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Disability benefits and paying for care

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Disability benefits and paying for care

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Non-technical summary

Attendance Allowance (AA) and the care component of Disability Living Allowance (DLAc) are paid to nearly four million elderly or disabled people who need help in their daily lives, at a cost of £9 billion per year.

It is widely agreed that more should be spent on social care for older people. The 2006 Wanless review of social care suggested that these disability benefits paid by the social security system should be curtailed, releasing resources that could be used to pay for social care services. Diverting funds from AA/DLAc to social care budgets is only one possible way to finance an increase in social care spending – the issue addressed here is not whether more should be spent on care, but whether less should be spent on disability benefits as part of the same package.

There has been very little research into the impact of AA/DLAc. This paper uses the Family Resources Survey to assess the needs and resources of disabled people. There is a strong tendency for people reporting several kinds of impairment to be receiving disability benefits; but some people seem to be getting benefit even though they report no impairments. Although AA and DLAc are awarded on the basis of the need for care, a high proportion of claimants seem not to be receiving any care, and only a quarter even of those living on their own are cared for by any paid workers. Either AA and DLAc are better at reaching disabled people than social services, or a large proportion of disability benefit payments are going to people who are getting by either with no care, or with help from their families.

Half of all AA/DLAc recipients also claim means-tested benefits. Four out of ten would be below the DWP's indicative poverty line of 60% of median income if their disability benefits were not available. AA and DLAc provide quite significant increases in money income to those receiving them. But the benefits were expressly intended by the governments which introduced them to contribute to the extra cost of living faced by disabled people, including, but not confined to, the direct costs of care-services. It is difficult to measure these extra costs, but disabled people receiving disability benefits experience almost as much material deprivation as non-disabled people not receiving the benefits.

A transfer of resources from social security benefits to the social services system cannot be evaluated in detail, because the social services system is likely to change too. But the switch would tend to:

- x deliver more care to a small number of very disabled people, and less cash to a large number of moderately disabled people;
- x reduce resources delivered to disabled people who have a partner or other family member to care for them;
- x involve rather more means-testing;
- x make resource allocation decisions more sensitive to individual circumstances, but less available to be claimed as of right;
- x subject the amount of public money available to disabled people to tight budgetary control, rather than allow it to float with the number of people in need;
- x reduce rather than increase disabled people's ability to spend the money as they choose, and their sense of independence.

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Abstract

Attendance Allowance and the care component of Disability Living Allowance are paid to nearly four million elderly or disabled people who need to help in their daily lives. In the course of recent debate about financing the growing demand for social care services, the Wanless report (2006) suggested that these disability benefits paid by the social security system should be curtailed, releasing resources that could be used by social workers to pay directly for care. This paper uses some new findings about the needs and resources of disabled claimants to comment on that proposal. It considers six issues of principle about the balance between cash and care in the delivery of support to disabled people. A decision to change policy would need to take account of the costs to the losers, as well as of the benefits to the gainers.

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The paper includes some new analysis of the Family Resources Survey, produced by the Department for Work and Pensions and supplied by the UK Data Archive. The data are Crown copyright.

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Aims

The attendance allowance (AA) is paid to 1.5 million elderly people who need help throughout the day, during the night, or both. The care component of the disability living allowance (DLAc) is paid to another 2.3 million (mostly) non-elderly disabled people who meet the same conditions, or who need help for part of the day, or cannot cook a meal. Together, these benefits cost £9.2 billion a year. (Here, and elsewhere in the main text of the paper, we have glossed over many details of these complex schemes. Some more precise information is provided separately at the end of this paper; readers who are unclear about the rules should start with that description.)

This paper discusses the impact of the attendance allowance and of the care component of disability living allowance (collectively known as AA/DLAc) on the resources of disabled adults. Since the need for care is the main criterion entitling people to claim, one important question is whether they receive (enough) care. The Wanless (2006) review of care needs (of elderly people) argued that the AA might not be the best vehicle both to provide support in meeting care costs and also compensate people for other needs-related expenditures. It recommended integrating support for care costs from AA into the care system to improve targeting of resources. The pre-Budget report of October 2007 suggested that the government was actively considering the same set of issues for disabled people of all ages.

