for Pension Credit (Figure 1).

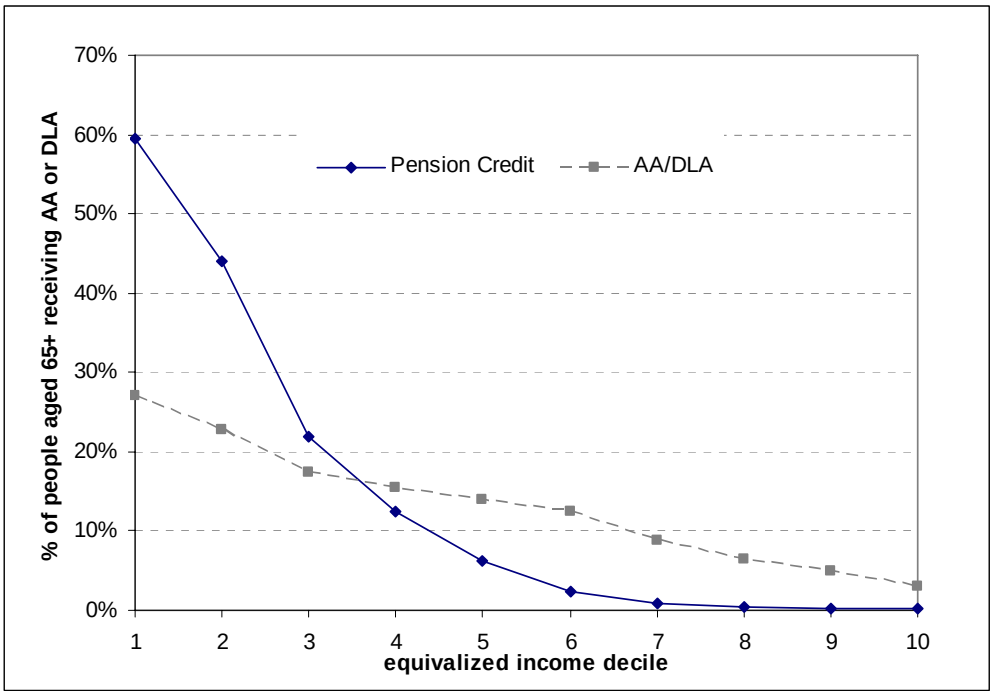

Figure 1: Rates of receipt of Pension Credit and Attendance Allowance/Disability Living Allowance amongst people aged 65+, against equivalent income before means-tested and disability benefits (Family Resources Survey 2002/3-2004/5).

[7] Income before means-tested and disability benefits, assuming that the cost of living for couples is 1.6 times that for single people.

Finding 6. Of those receiving any AA, and taking account of the level of disability, people on lower incomes and those without any savings are more likely to be receiving the higher than the lower rate of AA. Thus, within the group of AA recipients, there is evidence of further income targeting in the pattern of benefit receipt.

Finding 7. When we consider not only limitations in activities of daily living, but also all the other indicators of disability and ill-health available in ELSA, we find negligible numbers of AA/DLA recipients who are healthy on all measures. In the 2002/3 wave of ELSA, we identified 154 respondents aged 65+ (corresponding to approximately 220 thousand in the population of England as a whole) who reported income from AA/DLA but reported no difficulties in activities of daily living. When people who have limitations in instrumental activities of daily living (such as preparing a hot meal, doing work around the house or garden, taking medications) and difficulties in domains of life (such as walking 100 yards, climbing stairs without resting, getting up form a chair after sitting for long periods) are included this number falls to 26. Of these, 20 report at least one of the following medical conditions: high blood pressure or hypertension; diabetes; chronic lung disease such as chronic bronchitis or emphysema, arthritis and/or osteoporosis; cancer or malignant tumour. Of the six remaining cases, two were not receiving AA/DLA at the next wave of ELSA. Consequently, there is no evidence from this analysis of significant numbers of people receiving AA/DLA long term without an accompanying health problem.

Finding 8. Receipt of AA/DLA is strongly related to disability. The estimated probability of receipt for people in the lowest 20% of the distribution of the underlying disability index is zero, but this rises steeply in the top 20% of the distribution (Figure 2).

