Disability and poverty in later life

by Ruth Hancock, Marcello Morciano, and Stephen Pudney

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This report explores the relationship between disability and poverty among the older population. It emphasises the additional living costs that disabled people face, and the importance of taking disability costs into account when making poverty assessments in the older population. The report considers alternative directions of reform for the system of public support for older people with disabilities and casts doubt on some of the suggestions that have been made for improving the targeting of public support for older disabled people.

The report shows that:

- effective targeting does not necessarily require an extension of means-testing;
- the present benefit/social care system is reasonably well-targeted, but falls far short of full support for the most severely disabled;
- there is a case for tailoring the structure of disability benefits more closely to the severity of disability;
- there is a need for caution in considering proposals that would scrap national disability benefits in favour of an expansion of local authority social care funding.

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List of abbreviations

AA	Attendance Allowance
CTS	Council Tax Support (the successor to Council Tax benefit)
FGT	Foster-Greer-Thorbecke measure of extent and depth of poverty
FRS	Family Resources Survey
DCLG	Department for Communities and Local Government
DH	Department of Health
DLA	Disability Living Allowance
DWP	Department for Work and Pensions
ELSA	English Longitudinal Survey of Ageing
GC	Guarantee Credit (an element of the Pension Credit benefit system)
HB	Housing Benefit
NHS	National health Service
PC	Pension Credit
PIP	Personal Independence Payment
SC	Savings Credit (an element of the Pension Credit benefit system)

Summary of main conclusions

This study uses statistical analysis of two large-scale representative surveys to examine the effectiveness of public support for older people with disabilities. We have also simulated a number of illustrative hypothetical policy reforms to suggest promising ways to reform the system within the existing level of government spending. There are six main conclusions.

1. Disability brings with it additional living costs, which can be very large – sometimes hundreds of pounds a week. People with disabilities often receive government support in the form of disability benefit, designed to meet part of those additional costs. If we include disability benefit in income but fail to make any allowance for the higher living costs that disability brings, then disabled people appear to be better off than they actually are. In the policy debate, we often see comparisons between the incomes of disabled and non-disabled people, or of the younger and older population (the latter have higher rates of disability). These comparisons are often made without any allowance for differences in living costs and are misleading because they make older disabled people seem better off relative to the rest of the population than they really are.
2. Britain currently has a dual system of public support for older disabled people. Central government pays disability benefits (mainly Attendance Allowance and Disability Living Allowance), while local authorities manage the provision of social care services. The two systems are quite separate and have little overlap, and it is sometimes suggested that they should be merged into a single system of disability support. While this sounds neater and may save some administrative costs, it runs the risk that many more people may miss out on government support completely. We think it is too big a risk to take with such a vulnerable group.
3. The present system of social care/disability benefit is quite good at using limited resources to minimise the number of older disabled people in poverty. But it is much less effective in protecting people from very deep poverty. The people most affected by this are those with severe disability (and therefore high disability costs), especially those who are unaware of, or not able to negotiate, the systems for claiming help with their care needs.
4. There are failures in the targeting of the current system – the system misses some people in great need and it spends some public money on people with only moderate needs. But, in practice, no system of social support can avoid all such errors. Our findings suggest that the failure to meet severe need is a much bigger source of targeting error in the current system than is the spending of resources on the wrong people.
5. There is scope for improving the performance of the system of public support for older people with disabilities, by spending the current budget for disability benefit in a more effective way. Although introducing means-testing for Attendance Allowance or Disability Living Allowance is often suggested, it is possible to achieve similar improvements in poverty outcomes in a fully means-tested or a fully non-means-tested version of the disability benefit system. The reason for this is that people with low incomes are more likely to be affected by severe disability, and also have a stronger need for support and are therefore more likely to claim support.
6. Much more important than means-testing is the ability of the system to provide support to people living with severe disabilities and facing very high disability costs. Effective reforms of the disability benefit system could achieve major reductions in the burden of deep poverty by doing two things:

- adapting the amounts of benefit paid to claimants of *Attendance Allowance* or *Disability Living Allowance* to match the costs of disability more closely;
- increasing the reach of the system, particularly among the most disabled, by increasing take-up of entitlements and/or improving the quality of initial adjudication of claims.

A reform that achieved these objectives while staying inside the current level of spending on disability benefit would require a reduction in the *average* amounts paid to people with less severe disability, to pay for the increased levels of support for the most severely disabled, although it could also accommodate

small amounts of support to an increased proportion of those with modest disability levels. This seems a reasonable possibility to examine.

1 Introduction

Pensioner poverty is in the news again. This time, not because of concerns about the extent of poverty among older people, but because of concerns that older people are being unreasonably sheltered from recent economic hardships relative to the young. This new concern springs partly from comparisons of pensioner incomes and poverty rates with those in the non-pensioner population. For example, David Willetts MP has emphasised this issue, citing evidence from the Institute for Fiscal Studies (IFS) that median pensioner income has now overtaken median income in the rest of the population. [1] These concerns may be well-founded for a significant part of the pensioner population, but pensioners are not a homogeneous group and it is important to be careful in comparing the incomes of pensioners and non-pensioners. Disability is a major complication affecting such comparisons, but it is routinely ignored by policy-makers and commentators (including the IFS). Disability is particularly prevalent in the older population and it has two effects that distort income comparisons: it often generates large additional costs of living; and it also triggers payment of additional income through the disability benefit system. Traditional income analysis ignores the extra costs of living caused by disability but includes in income the benefit payments which are designed to help with those extra costs. It therefore gives a distorted picture, by making people affected by disability appear better off than they really are.

In our view, it is not possible to draw meaningful conclusions about incomes in the older population without making explicit allowance for disability. By causing very large increases in the cost of living for those affected, disability increases inequality and poverty, making summary measures like average or median income very unreliable as indicators of the economic welfare of pensioners. Our aim here is to look at pensioner poverty in Britain, taking those extra personal disability costs fully into account.

The picture we paint here of disability and poverty in the older population is necessarily fragmentary to some degree. Most of the available survey evidence relates to the household population and excludes people living in care homes and other institutions. There are also geographical limitations. Some of our evidence relates to England only, other sources relate to Great Britain. For that reason, it is not possible to give a full picture at the UK level, although we are confident that our main conclusions are applicable to the UK as a whole. It is also not possible to assess fully how the picture varies across the constituent countries of the UK. We discuss this further in section 6.

2 The current system of disability support for older people

Britain has a dual system of public support for older people with disabilities: a nationally-administered system of cash benefits[2], and locally-administered systems of social care provision.[3] The two parts of the system are essentially independent and are administered on rather different principles.

Disability benefits

In Britain, older disabled people may receive cash benefits to help with the additional costs that their disabilities bring. There are two types of disability benefit. The first type is non-means-tested and tax free. It comprises *either* Attendance Allowance (AA) which can be claimed from age 65 *or* Disability Living Allowance (DLA) which must be claimed before reaching age 65 but can continue in payment beyond 65 (see Hancock *et al*, 2012 for a comparison of AA and DLA recipients). From April 2013 DLA is gradually being replaced by the Personal Independence Payment (PIP), which differs from AA and DLA in certain details but like DLA is claimed before age 65 and then continues in payment beyond 65; very few over-65s are currently receiving PIPs. In 2015–16, AA is worth £55.10 or £82.30 per week, depending on the assessed level of need, while DLA can vary in the range £21.80 to £139.75. AA and DLA have considerable reach: in February 2015, there were 0.96 million DLA recipients aged 65 and over, and 1.6 million AA recipients[4], comprising respectively 8 per cent and 14 per cent of the over-65 population in Britain.

Claims for AA or DLA/PIP are made to the Department for Work and Pensions (DWP) in Great Britain, and there is a two-stage process of reconsideration and appeal against DWP decisions on claims for these benefits. The procedure for challenging DWP decisions is a formal national-level process with (in principle) no local variation.

In addition to providing flat weekly income supplements, AA and DLA also act as a gateway to increases in the levels of a further group of means-tested disability benefits, Pension Credit (PC), Housing Benefit (HB) and Council Tax Support (CTS).[5] These increases come about through a Severe Disability Addition (SDA) to the presumed level of need which determines PC, HB and CTS entitlements. The SDA is triggered by receipt of AA or DLA/PIP, subject to certain other conditions. This link to further means-tested benefits means that people on low incomes (who would satisfy the means test) have a particularly strong incentive to claim AA or DLA/PIP. The AA/DLA/PIP/PC/HB/CTB benefit system is extremely complex and is described in more detail in Appendix 1.

Social care

The reach of the social care system is much less than that of the disability benefit system. The number of older people in the household population receiving long-term local authority social care in England at 31 March 2015 was 254,000. If we include provision of local authority support to people in care homes, this figure rises to 411,000 – just 4.2 per cent of the total population in England aged 65+.[6]

Social care in England[7] is organised by local authorities who assess individuals' needs for care. Any resident (or their carer) has the right to request a needs assessment, which is normally carried out by a social worker or occupational therapist. Before April 2015, that assessment classified any care needs into one of four bands: low, moderate, substantial or critical. The 2014 Care Act has established a national minimum standard for eligibility, in force since April 2015, intended to be equivalent to the old 'substantial' needs category. This specifies a level of need having a significant impact on wellbeing by preventing the achievement of at least two out of a list of ten basic outcomes.[8] Under the old system, there was some variation across local authorities in the way that the four bands of need were interpreted and used in deciding eligibility.

In England and Wales, local authorities apply a means test to determine claimants' contributions to the cost of the care they are assessed as needing. In Scotland, there is a non-means-tested public subsidy for

personal care costs (means-tested charges are levied for 'hotel' costs in care homes and non-personal care provided at home). In England and Wales, local authorities have some discretion over the form of the means test for care provided to people in their own homes but national guidance determines the principles they must follow and implicitly the maximum charge, given income and wealth.[9] Appendix 2 gives a more detailed description of the social care means tests.
People applying for, or already receiving, local authority social care have rights to challenge decisions and resolve problems within a national framework provided by the 2014 Care Act. Nevertheless, the system for challenge and redress is much less formal than the system of reconsideration and appeal for disability benefits, and local authorities have considerable freedom to implement the complaints process in their own way. Appendix 2 gives further details.

With increasing pressure on their budgets, many local authorities withdrew support from the lower bands and are now only able to support people with high levels of assessed need (Fernandez et al. 2013). The number of older people who receive local authority-sponsored social care services has been declining over the last decade, despite the increase in the number of over-65s with care needs. For the over-65 household population in England, the number of recipients of local authority social care fell from 645,000 in 2005/6 to 418,000 in 2012/13[10] (Fernandez *et al.*, 2013; MacInnes *et al.*, 2015). Future demands on the disability support system are likely to rise. It has been projected that the number of older people in England needing help with at least one activity of daily living will rise from 1.15 million in 2015 to 2 million in 2035 (Wittenberg and Hu, 2015). Analysis of disability trends for successive birth cohorts by socio-economic status suggests stability of disability rates for better-off people, but a strongly rising trend of disability for population groups with relatively low incomes (see Morciano *et al.*, 2015). This suggests that the demand for public support may rise faster than the number of older people with disabilities.