The Wanless (2006) recommendation was in the context of the review's conclusion that "more should be spent on social care for older people" and that the system of financing care should have less means testing. Diverting funds from AA/DLAc to social care budgets is only one possible way to finance an increase in social care spending – the issue addressed here is not whether more should be spent on care, but whether less should be spent on disability benefits as part of the same package. A full evaluation of such a shift would need to consider other possible ways to fund increased social care spending. So we do not aim to reach conclusions on policy options. Rather we hope to highlight issues that will need further research and debate before conclusions can be reached.

The provision of personal assistance to disabled people is an important issue but not the only one. Disabled people, especially those of working age, typically have lower incomes than non-disabled people. And disabled people of any age face additional costs of living that leave them and their families worse off than non-disabled people with similar incomes. Both the AA and the DLA were originally intended to contribute to these extra costs – *not* specifically to pay for care. Sir Keith Joseph, for example, introduced the allowances as follows:

It was never suggested that £4 a week provided for in the Bill would be enough to provide professional help ... It would be a valuable additional cash resource for the long haul of chronic severe disability for households which had to bear the financial burden. (Hansard 1970)

Similarly, the white paper introducing DLA was quite explicit that the objective was "better coverage of assistance with the extra costs of being disabled" (DSS 1990).

It is not clear from these statements whether these extra costs were meant to include (without being restricted to) the costs of paid-for care. There has never been any suggestion that disabled people were not allowed to spend their benefit on private domestic or personal services. But after the 1988 Griffiths report the assumption that people should pay towards

care from local authorities became much stronger (Baldwin and Lunt 1996). Since then local authorities have tended to take AA/DLAc into account in assessing charges for home care (while allowing for other disability related costs). So the costs of state-provided care are now seen as a legitimate call on AA/DLAc.

Of course it will be open to policy makers in 2008 or 2009 to change the priorities, putting more or less emphasis on the provision of care in relation to meeting additional costs. But both sets of consideration have to be taken into account in an analysis of the roles of these benefits, to assess the potential drawbacks, as well as the potential advantages, of a change in provision.

Central to the debate are the relative merits of “cash” and “care”. AA/DLAc provides disabled people with regular cash, which they can spend however they wish. Historically, local authorities have addressed disabled people’s needs through the delivery of care services. The growing use of direct payments and recent pilot schemes for individual budgets are intended to give clients of social services much more control and flexibility over how their needs are met. The way money channelled through local authorities is used to meet the needs of disabled people is therefore in the process of change, a point to which we return.

The supply of care has been described as a “mixed economy”. Disabled people are helped in various ways by their families, by friends and neighbours, by NHS and local authority employees, and by paid carers. Some receive help in their own homes, while others live in specialist care or nursing homes. Direct and indirect costs of care are met in various ways by the disabled people themselves, by the carers themselves or by public bodies. Disabled people and their families face other additional costs, as well as the costs of care.

Sir Keith Joseph’s comment on the amount of benefit in relation to the cost of “professional help” is worth emphasising. The criterion for the top rates of AA/DLAc specifies the need for help throughout the day and supervision during the night. It would cost £840 a week to support 168 hours of assistance, at the minimum wage of about £5 per hour. The Independent Living Fund, which tops up the care resources available to severely disabled people in the community, pays an average of more than £300 per week, in addition to AA/DLAc, and at least £200 worth of funding or services directly provided by the local authority (ILF 2007, see also Henwood and Hudson 2007). So £65 (the top rate of AA/DLAc) could not meet the costs of the care implied by the eligibility criterion.

This mixed economy (that is, the overall combination of benefits and care services) can be compared with potential alternative policies in terms of five main criteria:

- Are the policies well targeted on disabled people, and especially on severely disabled people who are likely to have the highest level of support needs and/or highest disability-related costs?
- Are they well targeted on people and families with limited incomes?
- Do they help to promote, or at least not discourage, a supply of care appropriate to people’s needs?
- Do they compensate disabled people for other additional costs of living?
- Are the processes of assessment and allocation consistent with objectives such as consistency, independence, dignity, freedom of choice and so on?