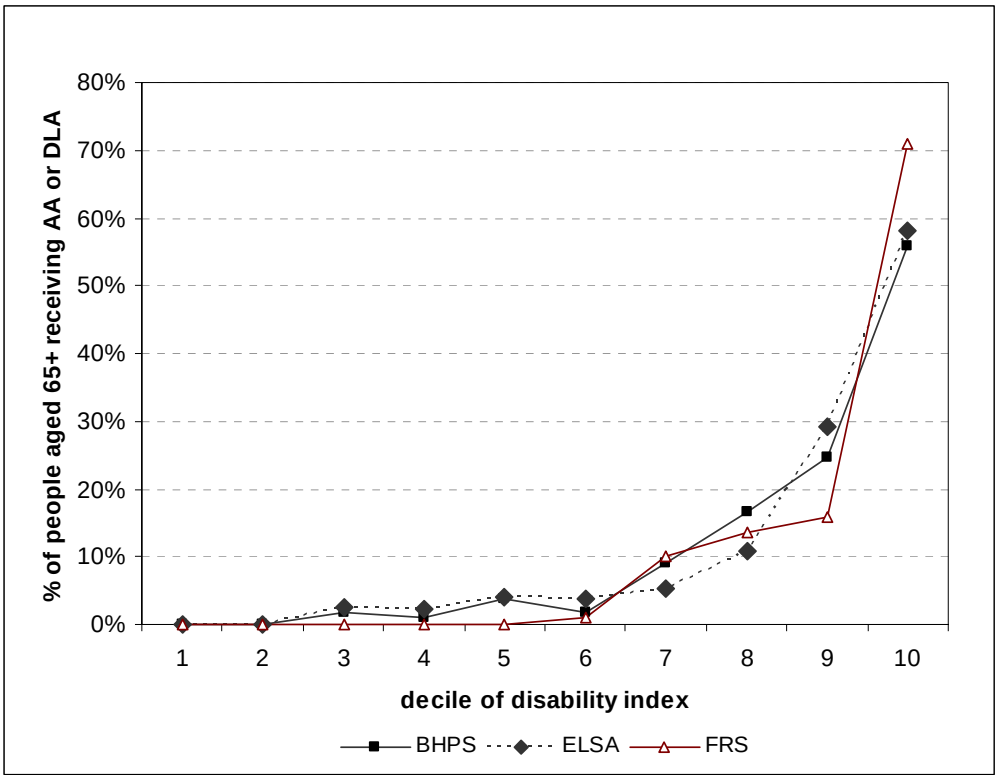

Figure 2 Receipt of AA/DLA among people aged 65+ against decile of disability, FRS, ELSA, BHPS 2002/3.

13. Our preliminary interpretation of these findings is that they support the view that there is a role for cash benefits like Attendance Allowance within the system of support for older disabled people. There is a significant problem of delivery of these benefits to those who might qualify for them, but we see no reason to believe that a system based purely on direct provision of care services would be more effective in its delivery. The strong disability gradient of claim behaviour suggests that a large proportion of potential beneficiaries do see cash benefits as a valuable form of support which is worth the considerable effort of claiming.

14. Evidence from FRS data suggests that the systems of AA/DLA and LA home care are quite different in their coverage of the older disabled population. Of those who receive LA home care, 34% receive no DLA/AA, while among DLA/AA recipients, 86% receive no LA care services.[8] Of people who are receiving night-and-day care from any source, 24% receive no DLA/AA payments and 87% receive no LA care services. It is sometimes suggested that the AA/DLA system is less well targeted than LA support, so that shifting of resources from cash benefits to LA care would improve targeting of support for older disabled people. This simple argument is not supported by the survey evidence, which suggests that LA care and AA/DLA payments are differently targeted relative to need – neither of them perfectly so.

[8] Analysis of 2002/3-2004/5 Family Resources Survey, over-65s.

15. What would be the consequence of removing the DLA/AA cash benefits and using the savings to increase LA home care provision? This question cannot be answered properly without consideration of uncertainties – both systemic and uncertainties faced by individuals in need of support. The policy debate and research on which it rests has largely neglected the important issue of risk.

16. *Individual uncertainty (risk)* arises from the variations inherent in any disability assessment procedure, where "need" and "disability" are matters of judgement. To a disabled person, applying for LA care and also for AA/DLA is like buying two lottery tickets. Compared to a unitary system with a single assessment procedure, this is equivalent to spreading your resources across two tickets rather than staking it all on one – risk is higher in a unitary system. Annex 1 sets out a detailed example of a typical case under realistic assumptions about the rates of error in LA and AA eligibility assessments. If AA/DLA is abolished and re-directed to LA care (a "unitary" system), the typical disabled person's risk of receiving no support at all rises more than sixfold. The general level of uncertainty[9] rises by over 20%. There may be some administrative cost savings in switching from a dual-support system to a unitary system, but the accompanying increase in the uncertainty faced by potential applicants should be set against those savings. The increased uncertainty will, in turn, reduce the likelihood that disabled people will choose to apply for support.

17. Increased *systemic risk* comes from the transfer of responsibilities from two bodies (DWP and the LA) to a single care provider (the LA). Arguably, public scrutiny of the political decisions on disability policy is stronger at the national (DWP) level than at the local (LA) level. Consequently, the policy risk is greater under a local unitary system. Moreover, there is evidence of considerable variation across LAs in the resourcing of care services and the way that eligibility assessments are carried out (Commission for Social Care Inspectorate, 2008) so a transfer of support from a uniform national source to a variable local source will result in greater inequality of treatment (the "postcode lottery"). This systemic aspect of risk is hard to quantify, but it is potentially very important.