Overlap of the social care and disability benefit systems

Evidence from survey data suggests a surprisingly modest degree of overlap of the two systems. Table 1, based on information from the nationally representative Family Resources Survey, suggests that over a third of local authority social care recipients get no disability benefit at all, and only a third receive higher-rate awards of AA or DLA. (There is some evidence of under-reporting of receipt of welfare benefits in survey data, and this may cause the degree of overlap to be underestimated. In our view, this measurement problem is unlikely to make a substantial difference to the conclusion here.)

Table 1: A significant minority of local authority social care clients receive no disability benefit, and only a third receive higher-rate awards

	Local authority-funded social care		All over-65s
	Recipients	Non-recipients	
% receiving no AA/DLA	35%	87%	85%
% receiving low-rate DLA	2%	1%	1%
% receiving standard-rate AA/DLA	30%	6%	7%
% receiving higher-rate AA/DLA	33%	6%	6%

Estimated proportions based on analysis of data on individuals aged over 65 in Great Britain, from the Family Resources Survey, 2003/4– 2007/8. Figures are rounded to the nearest whole percentage point.

Table 2 looks at the proportion of people at each level of AA/DLA award who also receive local authority social care. Even among recipients of high-rate AA or DLA (who are presumably the most severely disabled), no more than 13 per cent report receiving any help through local authority social care. This is partly due to the means test imposed on claims for social care, but non-take-up is also likely to be a significant factor. In terms of the number of people receiving help, the social care system is small relative to the disability benefit system (although the amounts paid out in social care may be much larger in some cases).

Table 2: Even among people receiving the highest rate of AA or DLA, only just over 1 in 8 receives any local authority social care

Disability benefit receipt	% receiving local authority social care
No AA/DLA	1%
Low-rate DLA	7%
Standard-rate AA/DLA	11%
Higher-rate AA/DLA	13%

Estimated proportions based on analysis of data on individuals aged over 65 in Great Britain, from the Family Resources Survey, 2003/4-2007/8. Figures are rounded to the nearest whole percentage point.

This separation of the two systems has suggested to some commentators that there are potential administrative savings to be made by integrating the two into a single system of social care, either locally or nationally administered. On the other hand – and this has rarely been mentioned in policy discussions – the availability of two separate sources of support may be an advantage in increasing the reach of the system, since potential claimants may miss one entry point to the system but still be able to get support via another. We discuss this and related issues in section 5.

3 What do we mean by poverty?

Poverty is a difficult concept. For the most part, in this report we use methods for measuring poverty which are quite standard in the research literature; Appendix 5 gives details. But there are some important considerations which arise in relation to disability and which are overlooked in most policy discussion of poverty and inequality. There are four specific issues that need to be addressed.

How should we define and measure economic welfare?

Poverty is typically measured in terms of low income. But this idea has been challenged by participants in policy debates, not least by the UK government, which has introduced new measures for monitoring subjective wellbeing; consulted on an abortive proposal for a multi-dimensional approach to (child) poverty measurement; and developed an index of material deprivation among pensioners.[11] Although there are powerful intellectual and practical advantages in broadening poverty measures beyond the traditional focus on income, these approaches involve substantial difficulties of their own and there is, as yet, no consensus in their favour.

A particular advantage of income-based analysis is that it links directly with the main strands of public policy, which involve transfers of income, either in cash disability benefits, or in cash-equivalent form of care services (which are increasingly purchased within the framework of an approved personal care budget). Because of this strong advantage, we use a conventional income-poverty approach, but with extensions to adapt it to the special context of an older population characterised by a high rate of disability prevalence.

We measure income as an equivalised net amount after housing costs. One unusual feature related to disability deserves comment here. We include in income an estimate of the value of any subsidy on care services which are supplied under the auspices of the local authority social care system or the NHS. To see why this is appropriate, compare an individual A who is given a cash benefit and uses it to buy a given amount of care services with another identical person B who is directly provided with the same bundle of care services. Both individuals reach the same level of welfare, but a conventional income measure restricted to cash income only would suggest – wrongly – that person B is poorer than person A. So it is important for us to include in income the market value of any public subsidy on care services. The valuation of care services is uncertain, but has been estimated by the Personal Social Services Research Unit. Uprated to 2015/16 prices, we take them as averaging £24.70 an hour of home visits by a care worker, and £67.80 an hour for home visits by NHS nursing staff.[12] At these unit costs, severe disability can lead to additional living costs that are far higher than average pension incomes, so their inclusion in income has a large impact for some households. All references to local authority social care relate to the value of local authority subsidies on care services, rather than the value of the care package as a whole.

To estimate the subsidy, we value the total amount of local authority-sponsored care services reported by a survey respondent and simulate the working of the local authority social care means test to estimate the amount the local authority requires the recipient to pay towards their care package. That amount is then subtracted to give the value of the local authority care subsidy. Box 1 gives two hypothetical examples of how this works

Box 1: Hypothetical example of local authority mean-testing*

Jill has income £400 per week and no significant financial assets. She has critical care needs assessed as 14 hours of help from a care assistant, costed by the local authority at £24.70 an hour, giving a total cost for the care package of £345.80 a week.

The Guarantee Credit level for a single person is £151.20 a week, and she must be left with at least 125 per cent of this amount (£189 per week) after contributing to the cost of the care package. Consequently, she will be required to pay £211 a week (= £400 - £189) towards the cost of care. So the local authority care subsidy to Jill will be £134.80 (= £345.80 - £211).

Jack has exactly the same income and assessed care needs, but has savings of £30,000. The first £23,250 of this is disregarded, but the remaining £6,750 is assumed to yield an additional income of £27, making £427 per week actual and notional income. He will be required to pay £238 (= £427 - £189) towards his care, so the local authority subsidy to Jack will be £107.80 (= £345.80 – £238).
*These examples ignore complications over the treatment of any AA/DLA which the individual receives (see Appendix 6f).

What additional living costs do people with disabilities face?

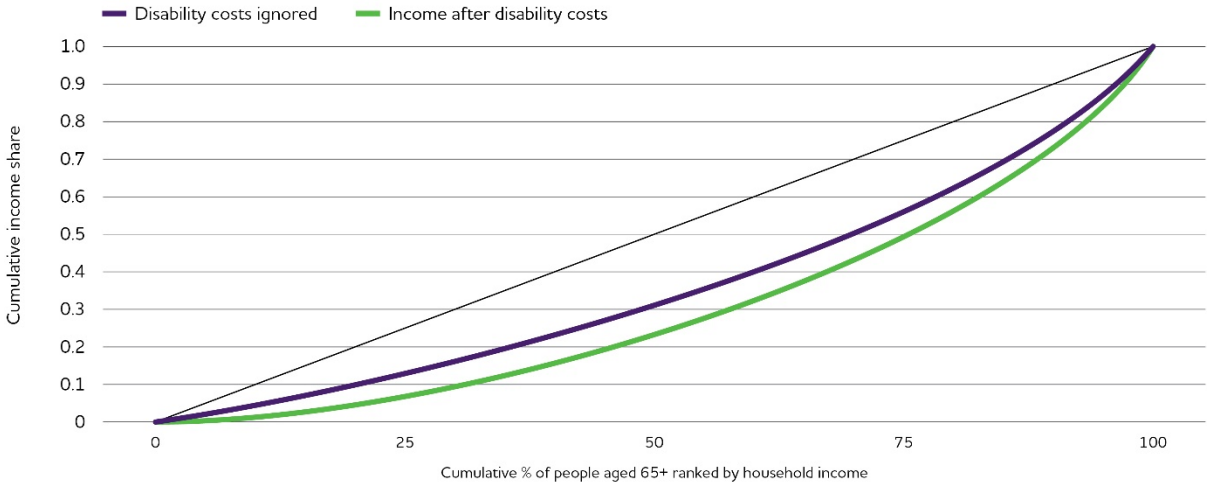
Additional disability-related costs may include care needs, for example help with getting into and out of bed, bathing, cleaning, gardening, shopping and cooking. Transport may become more difficult meaning normal functioning requires the use of taxis rather than buses. There may also be a need for adaptations of the home, such as installation of stairlifts, hoists or bathing facilities. There is a long history of research on the additional living costs linked to disability. Much of this work uses small-scale in-depth qualitative enquiry to evaluate the impact that various disabilities can have on individual lives. Other research has used survey-based quantitative methods which focus on the impact that various types of disability have on measures of wellbeing or material living standards. Appendix 4 reviews some of the UK estimates that appear in the research literature and explains the approach we use for estimating disability costs at the individual level. Differences in both the measurement and definition of disability costs mean that these estimates cover a very wide range. In our view, any estimate of disability cost should be treated with caution. For that reason, we explore the robustness of our estimates in section 7.

In very broad terms, our method works in the following way. We make a detailed statistical analysis explaining the indicators of disability and material living standards that we observe for individual survey respondents, in relation to their income and other characteristics. This model allows us to compare any disabled individual with an otherwise identical non-disabled individual who manages to reach the same living standard. Since the disabled person has higher living costs, the income they needed to reach that common standard of living will have been higher than the income needed by the comparable non-disabled person. Their income difference then tells us the level of disability cost faced by the disabled individual.

Personal disability costs make a big difference to income comparisons and consequently to any assessment of income inequality within the older population. One way of making such assessments is to take a given income level and estimate the share of total income received by people with incomes below that given level. The lower the share, the greater the degree of inequality in society with respect to that group. If we do this for a number of different income levels, we can plot the share against them, giving the *concentration curve* for income. Figure 1 shows the concentration curves estimated for two alternative definitions of income. The purple curve summarises the distribution of original income (total net cash income, after housing costs, but excluding any disability-linked benefit income and the value of any state contribution to care costs); this definition ignores disability costs. The lower green concentration curve is estimated using the same definition of income, but expressed after estimated disability costs are met. Because the green curve is lower than the purple curve, the degree of income inequality is greater when we take account of disability costs. This is because both the prevalence and severity of disability are higher among people with low incomes – a consequence of the well-

documented socio-economic disparities in health (see Marmot (2010). The impact of disability costs on inequality is large. For example, the 25 per cent of people with lowest incomes have an estimated 14 per cent share of total income if we ignore disability costs, compared with only 7 per cent if we use income net of disability costs; the lower 50 per cent of people by income have a 32 per cent income share ignoring disability costs, but only a 24 per cent share if we take account of those costs.

Figure 1: Allowing for disability costs changes the picture of income inequality



Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015

What income level should we use as the poverty line?

For most purposes, we measure income without subtracting disability costs but instead adjust the poverty line to reflect the increased living costs for people with disabilities. Official poverty statistics (DWP, 2015) use a relative poverty line defined as 60 per cent of median equivalised household income. Equivalisation is a process of adjusting for the economies of scale within households which mean, for example, that a couple can achieve the same standard of living at lower total cost than two single people. But equivalisation does not take account of other differences in the cost of living for different types of household, particularly the large differences that may be caused by disability. If a non-disabled person requires a given income to avoid poverty, then someone who has these extra costs will need a larger income to avoid poverty. Consequently, an appropriately increased poverty line needs to be used to determine the poverty status of a household affected by disability. The required adjustment to the poverty line for any particular household will depend on the severity of disability involved.