There has been astonishingly little research into the impact of AA/DLAc, considering the importance of these benefits both for public expenditure, and for the resources available to

disabled people.¹ The two surveys commissioned by the Department for Work & Pensions (Sainsbury et al 1995, Hawkins et al 2007) were more concerned with the process of claiming than with what difference the benefits made to the lives of recipients and their families.² The first half of this paper draws extensively on some new analysis of the Family Resources Survey. The FRS is the only large-scale survey combining data on social security benefits, household incomes, disability and sources of care for all age groups.³ But it should be noted that many of these FRS questions have hardly been analysed, and may be subject to as yet unidentified measurement problems.⁴

The FRS covers a sample of people in private households, and so provides no information about the needs or resources of people in care homes. Many of these receive AA/DLAc (if they are not funded by the NHS or their local authority). One of the main strategic objectives for the reform of care policy is to enable future generations of elderly and disabled people to remain in the community rather than enter care homes. If so, any transfer of resources associated with reform is likely to be away from people who would have lived in the community anyway, towards people who would otherwise have been in care homes. The FRS covers the likely losers in such a transfer, rather than the likely gainers.

The next two sections of this paper use the FRS to describe and assess the position of AA/DLAc claimants with respect to disability, and to income and living standards. The following two sections comment on reform options, focusing first on resource allocations, and second on some procedural differences between disability benefits and social services. The final section compares the advantages and the disadvantages of reform proposals.

Impairment and the need for care

Of course the FRS does not provide anywhere near as much detailed information on people's impairments as is required to assess their eligibility for disability benefits. Nevertheless, there is a strong correlation between impairments reported in the survey and receipt of AA/DLAc. Less than 1% of people who said they had no impairments said they were receiving the benefit; nearly three-quarters of those with seven or more difficulties were receiving it. But the same figures the other way round show that as many as 6% of benefit recipients in the survey reported no impairment. The survey provides prima facie evidence that the entitlement conditions or adjudication procedures might be tightened up (but see footnote 3).

The proportion of people saying that they had help with daily activities, and the number of hours of help received, also varied by the number and nature of people's impairments in a very similar way.

But the direct overlap between benefit and care is not as great as might be expected. Only 61% of adults receiving care are getting either of these benefits. Only 54% of adults getting

¹ Since the current paper was originally published, the DWP has taken preliminary steps towards a new study of the impact of disability benefits (Berthoud 2009)

² But for small-sample studies of AA/DLA claimants in various age-groups, see Baldwin (1985), Craig et al 2003), Horton and Berthoud 1990 and Preston 2005

³ Our analysis does not cover the small but important number of disabled children.

⁴ We will show, for example, that some FRS respondents say they are receiving AA/DLAc but report no health problems or impairments. On the face of it, they are receiving benefits to which they should not be entitled. But the possibility that either the benefits or the health problems have not been recorded accurately has to be allowed for. It is known that some survey respondents report benefits they do not actually receive, while others fail to report benefits that they do receive.

care-related benefits report receiving any care. These findings indicate either that the FRS questions on care received are under-reporting, or that a significant proportion of AA/DLAc recipients whose *need* for care has been recognised by benefit decision makers are not actually *receiving* the care they need.⁵

It is useful to analyse the FRS in terms of three main sources of help for disabled people living in their own homes – collectively referred to as “care”.

- *Help provided by other members of the household living with the disabled person.* Half of disabled people receiving AA/DLAc live with a partner. Another one in eight live with someone other than a partner, commonly a parent (among young disabled people) or son or daughter (among older disabled people). Co-resident family members provide a ready supply of help, which for the most part is not paid for directly by its recipient. AA or DLA money is commonly just added into the household budget (Hawkins et al 2007) and this relieves the financial strain on the carer as well as on the disabled person.
- *Help provided by friends and relatives who do not live with the disabled person.* Non-resident informal carers are obviously more important to disabled people who live on their own. They are about evenly distributed between relatives and friends or neighbours. It is not uncommon for the disabled person to pay over their AA or DLA benefit direct to such carers, not as payment for services in the sense of a market transaction but in acknowledgement of a sense of obligation (Horton and Berthoud 1990)
- *Help provided by paid workers.* Formal help recorded in the FRS includes care provided by local authority social services departments, by nurses, by voluntary or commercial agencies and by assistants working directly for the disabled person. Such care is clearly especially important to those who live alone, but can also be designed to support family carers. The characteristic of these services is that the worker is paid. AA/DLA money often contributes directly or indirectly, but would rarely be enough to meet the whole cost.