    Finding 12. A reform that moves from the current dual benefit + care system to a unitary care-only system is likely to lead to a significant increase in the uncertainty facing potential applicants for support.

18. Our work on this project is due to be completed by 30 September 2010.We will keep the committee informed of further findings as they emerge.

[9] As measured by the standard deviation of the cash value of support.

References

Berthoud R and Hancock R (2008) 'Disability Benefits and Paying for Care' in Churchill N (Ed) *Advancing opportunity: older people and social care*, London: The Smith Institute.

Commission for Social Care Inspectorate (2008) *Cutting the cake: CSCI review of eligibility criteria for social care,* London: Commission for Social Care Inspectorate.

Curtis, L. (2009). *Unit Costs of Health and Social Care 2008*. London: Personal Social Services Research Unit.

Department of Health (2009) 'Shaping the Future of Care Together' London: DH.

Department of Health (2009a) 'Impact Assessment of the Care and Support Green Paper' London: DH.

Forder, J and Fernandez, J-L (2009) 'Analysing the costs and benefits of social care funding arrangements in England: technical report. London: LSE. PSSRU Discussion Paper 2644.

Morciano M,. Zantomio, F., Hancock R and Pudney S (forthcoming). Measuring Disability Status in the Older Population; a multi-survey latent variable approach. ISER working paper. Colchester: Institute for Social and Economic Research, University of Essex.

Pudney, S. (2009) Participation in disability benefit programmes: a partial identification analysis of the British Attendance Allowance system. ISER working paper No. 2009-19. Colchester: Institute for Social and Economic Research, University of Essex.

Pudney, S. (forthcoming) Disability Benefits for Older People: how does the UK Attendance Allowance System Really Work. ISER working paper. Colchester: Institute for Social and Economic Research, University of Essex.

SSSC (1999) *Select Committee on Social Security. Third Report: Disability Living Allowance*. London: House of Commons, 3 February 1999. Available at http://www.parliament.the-stationery-office.co.uk/pa/cm199899/cmselect/cmsocsec/63/6302.htm

Wanless D., Forder J., Fernandez J-L. et al. (2006) 'Securing Good Care for Older People: Taking a long-term view' London: King's Fund.

Zantomio, F. (forthcoming) Older people's participation in disability benefits: targeting, timing and financial wellbeing. ISER working paper. Colchester: Institute for Social and Economic Research, University of Essex

Annex 1 Example of individual risk under dual and unitary care/benefit systems

Consider a person in great need – who should therefore be judged entitled to both AA and to LA services – and who applies for both forms of support. Assume the relevant rates of support are the lower rate of AA (£43.15 per week in 2007/8) and 10 hours of LA home care, valued at £19.30 per hour (Curtis 2009, p. 38).

Under the current dual support system, this person will experience one of four possible outcomes, depending on the result of the two eligibility assessments: (i) no support at all (£0 per week); (ii) AA only (£43.15 per week); (iii) LA only (£193 per week); (iv) both AA and LA £236.15 per week). There is evidence of a high rate of error in eligibility assessments.[10] Suppose that, on average, 15% of LA assessments are wrong and that the proportion of incorrect AA adjudications is 15% if LA care is not received but only 5% if adjudicators know that LA care is received.[11] Under these assumptions, the applicant has a 2.25% chance of getting nothing, a 12.75% chance of receiving £43.15, a 4.25% chance of receiving £193 and an 80.75% chance of getting the full £236.15. The average outcome over a large number of similar people, would be £204.40.

Now suppose that the system is replaced by a unitary system of LA home care with a single eligibility assessment, which has a 15% chance of an incorrect rejection of the claim. If the reform is to be budget-neutral[12] it must offer this individual the prospect of care services to the value of £240.47. Then, the applicant has a 15% chance of receiving nothing and an 85% chance of receiving £240.47 (implying the same average amount of £204.40).

Table A1 summarises the degree of individual uncertainty involved in the two systems:

	Dual system (AA + LA home care)	Unitary system (LA home care only)	Proportionate increase in risk
Risk of receiving no support	0.0225	0.15	567%
General uncertainty (standard deviation of value of support)	71.2	85.9	20.5%

LAs are permitted to take account of AA/DLA when means-testing individuals for care services,[13] which would have the effect of reducing the total value of support received when both assessments are positive. This would strengthen the argument for a dual system: it would make no difference to the risk of receiving no support and would reduce the level of general uncertainty under the dual system.

[10] Note that the 1999 Social Security Select Committee reported a 29% error rate for DLA assessments (SSSC 1999, para. 17).
[11] There is a question about receipt of care services on the AA application form, so this presumably strengthens the claim of need.
[12] In other words, to have the same average cost for this type of individual as the previous dual system.
[13] Although they are required to make allowance for the additional costs of disability.