The official 60 per cent median income poverty line is a widely used general-population criterion, but it is not universally accepted, is not tailored specifically to the older population, and is not the only official low-income criterion in use. Pension Credit is made up of two parts – Guarantee Credit and Savings Credit. Guarantee Credit tops up weekly income if it is below £155.60 (for single people) or £230.85 (for couples). Savings Credit is an extra payment for people who saved some money towards their retirement, e.g. a pension. The Guarantee Credit level incorporates both an absolute judgement about the minimum socially acceptable income level for older people, and an equivalisation rule. The standard Guarantee Credit levels for single people and couples imply that living costs for a single person are 65 per cent of that for a couple. Yet a third official minimum income criterion is built into the local authority social care system; there, claimants must be left with an income of at least 125 per cent of the Guarantee Credit level after contributing to the cost of social care.

A benefit unit is defined as an adult living alone or a couple living alone or with dependent children. To allow for a range of views about what constitutes a minimum acceptable income level for a benefit unit, we make our analysis using alternative poverty lines, each defined as a multiple (from 90 per cent to 140 per cent) of the Guarantee Credit level.[13] For benefit units affected by disability, we modify this poverty line by adding to it an estimate of the additional living costs generated by the disability in question.

Should we measure the extent of poverty or also the depth of poverty?

Pensioner poverty is sometimes described as being wide but not deep – in other words, many older people appear to fall below the poverty line but few are very far below it. This view has become more prominent during the recent recession, since the state pension and welfare benefits for older people have been better protected from government austerity measures than other parts of the benefit system. But public comment about the relatively favourable position of older people generally neglects the role of disability costs and, for that reason, is often misleading. The cost of care services can be extremely high if disability is severe, so an apparently high level of benefit income may be much less generous in reality. Another consequence of high care costs is that a system of public support for disabled people may be good at reducing the count of people below the poverty line (even a disability-adjusted poverty line), yet still perform poorly in protecting people from very deep poverty.

It is important to consider both the extent and depth of poverty. A measure of the extent of poverty tells us how many people are poor. A more comprehensive measure that captures also the depth of poverty will take into account both the number of people who are poor, and how far they are below the poverty line. We use two complementary measures in our discussion; technical details are given in Appendix 5.

- The *headcount* is the proportion of over-65s living in households with income below the (disability-adjusted) poverty line.
- A poverty measure first proposed by Foster, Greer and Thorbekke (1984) (known as the *FGT* measure) modifies the headcount by giving much greater weight to people who are far below the poverty line than to those who are close to it.[14]

These two measures can give very different pictures of poverty and the difference between them highlights the importance of disability costs. Table 2 shows that, when we express income net of estimated disability costs, both the extent and depth of measured poverty increase, but (except at very low poverty lines) the depth of poverty increases more than its extent. For example, at the local authority social care income threshold of 125 per cent of the Guarantee Credit level, the estimated number of people in poverty rises by 72 per cent in the older population as a whole or nearly 110 per cent in the group affected by disability when we allow for disability costs.[15] But the FGT measure which reflects both the extent and depth of poverty rises by over 280 per cent and 430 per cent respectively.[16] The distinction between extent and depth of poverty will also prove important when we look at possible reforms to the current system in section 5.

Table 3: Disability costs increase the depth of poverty more than its extent

Income concept	Poverty measure					
	Extent (headcount)			Extent and depth (FGT)		
	Poverty line as % of GC					
	90%	100%	125%	90%	100%	125%
Poverty among all individuals aged over 65[*]						
Unadjusted poverty line	4.6	7.0	28.6	.005	.007	.017
Poverty line adjusted for disability costs	30.9	35.6	49.1	.038	.044	.065
Poverty among individuals aged over 65[*] *affected by disability*						
Unadjusted poverty line	4.9	7.2	31.2	.006	.008	.018
Poverty line adjusted for disability costs	47.8	53.8	64.6	.059	.069	.096

Analysis of FRS data 2003/4-7/8, uprated to 2015. Income definition is full income including all public disability support, expressed after housing costs.

[*] Single individuals aged 65 and over and individuals aged 65 and over with a partner over state pension age.

4 How does the current system work?

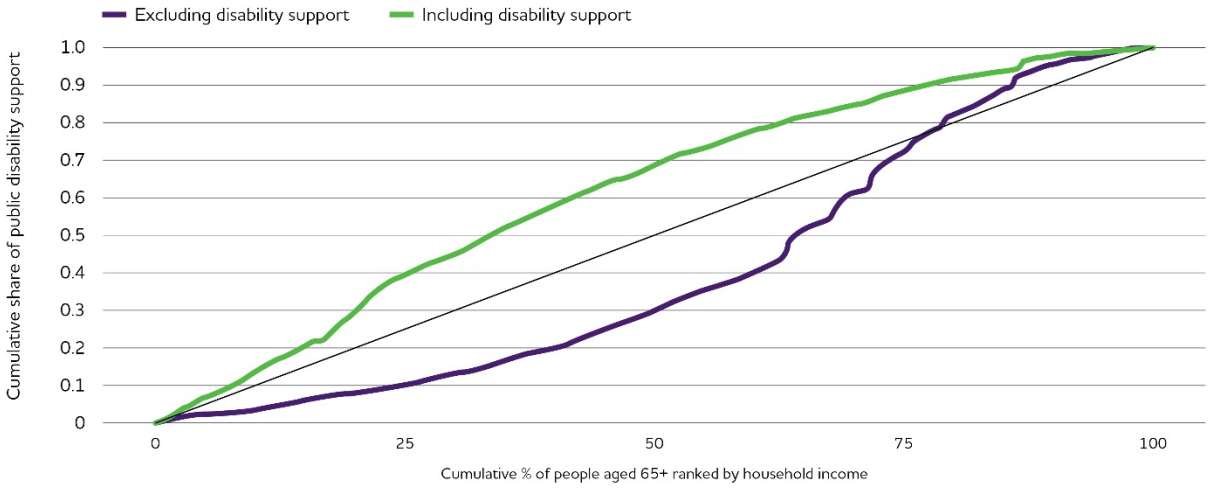
How is public disability support distributed in relation to income?

Figures 2 and 3 aim to show where the recipients of public disability support tend to be located within the income distribution. We again use concentration curves, which indicate the proportion of spending that goes to people below any given position in the income distribution. To do this, we need to rank people according to their income, but it is important to do the ranking appropriately; otherwise it is possible to arrive at quite misleading conclusions.

In Figure 2, for example, the lower purple curve is based on a conventional definition of total net income after housing costs – so it includes the value of any disability benefit or care services received, but ignores the additional living costs of disability. The result is alarming – public disability support appears to be going to relatively well-off people. For example, the poorest 50 per cent of the older population appear to be receiving only 30 per cent of public spending. But that would be a seriously misleading conclusion, since it takes account of support received but ignores the additional living costs which that support is designed to address. This highly distorted way of depicting the distributional pattern of disability spending was unfortunately used in the influential Wanless *et al.* (2006) report which floated the idea of reallocating spending away from non-means-tested disability benefits to the social care system, and was repeated in the 2009 Green Paper (HMG, 2009) and the State of the Nation Report of the following year (HMG, 2010a).

A rather better option is to rank people by the income they would have in the absence of disability benefit and social care subsidy. That ranking leads to the upper green curve in Figure 2, which suggests a slightly progressive distribution of disability support. For example, the poorest 50 per cent of people now appear to be receiving almost 70 per cent of disability support spending. Although an improvement, this is also potentially misleading. By taking no account of either public disability support or the extra living costs which that support is intended to address, it implicitly makes the implausible assumption that all disability costs are fully offset by whatever public support is received and those who receive no support face no costs.

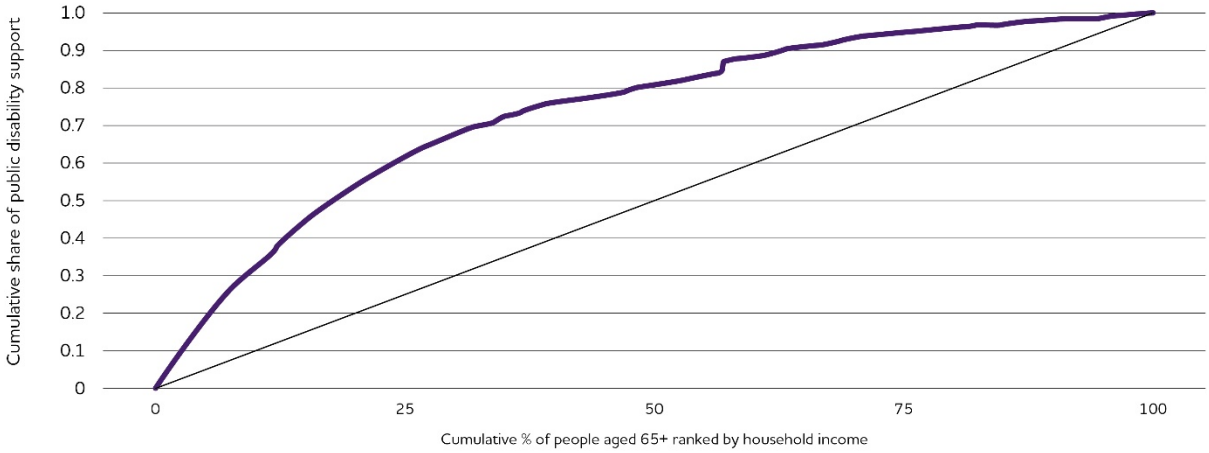
Figure 2: Including disability support in measured income without allowing for disability living costs gives a misleading picture of the distribution of public disability support



Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015

But if it is possible to estimate individuals' levels of disability cost, a much better analysis can be made. To capture the idea of need for support, the most appealing option is to rank people using a concept of income that represents the economic welfare that they would have in the absence of any disability support. Income is then measured excluding any disability support received and also net of the additional living costs caused by disability. The result is the concentration curve in Figure 3, which suggests that disability support is distributed very progressively, despite the lack of means testing in the AA/DLA benefit programmes. With income measured in this way, the 50 per cent of older people who would be poorest in the absence of public disability support receive four-fifths of public disability support, and those who would be in the poorest 25 per cent receive over 60 per cent.