Help provided by the family (or friends and neighbours) is easily the largest source of care for elderly and disabled people. It is commonly referred to as “informal”, and is free in the sense that no money changes hands – although there is plenty of evidence that much of the cost is borne by the carers themselves in terms of lost earnings (Arksey et al 2005). But it is the provision and resourcing of the third type of help, by paid workers, that is the focus of recent policy debates. How well does it meet the need for care, and how does it compare with AA/DLAc at targeting resources on need?

Table 1 shows that, of course, all the within-household help available to severely impaired adults goes to those who live with another adult – though even so, only half of them report receiving it. These co-resident disabled people sometimes report help from relatives or friends outside the household, or from paid workers as well as, or instead of, within-household help. These external sources are obviously much more important to disabled people living alone.

Nevertheless, only about a third of severely disabled lone people report each of these external sources of help. And they clearly fail to make up for the lack of within-household care – those living alone typically receive only about a quarter of the total help available to those

⁵ The Wanless review’s analysis of the English Longitudinal Study of Ageing reported that 29% of AA recipients were receiving no care (Wanless 2006). The equivalent figure for over-65s in the FRS was 37%

living with family. In each case, AA/DLAc recipients get more care, but it is not clear whether this is because they need more, or because it enables them to secure more.

Table 1
Receipt of help by adults with at least three impairments

| | Lives with other adults | Lives alone |
|--|-------------------------|-------------|
| <i>Help from:</i> | | |
| member of household | 50% | n/a |
| other relatives and friends | 11% | 36% |
| paid workers | 12% | 27% |
| none of these | 56% | 56% |
| <i>Average total help received per week:</i> | | |
| if receiving AA/DLA | 64 hours | 16 hours |
| if not receiving AA/DLA | 15 hours | 4 hours |

Source: Family Resources Survey, 2004/05

Help from paid workers (“formal care”) is needed either to complement care provided within the home (especially if the home carers are themselves elderly or disabled), or to substitute for it. Even where a non-resident relative or friend is ready to take part, the availability of paid-for care will often be crucial to the viability of the package of support that can be assembled. It is not clear from the FRS data how much of the cost of these paid workers is met directly or indirectly by social and health service providers, how much by AA/DLAc receipts, and how much out of the own income of the disabled person and their family.⁶ But current social service provision represents only a fraction of either the need for or the supply of care to disabled people in the community.

This conclusion can be interpreted in two ways, with diametrically opposed policy implications.

- At one extreme it could be argued that AA and DLAc reach far more disabled people; so social services’ role should remain residual, addressing exceptional need in individual cases.
- At the other extreme it could be argued that a large proportion of AA/DLAc payments are going to people who can get by either with no care, or with help from their immediate families – so the money should be redistributed, through social services departments, to those in greater need.

The incomes and living standards of disabled people

However, as discussed at the beginning of this paper, the need for care may be the criterion on which eligibility for AA and DLAc is assessed, but paying for care is by no means the only objective. The weekly amounts involved are not enough to pay directly for the hours of care theoretically required. The benefit is paid unconditionally – recipients and their families

⁶ It has been estimated that AA could be contributing up to 16% of the costs of formal care services provided to older people in their own homes, with a similar proportion contributed by the severe disability premium within pension credit. Local authorities contribute 54% on average and the rest – 14% – comes from recipients’ own incomes. See Hancock et al (2007) figure 3.

can spend it on whatever they like. And disabled people face other potential additional costs, besides paying for care.

A first set of questions is: what income could AA/DLAc recipients count on if they were not receiving these benefits? Hardly any AA recipients (or their partners) have a job. Less than one in ten DLAc recipients of working age have a job, and only a quarter live in families where either partner is employed. Earnings provide a source of income for only a fraction of the families under consideration.