Figure 3: Public spending on the older disabled population is seen to be distributed progressively when income is measured net of estimated disability costs

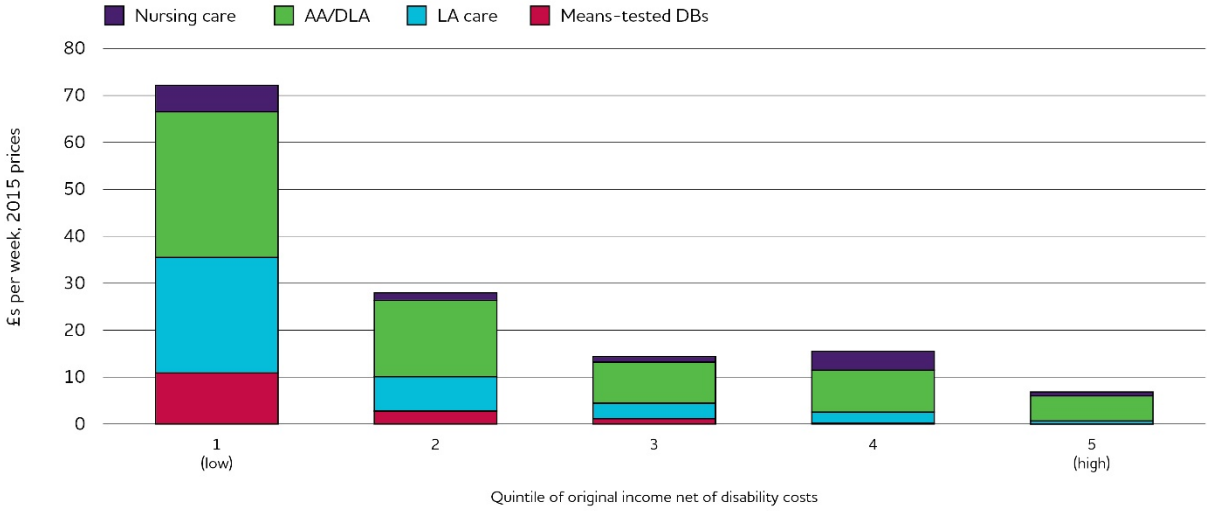


Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015

We can look at the relationship of public disability support to income in more detail by examining average levels of receipt for means-tested and non-means-tested components of support. In Figure 4, we do this for receipt of three categories of support: (i) non-means-tested AA/DLA; (ii) additional PC/HB/CTS amounts triggered by the AA/DLA; (iii) the value of social care services paid for by the local authority. These average amounts are plotted for the five quintile groups of the distribution of original income net of disability costs. Although AA/DLA is not means-tested, there is a considerable degree of income

targeting for two reasons: there is a greater incidence of disability further down the socio-economic scale [17], and there is a greater take-up incentive for people on low incomes. The additions to PC/HB/CTS triggered by receipt of AA/DLA is still more strongly targeted as a consequence of their means-tested design. Local authority social care is also strongly targeted on income and is worth as much on average as AA/DLA to those in the lowest income quintile.

Figure 4: Public disability support is progressively related to income[18]



How is public disability support distributed in relation to severity of disability?

One would expect public support for people with disabilities to be closely linked to severity of disability, given the disability assessment involved in the AA/DLA and social care claim processes. The 2012 English Longitudinal Survey of Ageing (ELSA) and the Family Resources Surveys both suggest that this is indeed the case. Table 4 shows the proportion of people receiving support, which rises from very small proportions for people with low levels of disability, to over 50 per cent for those in the top fifth of disabled people ranked by (estimated) disability level.[19] The imperfect reach of the system and the means-testing of local authority social care are the primary reasons for the surprisingly low average level of support received by the severely disabled.

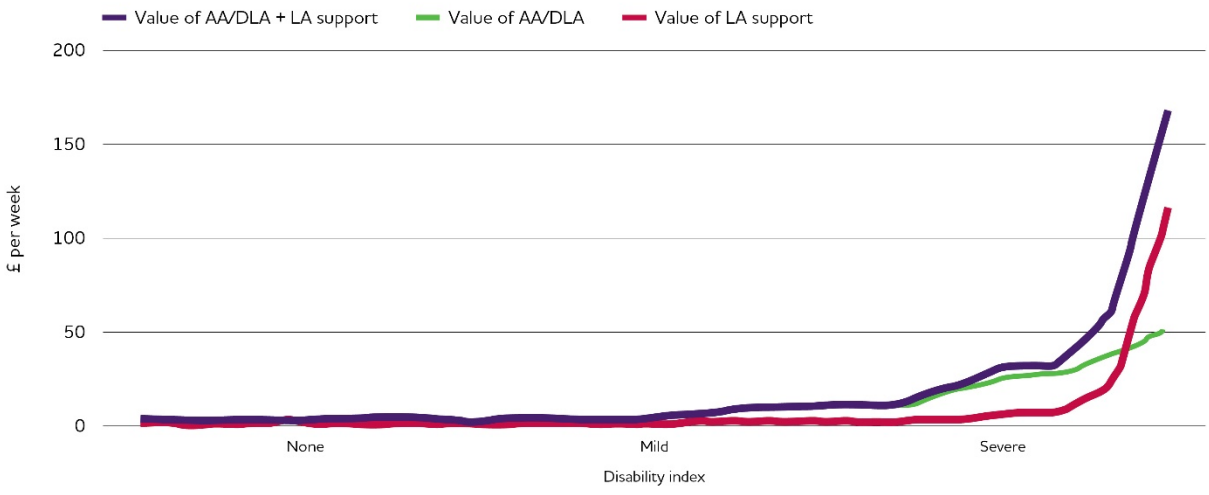
Table 4: The reach of the AA/DLA and social care systems is strongly related to severity of disability, but is far from perfect

Estimated disability level	Receiving AA/DLA	Receiving local authority care	Receiving AA/DLA or local authority care
Analysis of FRS data 2004/5 – 2007/8 [1]			
None	0.9%	0.1%	0.9%
1st disability quintile	6%	1%	7%
2nd disability quintile	15%	2%	16%
3rd disability quintile	21%	3%	23%
4th disability quintile	38%	6%	39%
5th disability quintile	57%	13%	61%
All with disabilities	27%	5%	29%
All	14%	3%	15%
Analysis of ELSA wave 6 data, 2012/13 [2]			
None	2.1%	0.1%	2.2%
1st disability quintile	6%	0%	7%
2nd disability quintile	13%	1%	14%
3rd disability quintile	18%	4%	21%
4th disability quintile	35%	5%	38%
5th disability quintile	55%	21%	64%
All with disabilities	26%	6%	29%
All	14%	3%	15%

All estimates weighted. [1] Based on 33,535 FRS respondents aged 65+, either living alone or with partner over state pension age, with no missing values on relevant variables. [2] Based on 5,174 core ELSA members aged 65+ with no missing values on relevant variables.

Figure 5 shows that the progressive pattern of receipt of AA/DLA and local authority-funded care by severity of disability is still more marked in terms of the cash value of support received, with the average amount rising from a few pounds a week for moderate disability to around £150 a week for the older population with the highest level of disability.

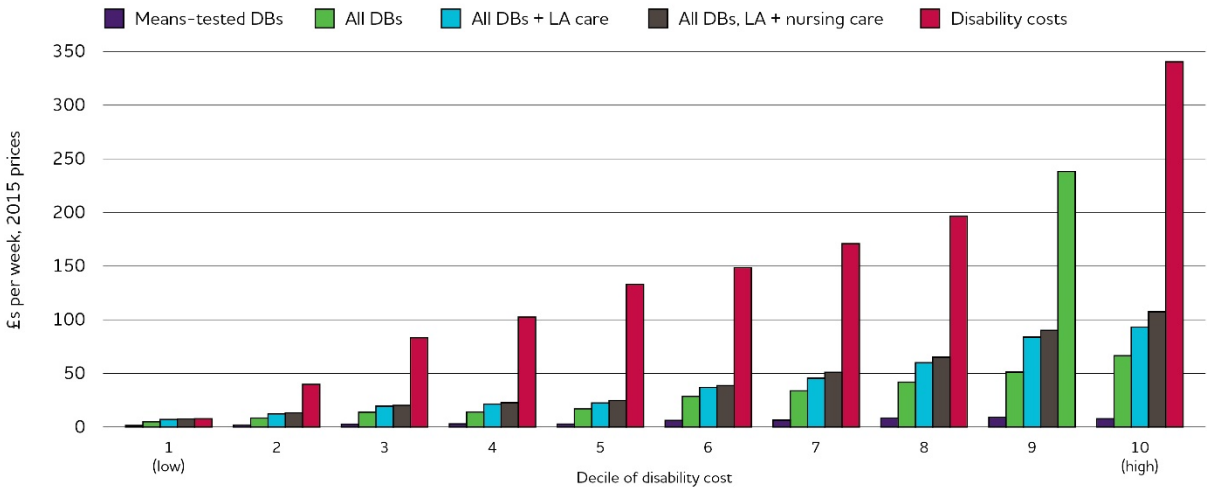
Figure 5: The amounts of support delivered by the AA/DLA and social care systems are very strongly related to severity of disability



Based on analysis of data from over-65 respondents to ELSA wave 6 (2012), uprated to 2015 prices.

Figure 6 shows that the average levels of disability benefit support (including means-tested disability benefits – that is, the amounts of Pensions Credit, Housing Benefit and Council Tax Support which are attributable to the Severe Disability Addition) fall far short of our estimates of average disability costs, especially at the highest levels of disability. Adding in the value of local authority-funded social care closes the gap only slightly. Note that Figure 5 (based on individuals and including those with no disability) uses ELSA data, whereas Figure 6 (based on benefits units containing at least one disabled person aged 65+) uses FRS, so they are not directly comparable. In ELSA, the relationship between the value of social care received and disability displays a steeper gradient than in the FRS but still suggests a substantial gap between state support and disability costs at the highest levels of disability.

Figure 6: Levels of public support are far below estimated disability costs on average



Based on analysis of data on benefit units containing at least one disabled person aged 65 or over and no-one under pension age, from the Family Resources Survey 2004/5 to 2007/8, uprated to 2015 prices.

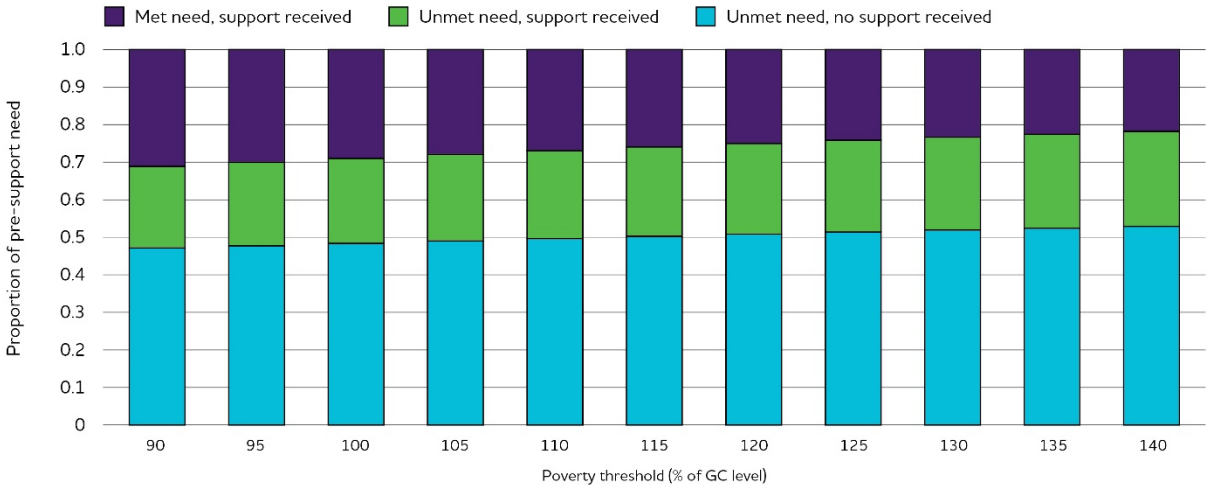
The targeting of public disability support: unmet need

The targeting efficiency of public spending has two aspects. On one hand, we want to minimise the amount of need that remains unmet after the social care/disability benefit system has operated; on the other, we want to avoid allocating resources to parts of the population where need is relatively light. Practical design or reform of a support system involves finding a balance between these two conflicting aims. Our analysis is designed to distinguish these two aspects of targeting (see Appendix 5 for technical details).

The issue of unmet need is concerned with the reach of the system – a combination of take-up decisions by potential claimants and the decisions made by adjudicators on the claims that are made. To make the concept of unmet need operational requires a workable definition of need at the level of the individual. We define it here as the difference between income and the disability-adjusted poverty line (so 'need' is classified as zero for anyone above the poverty line). Under this definition, income is the total of resources available, including any disability benefit and the value of social or nursing care provided. It is helpful to split unmet need into two components – need which is unmet because no support is provided; and need which is unmet because the support which is provided is insufficient to take the individual out of (disability adjusted) poverty.

Figure 7 shows that the proportion of need which the system succeeds in meeting is only around 30 per cent. The greatest source of unmet need – around 50 per cent of the total – is among people who receive nothing at all from the system. The remaining 20 per cent or so is unmet need among people who receive some support, but not enough to lift them out of poverty. The clear message from Figure 7 is that the limited reach of the disability support system is the main source of targeting error in terms of unmet need.

Figure 7: The primary source of unmet need is the limited reach of the benefit/social care system



Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015.

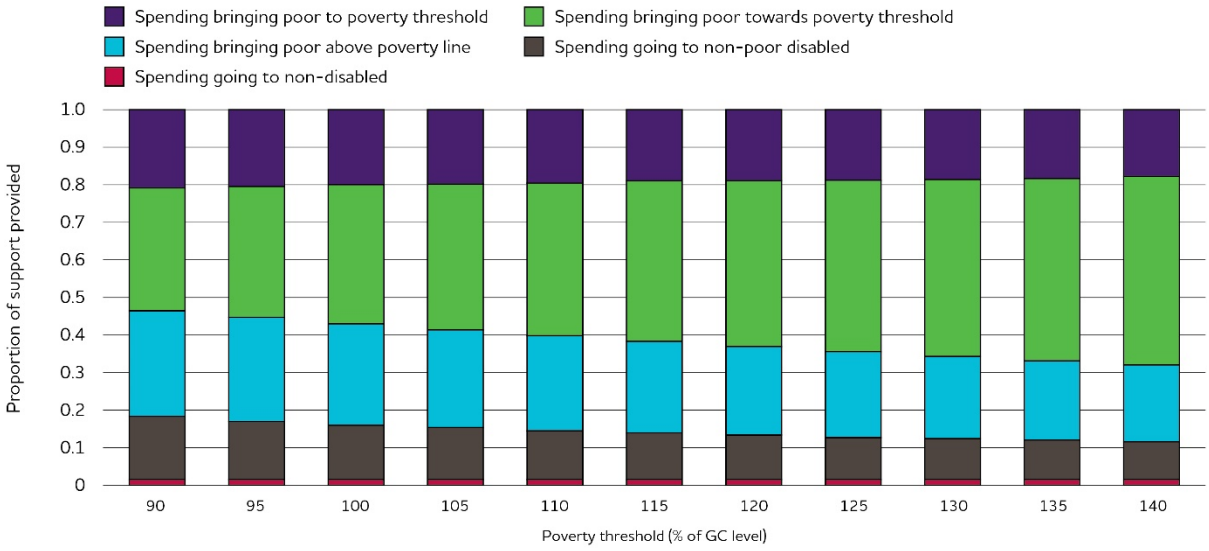
The targeting of public disability support: use of resources

The second aspect of targeting relates to the way that public resources are used. If we view the objective of the system as supporting disabled people who are below a (disability-adjusted) poverty line, it is natural to measure the extent of targeting errors in public spending as the proportion of spending that goes to people who are either without disability or are above the disability-adjusted poverty line. Note that this is a very stringent criterion, which conflicts with the principle of universality underpinning the non-means-tested AA/DLA benefit programme.

Figure 8 presents an analysis of spending on disability support for older people, for a range of alternative choices for the poverty line. Despite the conflict between the non-means-tested nature of AA/DLA and the stringent poverty-oriented nature of this concept of targeting, we see surprisingly little targeting error. The first, red, part of each bar is the proportion of public resources going to people with no evidence of any disability. It is a very small amount, so disability targeting seems very good. The second, grey, part of each bar is spending on people who would not qualify as poor even without any support. For all poverty lines, this share of spending is well below 20 per cent and only 10 per cent when the poverty line is set at 125 per cent of the Guarantee Credit level. The third, blue, part of each bar represents a concept of 'over-spending' – the additional amount spent beyond the minimum needed to move any disabled person up to the disability-adjusted poverty line.

The fourth and fifth parts of each bar represent the share of spending which goes to move people who would be classified as poor in the absence of support towards, or all the way to, the poverty line. Together, they represent nearly 60 per cent of total spending on disability support for older people if we use the Guarantee Credit level as the poverty line, and almost 70 per cent if we were to draw the poverty line at 140 per cent of the Guarantee Credit level. For this range of choices for the poverty line, we find that over 80 per cent of public spending goes to disabled people who would be classed as poor without any public support. Given that AA/DLA is not means-tested and that the local authority social care means test has a minimum income constraint set at 125 per cent of the Guarantee Credit, this constitutes a surprisingly efficient targeting regime. Nevertheless, there appears to be some scope for achieving better targeting by redesigning the benefit system to better align the amount of disability benefit with the level of disability costs.

Figure 8: Despite the absence of a means test for AA/DLA, 'leakage' of public resources to people who are above the poverty line is modest



Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015

Appendix 5 explains our measures of targeting errors in more detail.

5 Possibilities for reform

At a time when population ageing and increasing life expectancy are raising the burden of care costs, policy reform is always on the agenda. Indeed, at the time of writing we are awaiting a public consultation on a possible reform that would see responsibility for Attendance Allowance transferred from the DWP to local authorities (see DCLG, 2015) Various possibilities have been mooted, including diversion of resources for disability benefit into the social care budget; means-testing the AA/DLA system; and making disability benefits liable to income tax. We will not consider specific reforms in detail, since it is impossible to predict the exact form that reform would take in practice. Instead, we consider three hypothetical reforms that will serve to indicate the likely consequences of alternative broad directions of reform. These reform simulations are further developments of a subset of the reforms considered in our earlier paper (Hancock and Pudney, 2013).

Importantly, we have kept each scenario within the current level of spending on public disability support for the older population ('budget neutrality'). This focuses attention on the structure rather than scale of the disability support system and also reflects our view of the political reality that there is little prospect of a significant increase in public spending per member of the disabled older population. Table 5 sets out the details of the three hypothetical reforms. Appendix 6 outlines how the reforms are simulated.

Table 5: Three hypothetical reforms to the disability benefit system illustrating the roles of reach and means-testing in the distributional impact of policy

		Benefit rates affordable under revenue-neutrality (% of personal disability costs)	
Reform	Details	Lowest 70% of disability[1]	Highest 30% of disability[1]
1	(*i*) no change in take-up/claims assessment (*ii*) benefit rate proportional to disability costs, with higher ratio for the 30% most disabled (*iii*) removal of DB means-testing (abolish SDA + raise AA/DLA)	29%	59%
2	(*i*) increased reach among the 30% most disabled[2] (*ii*) benefit rate proportional to disability costs, with higher ratio for the 30% most disabled (*iii*) removal of DB means-testing (abolish SDA + raise AA/DLA)	19%	40%
3	(*i*) increased reach among the 30% most disabled[2] (*ii*) benefit rate proportional to disability costs, with higher ratio for the 30% most disabled (*iii*) all DBs means-tested (AA/DLA replaced with higher SDA)	40%	82%

[1] Among those living in benefit units where at least one partner is disabled. [2] Achieved by predicting receipt using an estimated logit model but increasing the coefficient on disability by 25 per cent.

To means-test or not?

Means-testing is often assumed to be an effective way of improving benefit targeting. Instead, we find means-testing to be unnecessary if other design features of the system can also be varied. Reforms 1 and 2 remove all means-testing from the disability benefit system – the Severe Disability Addition (SDA), which has the effect of raising entitlements to Pension Credit (PC), Housing Benefit (HB) and Council Tax

Support (CTS) for recipients of Attendance Allowance/Disability Living Allowance (AA/DLA), is scrapped and the resulting savings are ploughed back into the universal AA/DLA system. Both reforms tailor the rate structure of the universal benefit much more closely to actual disability costs (particularly for the most disabled). Reform 1 does this without increasing the reach of the system. In reform 2, we assume that some additional action is taken to increase delivery of benefit to the most severely disabled. Such actions could include government initiatives to promote exchange of information between the DWP and local authorities or to raise awareness of the availability of support and help with the claims process, although past evidence on the effectiveness of such initiatives is mixed. Note that, under revenue neutrality, improving the delivery of benefit entails some reduction in rates of benefit to remain within the fixed spending limit.

Reform 3 takes the opposing route of scrapping the universal element and channelling all disability benefit through an increased SDA in the means-tested PC, HB and CTS systems. We also assume increased reach among the most disabled.

Compared with the current system, reforms 1 and 2 increase slightly the proportion of need that is met – by 2 percentage points when the Guarantee Credit level is used as the poverty threshold and by 1 percentage point when using 125 per cent of the Guarantee Credit level. The proportion of need that is met is increased more by reform 3 (full means-testing) – to 37 per cent (poverty threshold=GC) or 29 per cent (125 per cent of GC) (Table 6). However, the proportion of unmet need among disabled people who do not receive benefits is lowest under reform 2 (no means-testing and improved reach) falling from 48 per cent (poverty threshold=GC) or 51 per cent (threshold = 125 per cent of GC) under the current system to 30 per cent or 33 per cent respectively. Full means-testing risks more need going completely unsupported by the disability benefits system.

Table 6: Revenue neutral reforms could reduce unmet need

Policy	Poverty line	Met need	Unmet need		
			Non-recipients	Recipients	Total
Current system	GC	29%	48%	23%	71%
	125% GC	24%	51%	24%	75%
Reform 1 (no DB means-testing)	GC	31%	48%	21%	69%
	125% GC	25%	51%	24%	75%
Reform 2 (no DB means-testing, improved reach)	GC	31%	30%	39%	69%
	125% GC	25%	33%	42%	75%
Reform 3 (full means-testing, improved reach)	GC	37%	48%	18%	63%
	125% GC	29%	48%	23%	71%

Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015.

All three reforms reduce the proportion of 'excess' spending taking people beyond the poverty line, from 27 per cent (poverty threshold=100 per cent of GC) or 23 per cent (125 per cent GC) to 21–22 per cent or 19–20 per cent (Table 7). They also reduce the share of spending that takes poor disabled people up to the poverty threshold from around 20 per cent to about 14 per cent. The proportion of spending taking people towards but not up to the poverty line rises substantially under all three reforms. The largest rise occurs under reform 3 where this proportion is over 60 per cent compared with 37 or 44 per cent under the current system. Full means-testing has the lowest share of spending going to non-poor disabled at around 5 per cent compared with 11–14 per cent under the pre-reform system.