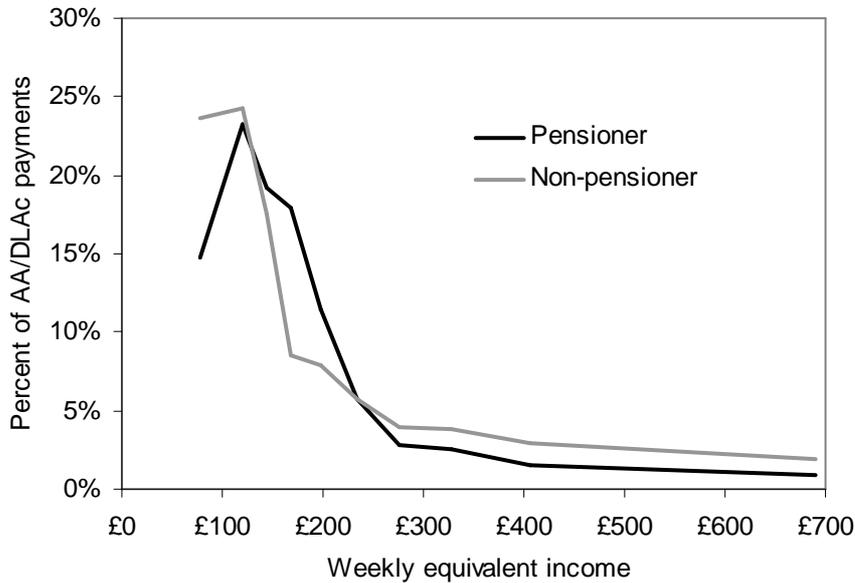
So most of them rely on benefits for a substantial proportion of their incomes. About two-fifths of both elderly and working-age AA/DLAc recipients depend on pension credit, or on income support, the twin means-tested benefits providing a minimum income for the two age groups. The proportion receiving means-tested benefits rises to more than half (52%) if housing benefit or council tax benefit are taken into account. Most of these families are poor enough to require income supplementation, even without taking account of their impairments.

The amounts of benefit contingent on the need-for-care criterion are quite generous by the standards of the basic income maintenance system. The minimum income made available to a single non-disabled person between 25 and 59 is £59 per week (income support); above 60 it is £119 (pension credit). For a disabled person living alone and receiving the top rate of AA/DLAc it rises by the disability benefit itself of £65, plus the severe disability premium of £48. That is, the need-for-care criterion nearly trebles the minimum income of the younger person, and nearly doubles it for the older person.

The key question is what disabled people's family incomes would be if they did not receive AA/DLA.⁷ Figure 1 shows the income distribution of individuals receiving the two benefits, where income is calculated before adding in AA/DLA or the associated premiums. Pensioner and non-pensioner families are distinguished although their profiles turn out to be similar. Although some recipients live in fairly prosperous households, most have quite modest starting points. Nine out of ten AA/DLAc benefit payments go to households whose starting income was less than £250 per week (equivalent to a single-person household). Four out of ten would be below the Department for Work & Pensions' indicative poverty line of 60% of median income if their disability benefits were discounted.

⁷ Wanless (2006, p95) shows that relatively few AA recipients have very low incomes. But that is at least partly because the AA itself, and the severe disability premium, were included in the measure of income.

Figure 1 Distribution of AA/DLAc payments by (pre-AA/DLA) equivalent household income



Note: The horizontal axis shows what the income of the household in which the individual lives would have been, in the absence of AA/DLA, calibrated as equivalent to a single adult household. The 10 data points are the decile groups of the distribution of household equivalent income, plotted at their medians. Estimates are based on the tax-benefit model POLIMOD (Redmond et al 1998), using FRS data for 2003/04 and 2006/07 rates of benefit .

The actual incomes of AA/DLA recipients are higher than these starting incomes. The intention is that this extra income should be spent on extra costs, leaving recipients and their families in much the same position as other households with neither extra needs nor the extra benefit. What are these extra costs, and how much do they add up to (Tibble 2005)? A survey of DLA recipients (Sainsbury et al 1995) reported an average of two items of expenditure per person required solely because of disability (incidental expenses of hospital visits, chemist's items and so on), and another four items in which normal expenditure had to be increased because of disability (heating, transport, phone calls and so on). But the only structured survey that has tried to put a figure on these amounts with direct questions (Martin and White 1988) came up with an average total for very severely disabled people of only £28 per week (at 2007 prices)⁸ – substantially less than the top rates of disability benefits. Either the benefits are more than generous in their allowance for extra costs, or survey respondents have difficulty in calculating them in response to a bald question. Indeed, the disability lobby lost no time in finding samples of disabled people with clearly identifiable extra costs far above those reported by the survey (Thompson et al 1990).