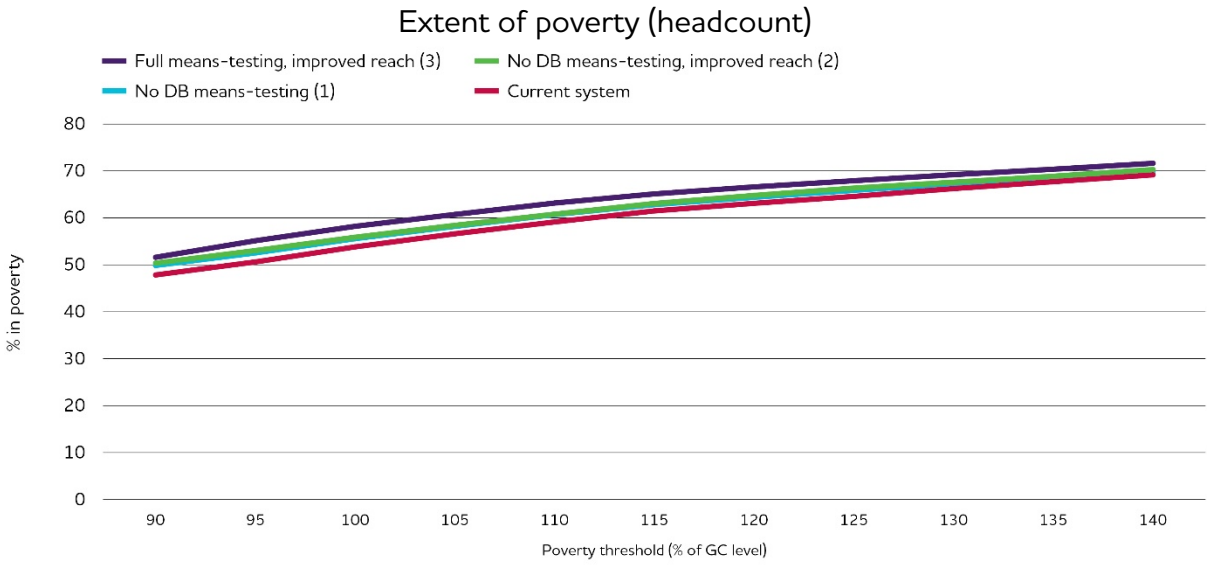
Table 7: The share of spending going to non-poor disabled older people is lowest under full means-testing but all reforms reduce the proportion of spending taking people above the poverty line

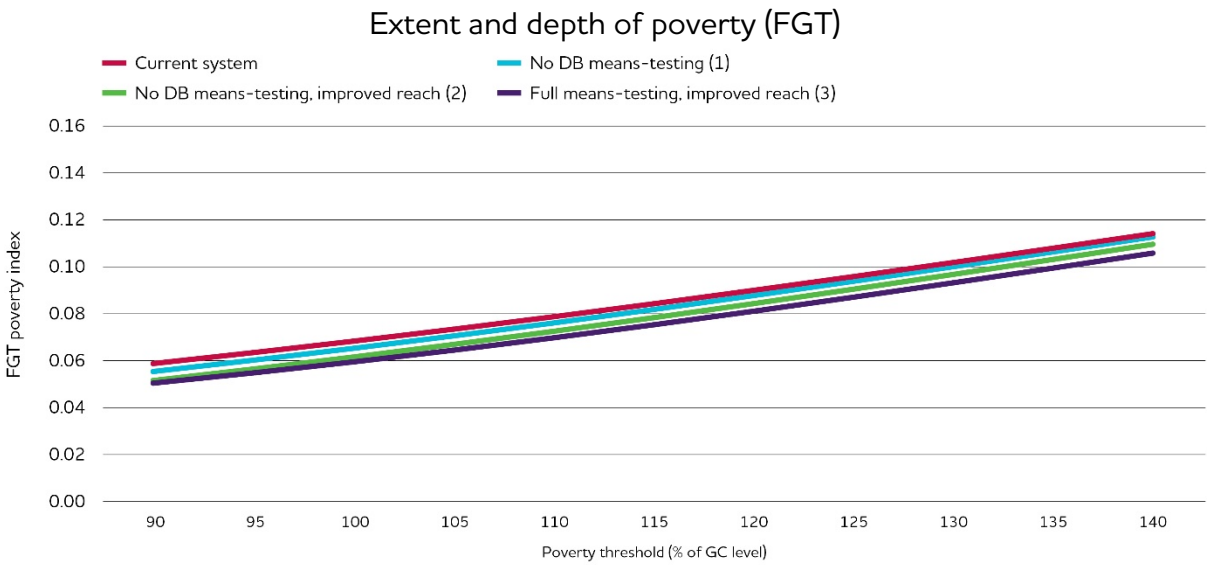
Policy	Poverty line	Spending to non-disabled	Spending to non-poor	Spending beyond poverty line	Spending up to poverty line	Spending under poverty line
Current system	GC	2%	14%	27%	20%	37%
	125% GC	2%	11%	23%	19%	44%
Reform 1 (no DB means-testing)	GC	0%	16%	22%	14%	47%
	125% GC	0%	13%	20%	14%	53%
Reform 2 (no DB means-testing, improved reach)	GC	0%	16%	22%	14%	47%
	125% GC	0%	13%	20%	14%	53%
Reform 3 (full means-testing, improved reach)	GC	0%	5%	21%	13%	60%
	125% GC	0%	4%	19%	14%	63%

Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015.

The analysis in Tables 6 and 7 might suggest that means-testing is a good way to reduce targeting errors. However it does not tell us whether a large proportion of need going unmet represents a small amount of unmet need for a large number of people or a large amount of unmet need for a small number of people. If the objective is to reduce poverty, considering appropriate measures of poverty under different policy regimes provides a fuller picture of the effectiveness of each regime. Figure 9 compares poverty rates (headcount) and depth (FGT) under the current system of disability benefits and under the three hypothetical reforms for poverty lines ranging from 90 per cent of the Guarantee Credit level to 140 per cent of the Guarantee Credit level. There are three main findings. First, although the current system results in the lowest rates of headcount poverty, it produces the deepest poverty levels. Second, to reduce the depth of poverty it is very important to extend the reach of benefits; reforms 2 and 3 reduce the depth of poverty much more than reform 1. Finally, comparing the two reforms under which the reach of benefits is increased, the depth of poverty is only a little lower when benefits are fully means-tested than when they are all non means-tested, despite the fact that higher rates of benefits can be afforded under full means-testing. Extending the reach of disability benefits among those with the severest disabilities and hence the highest disability costs is essential to reducing the depth of poverty among disabled older people.

Figure 9: Reforms to disability benefits could reduce the depth of poverty





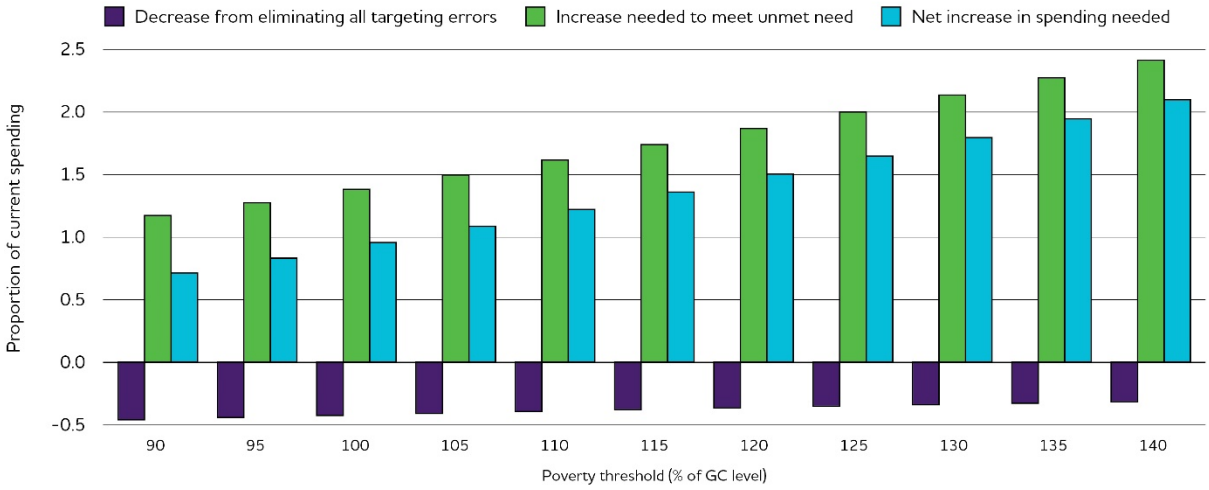
Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015.

What would it cost to eliminate poverty among disabled older people?

Our analysis of unmet need gives a guide to the extra public resources that would be needed to eliminate poverty among older people living with disabilities in their own homes. There are two components to consider. The first is how much more would need to be spent to bring the incomes of those who remain in poverty under the current system up to the poverty line. The second is how much could be saved if all spending which goes to non-disabled people, non-poor disabled people or brings poor disabled people above the poverty line were eliminated. Subtracting the second from the first provides an estimate of the net cost of eliminating poverty if – a very important if – it were possible to target resources perfectly. The answer clearly depends on the choice of poverty line.

Figure 10 plots the two components and their net effect for the usual range of poverty lines. At a poverty line of the Guarantee Credit level, the net extra spending needed amounts to almost 100 per cent of current public spending on disability benefits and care for older people living in private households. In other words spending would need to double to eliminate poverty among older disabled people at this poverty line. If the chosen poverty line were 125 per cent of the Guarantee Credit level, the increase would need to be nearly 170 per cent. If it is not possible to target resources perfectly, the required increases in spending would be higher.

Figure 10: Public spending on disability benefits and care would need to at least double to eliminate poverty among older disabled people even with perfect targeting



Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015.

A unitary or dual system of support?

The idea of bringing together funding for disability benefits and funding for social care has been debated for some time. Most recently, the Barker review (Commission on the Future of Health and Social Care in England, 2014a) recommended that Attendance Allowance be brought within an integrated health and social care system to contribute to a more graduated pathway of support. Under this proposal, Attendance Allowance would no longer be administered by the Department for Work and Pensions but by a body (or bodies) responsible for commissioning health and social care, possibly by local health and wellbeing boards.

The diversion of (some of) the resources currently used for disability benefits into the social care system was also suggested in the 2006 review of social care (Wanless, 2006) and floated again in the 2009 Social Care Green Paper (HMG, 2009). Subsequently the 2010 Social Care White Paper (HMG, 2010b) ruled out, at least for the next Parliament, any reform of Attendance Allowance (or the alternative benefit Disability Living Allowance) to fund its proposed reform of social care. The Dilnot Commission on Funding Care and Support (Commission on Funding Care and Support, 2011) established by the Coalition Government formed in May 2010, considered the role of Attendance Allowance. It concluded that Attendance Allowance should remain a non-means-tested social security benefit but that it should be 'rebranded', an idea which has been developed by Lloyd (2013).

The consequences of combining AA/DLA and care provision into a single fund cannot be assessed properly without considering systemic and individual uncertainties. The issue of uncertainty or risk has been largely ignored in the policy debate and the research which informs the debate.

Public scrutiny is an important factor promoting effective delivery of disability support, and that scrutiny may be more intense at the national than at the local level. The visibility of policy and the accountability of policy players are involved here. Central government departments like the DWP are subject to close coverage by national news media, while coverage of local authorities' decisions is more piecemeal. The accountability issue arises because central government funding decisions affect what local authorities can achieve, without taking direct responsibility for the local consequences. Consequently, a concentration of responsibility for delivery in the hands of local bodies may increase the systemic risk of unevenly targeted delivery of support.

Risk is also important at the individual level. Any system of claim assessment is necessarily uncertain, since it relies on officials' judgements about disability and need – and the high success rate in claim appeals

procedures (see Appendix 1) demonstrates how uncertain those judgements can be. Moreover, some people with strong potential claims may not be aware of their potential eligibility, and so not make a claim (Pudney, 2009). Given these uncertainties, the existence of two parallel forms of support with separate assessment procedures can be expected to reduce the risk of being missed completely by the system and, consequently, to reduce the number of people in severe need who receive no support at all. [20]

These potential disadvantages of localisation should be set against any advantages of flexibility and administrative efficiency claimed for a unified, locally administered system of disability support. Overall, given our research findings, we see a distinct role for cash benefits like AA/DLA within the system of public support for older disabled people. The delivery of benefits to those in need is far from perfect but we see no reason to believe that a unitary system of disability benefits and care service would be better targeted, and there is a risk that it would be considerably worse in terms of delivery of support to those in greatest need.

6 Extensions

The UK picture

Our analysis has focused on Great Britain where disability benefits are the responsibility of the DWP. In considering reforms to disability benefits we have allowed for the effect of changes in an individual's income from disability benefits on their entitlement to local authority-funded care and hence on their net income, measured to include the value of local authority-funded care. Our simulation evidence takes account of the major difference between Scotland, where entitlement to publicly funded personal care does not depend on income, and England and Wales where it does (although with some differences between England and Wales in the guidance on how local authorities should assess people's contributions to their care costs). For largely technical reasons, our analysis does not cover Northern Ireland which operates a similar means-test to England and Wales for care provided in a care home, but where charges for care provided to people in their own home have traditionally been low (Law Centre (NI), 2015).

The situation in England inevitably dominates any UK analysis in the sense that England accounts for the largest share of the UK population. People aged 65 and over in England account for 84–85 per cent of the UK and GB older populations. This is not to say that differences between the constituent countries are unimportant – and as more powers are devolved to them with the potential for policies to diverge more, differences may become more pronounced. But it is very unlikely that the main messages of our analysis for Great Britain would be changed if we were able to extend it to include Northern Ireland.

The care home populations

Our analysis has been confined to the household population. There are a number of points that need to be made in considering how the issues we have analysed apply to the care home population. The first is that the concepts of poverty and disability costs that we have used for the household population do not translate well for use in the care home population. The means test for care home fees (or the hotel component of fees in Scotland) are designed to leave residents with a small personal expenses allowance for meeting the costs of items and services that are not included in the care home fees. The adequacy of the level of the personal expenses allowances has been questioned and variations across care homes in what is and is not provided within the care home fee may vary (Easterbrook, 2001; Griffiths, 2000) This is an area where further analysis is likely to be the most fruitful route to understanding how to address poverty for older people living in care homes, rather than trying to incorporate the care home population directly within the framework used in this paper.

A second issue is the way the benefits and care home funding systems work together. Payments of AA, the care component of DLA and the SDA in Pension Credit cease if the recipient starts to get financial support from their local authority with care home fees. In effect, local authorities will pay the equivalent amount towards the recipient's care home fees so there is no net effect on the care home resident but rather a cost is transferred from the DWP to the local authority. One implication of this is that the reforms to disability benefits that we have examined would have no effect on local authority-funded care home residents (effectively all residents in Scotland). Self-funded residents could be affected but since they are unlikely to be entitled to means-tested benefits, they would be unlikely to benefit from the fully means-tested reform.

Potential reforms to the care charging system

We have considered hypothetical reforms to the disability benefits system but not reforms to the system of charging for care. Since care is received by far fewer older people than receive disability benefits, the potential for reforms to the care charging system to affect poverty among older disabled people is much less than that of reforms to the disability benefit system. Nonetheless, variations in charging for care across countries of the UK and differences between care-charging means tests and means-tested benefits suggest areas that might be considered.

The main country differences in charging for care provided to people living in their own homes are:

- Scotland does not charge for personal care.
- Wales has a maximum charge of £60 a week. Its upper and lower capital limits are equal (implying no tariff income – see below). It uses a 35 per cent rather than 25 per cent 'buffer' above the Guarantee Credit level and sets a minimum 10 per cent of the GC-level allowance for disability-related expenditure
- In Northern Ireland charging has historically been limited to home helps and meals-on-wheels.
- From 2020, there will be a lifetime cap in England on individuals' liability for care charges. The effects of this will be mainly on people who enter residential care (and then only those who currently do not qualify for state help). The means test for care at home is not changing although the value of assessed need for home care will count towards the cap.

Some differences between the domiciliary care means tests and means-tested benefits are:

- Tariff income: in England capital between the lower capital limit and the upper capital limit is assumed to generate £1 a week of income for every £250 of capital between those limits. Since Wales' upper and lower capital limits coincide, there is no tariff income. In means-tested benefits, capital is assumed to generate income of £1 for every £500 of capital i.e. at half the rate used in the means test for home care in England. For Pension Credit there is no upper capital limit; tariff income is assumed to be generated on all capital above the lower limit.
- Means tests for home care embody 100 per cent marginal withdrawal rates i.e. charges increase £ for £ as income increases once the threshold (GC level plus 25 per cent or 35 per cent for England and Wales respectively) for charges has been reached. This contrasts with Housing Benefit and Council Tax Support which have 'tapers' so that benefit is withdrawn by less than income increases. The Savings Credit[21] component of Pension Credit involves a taper of 40 per cent.

Aspects of the home care means test which might therefore warrant debate, but where there is little or no research evidence, include:

- the appropriate level of the so-called buffer above the ordinary GC level i.e. 25 per cent in England, 35 per cent in Wales, and whether it could be applied differently to avoid 100 per cent marginal withdrawal rates;
- disability-related expenditure: how it is established and treated in the means test for home care;
- the capital limits and what income is assumed to be generated from capital between the upper capital limits.

7 How robust is the evidence?

Alternative estimates of disability costs

To investigate how sensitive our findings are to levels of disability costs we repeated our analysis assuming that the relationship between disability costs and disability levels is unchanged but that disability costs are 35 per cent higher or lower than those used in our main analysis. Our conclusions on how the current system works are changed remarkably little by this sensitivity analysis. State support for disability costs in later life is still concentrated on poorer people when income is measured net of disability costs. It still falls short of disability costs, especially at the most severe levels of disability, even if these costs are 35 per cent lower than previously assumed. Altering assumed disability costs has some effect on targeting as measured by (un)met need and use of resources. A reduction in disability costs of 35 per cent increases the level of met need mainly by reducing the level of unmet need among those who receive some support. For example at a poverty threshold equal to 100 per cent of the Guarantee Credit (GC) level, met need increases from 29 per cent (Table 6) to 36 per cent; unmet need among recipients of benefit falls from 23 per cent to 15 per cent. Corresponding changes at a threshold of 125 per cent of the GC level are a rise from 24 per cent to 36 per cent and a fall from 24 per cent to 18 per cent respectively. A 35 per cent increase in disability costs has the opposite effect. At 100 per cent of GC met need *falls* to 23 per cent and unmet need among recipients *rises* to 28 per cent. Equivalent percentages at 125 per cent of GC are a fall to 20 per cent and a rise to 29 per cent.

Higher or lower disability costs would affect the levels of benefits, expressed as proportions of disability costs, which could be afforded under the reforms examined in Section 5 within the current level of public spending on support for older people with disabilities. Here we consider variations to the reforms in which we increase or decrease the rates of disability benefits to retain budget neutrality under lower or higher disability costs. Higher benefit rates can be afforded if disability costs are lower; reduced benefit rates can be afforded if disability costs are higher. Under the reforms which remove all means-testing in disability benefits (reforms 1 and 2) the rates of benefits that can be afforded for the highest 30 per cent of disabled older people remain at twice the level of those for the lowest 70 per cent of disabled people. This is also the case where all disability benefits are means-tested and costs are 35 per cent higher than previously used. If disability costs are 35 per cent lower and all disability benefits are means-tested, benefit rates can be set at 100 per cent of disability costs, for all levels of disability. Details are set out in Table 8.

Table 8: Hypothetical reforms to the disability benefit system under higher and lower levels of disability costs

		Benefit rates affordable under revenue-neutrality (% of personal disability costs)			
		Disability costs reduced by 35%		Disability costs increased by 35%	
Reform	Description	Lowest 70% of disability	Highest 30% of disability	Lowest 70% of disability	Highest 30% of disability
1	No means-testing in DBs, no change in reach	45%	90%	20%	40%
2	No means-testing in DBs, improved reach	30%	60%	14%	28%
3	Full means-testing. improved reach	100%	100%	30%	60%

For full details of reforms see Table 5.

Comparisons of targeting among the different policy regimes are not affected greatly by altering disability costs and benefit rates. The exception is where disability costs are reduced by 35 per cent and disability benefits are fully means-tested. In this case, unmet need among benefit recipients falls from 15 per cent under current policy, to just 4 per cent of total need if the poverty threshold equals the GC level (it does not fall to zero because some needs unrelated to disability may still be unmet, for example if Housing Benefit and Council Tax Support are not claimed or do not meet all housing costs). The proportion of spending on non-poor disabled people falls from 21 per cent (threshold=100 per cent GC level) or 15 per cent (125 per cent GC level) to 8 per cent or 6 per cent respectively. These relatively large differences are driven by the fact that at the lower levels of disability costs and under full means-testing, benefit rates can be set at 100 per cent of costs for all disability levels.

At 35 per cent lower disability costs, the choice of poverty threshold and of poverty measure becomes very important in assessing the performance of the different policy regimes (Figure 11). At thresholds below about 110 per cent of the GC level, headcount poverty under reform 3 (full means-testing) is considerably lower than under reform 2 (no means-testing, improved reach). But using the FGT measure of the depth of poverty, there is much less to choose between these two reform options; indeed poverty is a little less under reform 2 at low poverty thresholds. In contrast, at 35 per cent higher disability costs, reform 3 produces the lowest FGT poverty levels at all thresholds. There is thus a suggestion here that given a fixed budget, the case for means-testing may be greater, the higher the overall level of disability costs.

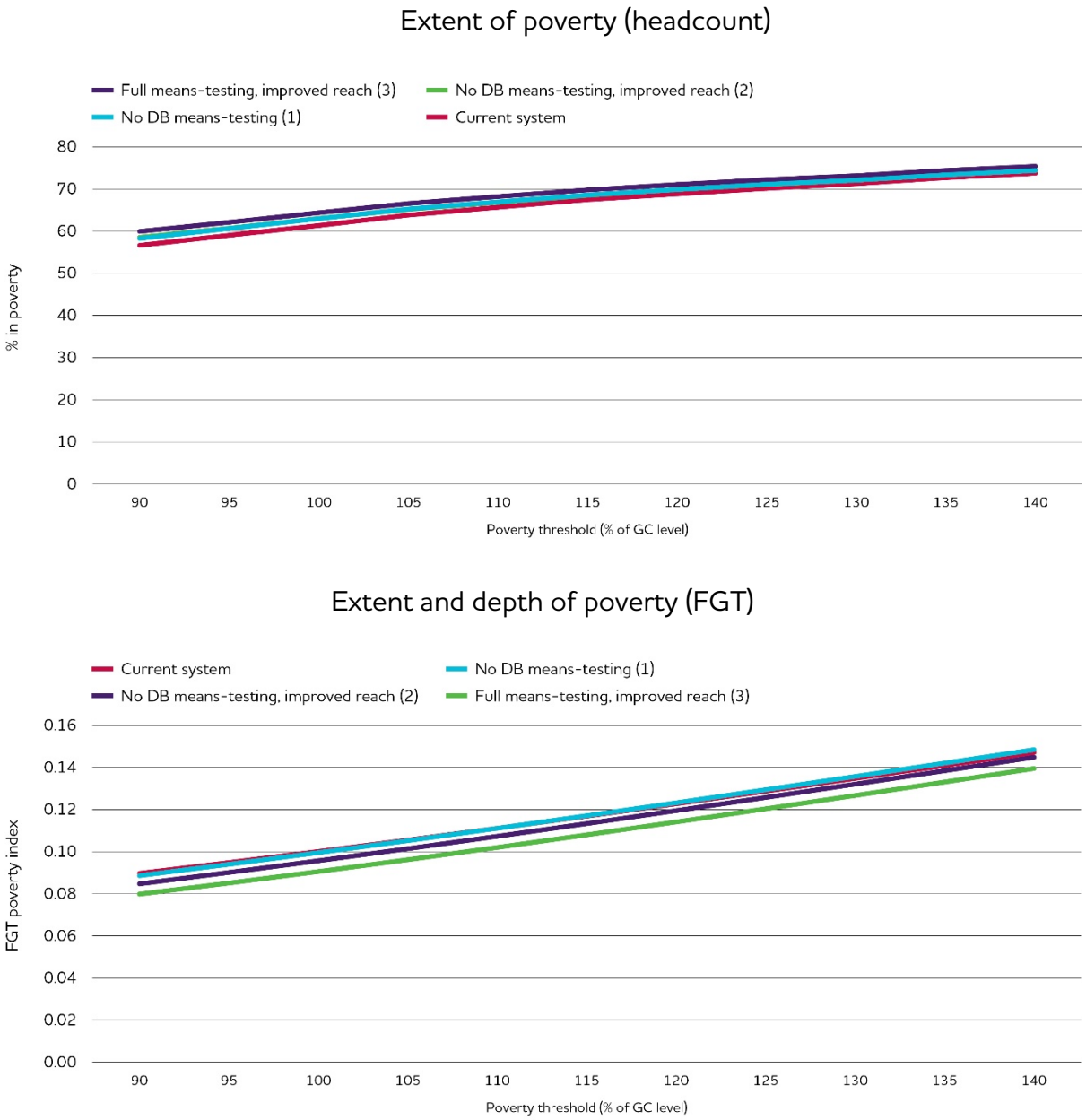
Finally, the general pattern of increases in public spending needed to eliminate poverty is not very sensitive to the reduced or increased levels of disability costs that we have examined. However the level of necessary rises in spending are lower when disability costs are assumed to be less and higher when the costs are assumed to be more. For example at a poverty threshold of 100 per cent of the GC level, the net additional increase in spending needed to eliminate poverty falls from 97 per cent (see figure 10) to just 17 per cent if disability costs are 35 per cent lower than in our main analysis but rises to 183 per cent if disability costs are 35 per cent above our main analysis levels. Equivalent comparisons at 125 per cent of GC are a fall from 166 per cent to 80 per cent or a rise to 257 per cent.

It is likely that our findings would be more sensitive to changes in the relationships between disability costs and severity of disability, and between disability and income. Although we have not examined this directly, in general the case for rebalancing rates of benefit to more closely match disability costs will be greater, the steeper the gradient between disability costs and disability level. The case for a mostly non-means-tested system will be greater the steeper the (negative) gradient between disability levels and income; conversely the case for a more means-tested system would be greater if there were a less steep relationship between disability severity and income.

Figure 11: Extent and depth of poverty: disability costs 35 per cent lower

Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015.

Figure 12: Extent and depth of poverty: disability costs 35 per cent higher



Based on analysis of data from over-65 respondents to the Family Resources Survey 2004/5 to 2007/8, uprated to 2015.

8 Conclusions

In this study we have used statistical analysis of two large-scale representative surveys to examine the effectiveness of the system of public support for older people with disabilities. We have also used simulation of a number of hypothetical policy reforms to suggest promising ways to reform the system within the existing level of government spending. There are six main conclusions.

1. Disability brings with it additional living costs, which can be very large – sometimes hundreds of pounds a week. People with disabilities often receive government support in the form of disability benefit, designed to meet part of those additional costs. If we include disability benefit in income but fail to make any allowance for the higher living costs that disability brings, then disabled people appear to be better off than they actually are. In the policy debate, we often see comparisons between the incomes of disabled and non-disabled people, or of the younger and older population (the latter have higher rates of disability). These comparisons are often made without any allowance for differences in living costs and are misleading because they make older disabled people seem better off relative to the rest of the population than they really are.
2. Britain currently has a dual system of public support for older disabled people. Central government pays disability benefits (mainly *Attendance Allowance* and *Disability Living Allowance*), while local authorities manage the provision of social care services. The two systems are quite separate and have little overlap, and it is sometimes suggested that they should be merged into a single system of disability support. While this sounds neater and may save some administrative costs, it runs the risk that many more people than at present may miss out on government support completely. We think it is too big a risk to take with such a vulnerable group.
3. The present system of social care/disability benefit is quite good at using limited resources to minimise the number of older disabled people in poverty. But it is much less effective in protecting people from very deep poverty. The people most affected by this are those with severe disability (and therefore high disability costs), especially those who are unaware of, or not able to negotiate, the systems for claiming help with their care needs.
4. There are failures in the targeting of the current system – the system misses some people in great need and it spends some public money on people with only moderate needs. But, in practice, no system of social support can avoid all such errors. Our findings suggest that the failure to meet severe need is a much bigger source of targeting error in the current system than is the spending of resources on the wrong people.
5. There is scope for improving the performance of the system of public support for older people with disabilities, by spending the current budget for disability benefit in a more effective way. Although introducing means-testing for *Attendance Allowance* or *Disability Living Allowance* is often suggested, it is possible to achieve similar improvements in poverty outcomes in a fully means-tested or a fully *non*-means-tested version of the disability benefit system. The reason for this is that people with low incomes are more likely to be affected by severe disability, and also have a stronger need for support and are therefore more likely to claim support.
6. Much more important than means-testing is the ability of the system to provide support to people living with severe disabilities and facing very high disability costs. Effective reforms of the disability benefit system could achieve major reductions in the burden of deep poverty by doing two things:

- adapting the amounts of benefit paid to claimants of *Attendance Allowance* or *Disability Living Allowance* to match the costs of disability more closely;
- increasing the reach of the system, particularly among the most disabled, by increasing take-up of entitlements and/or improving the quality of initial adjudication of claims.

A reform that achieved these objectives while staying inside the current level of spending on disability benefits would require a reduction in the *average* amounts paid to people with less severe disability,

to pay for the increased levels of support for the most severely disabled, although it could also accommodate small amounts of support to an increased proportion of those with modest disability levels. This seems a reasonable possibility to examine.

Notes

1. See D. Willetts. 'Pensioners prosper, the young suffer. Britain's social contract is breaking', (*The Observer*, 26 October 2015) and Willetts (2011).

2. The system of disability benefits is administered separately in Northern Ireland but follows the British system very closely. The analysis in this paper relates to Great Britain unless otherwise stated.

3. There is also a national system of nursing care provided through the National Health Service. This is small in comparison to the benefit and social care systems. We take account of it in our analysis but do not discuss it.

4. Source: DWP tabulator tool (gov.uk/government/collections/dwp-statistics-tabulation-tool; accessed 6 Jan 2016).

5. Council Tax Support, as it is now known, is administered by local authorities (councils). Our data comes from the period when it was administered nationally and known as Council Tax Benefit (CTB). For simplicity, we use the acronym CTS to refer to either system as appropriate.

6. Source for numbers of social care recipients: Health and Social Care Information Centre (2015).

7. Similar arrangements exist in Wales and Scotland. In Northern Ireland social care is organised by health and social care trusts.

8. Our analysis is based on data before April 2015, and it remains to be seen how the Care Act will change the social care system in practice.

9. Wales has a maximum charge of £60 a week (from April 2015) which applies if the means test would otherwise result in a charge higher than this.

10. A change in the way statistics on social care are reported to the Health and Social Care Information Centre means these figures are not directly comparable with the 254,000 figure for 2015 mentioned earlier. The 2015 figure excludes care provided on a short-term basis.

11. See Tinkler and Hicks (2011), HMG (2012) and DWP (2011) respectively.

12. Curtis (2014) Tables 11.6 and 10.1 respectively. We assume that all nursing care reported in the FRS is provided under the NHS.

13. It is in any case possible to have an income above the GC level when receiving means-tested benefits because certain sources of income are disregarded when applying the means test and some components of means-tested benefits are not withdrawn pound for pound as income rises.

14. We use the square of the proportionate distance below the poverty line, so a person with income 50 per cent of the poverty level is weighted 25 times more heavily than someone with income 10 per cent below the poverty line.

15. Calculated from Table 2 as (49.1-28.6)/28.6 and(64.6-31.2)/31.2 respectively.

16. Calculated from Table 2 as (.065-.017)/.017 and(.096-.018)/.018 respectively.

17. Unless there is a reversal in the recent trends towards an increasing socio-economic gradient in later life disability (Morciano *et al.*, 2015b), the degree of implicit income targeting in AA/DLA will, if anything, increase in future.

18. The relatively large amount of nursing care apparently received by people in quintile 4 is essentially a 'blip'. Nursing care is uncommon but relatively expensive, so large blips of this kind can occur purely by chance, as an outcome of random sampling.

19. It should be borne in mind that we are using an approximate estimate of disability severity, so the small but positive rate of AA/DLA receipt by people in the lower quintiles of the disability distribution may be due to errors in the classification of people into disability quintiles rather than delivery of benefit to ineligible people.

20. Pudney *et al.*, 2010; annex 1 gave an illustrative calculation showing a plausible six-fold increase in the risk of receiving no support with the adoption of a unitary assessment process.

21. However, the Savings Credit is being abolished for people who reach state pension age after 2016 as part of the state pension reforms due to come in then.

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