It is increasingly argued that poverty should be measured in terms of low living standards, using deprivation indicators, rather than directly as low income (Pantazis et al 2006). An alternative approach is to estimate extra costs indirectly, using standard of living indicators to show how much worse off severely disabled people are than non-disabled people with the same income (Berthoud et al 1993). The assumption here is that the extra costs have diverted income away from the normal spending patterns of the rest of the population. One recent analysis (Zaidi and Burchardt 2005) suggested that the drain on a single severely disabled

⁸ Inflation factor based on the top rates of AA/DLAc in payment in each year.

person's resources amounted to £175 per week for a non-pensioner and £215 for a pensioner (at 2007 prices). On this basis, disability benefits (including the mobility component of DLA) fall well short of compensating people for the costs of disability, and disabled people are actually much poorer than income calculations imply.

New analysis of the deprivation indicators included in the FRS (Table 2) shows that only 10% or 12% of non-impaired people not receiving pension credit or income support are in "material hardship" – defined arbitrarily as the most deprived fifth of all families.⁹ Elderly people receiving pension credit are at greater risk of hardship. If they or their partner report an impairment, their risk of hardship rises again. If they are also receiving disability benefits (mainly AA) at the same time as pension credit, elderly people show the same rate of hardship as non-disabled pension credit recipients – that is, the AA seems to have cancelled out the increased cost of living. For non-elderly income support recipients, rates of hardship are much higher.

Again, impairment increases hardship in the absence of disability benefits; but DLA payments seem to compensate. In fact, recipients of both income support and DLA are slightly better-off than those receiving income support on its own – but more than half of them are still in hardship.

Table 2
Proportion of families in material hardship, by benefits received

| | Not on pension credit | Elderly On pension credit | Non-elderly Not on income support | Non-elderly On income support |
|-------------------------------------|-----------------------|---------------------------|-----------------------------------|-------------------------------|
| No impairment | 10% | 37% | 12% | 66% |
| Impaired, but no disability benefit | 15% | 49% | 21% | 72% |
| Disability benefit | 23% | 36% | 32% | 56% |

Material hardship defined as the worst-off fifth of all families, using an index based on the FRS sequence of deprivation questions.

Disability benefits means AA, or DLAc and/or DLAm.

Families means benefit units; that is a single adult, or a couple, with or without dependent children.

Pensioners means families with (either) adult aged 60 plus.

Source: Family Resources Survey 2004/05

This evidence suggests that the significant boost provided to disabled people's household incomes by AA and DLA may compensate them for the additional costs imposed by their impairments, but leaves them little or no better off than other income support and pension credit claimants.

⁹ We have shown elsewhere (Berthoud et al 2006) that deprivation indicators are sensitive to age as well as to income, disability and so on. The analysis reported here controls for age as well as household composition.

At the same time, it can be asked whether AA and DLA provide the best possible vehicle for supporting the extra costs of living faced by disabled people. The attendance criterion was intended as a proxy for severity, and so an indicator of likely additional costs. Research evidence provides no basis for estimating extra costs directly (for example, £x for heating, £y for bus fares and so on). The problem with the attendance criterion, as this debate demonstrates, is the potential ambiguity of the policy intention.

Integrating support for care costs from AA/DLAc into the care system

The foregoing analysis of the experience of disabled people receiving disability benefits has been intended to provide an empirical base for an analysis of policy options. The Wanless review recommended integrating support for care costs from AA (and DLA) into the care system, to improve targeting of resources. What are the likely effects of such a policy reform, and who would be affected?

We consider which groups are likely to lose or gain from the structural changes implied in the proposal. Given the complexity in the existing systems of benefits and of care-charging, this is a field where the devil really is in the detail¹⁰ and a proper evaluation requires proposals to be worked out much more thoroughly. A main difficulty is that the destination is itself a moving target. It is unlikely that the resources diverted to care provision would be allocated to local authorities' care budgets without accompanying reforms to the care financing or allocation systems. The Department of Health and local authorities are already changing their policies. The reallocation of AA/DLAc might be part of a more fundamental shift that would see more care offered on a more universal basis.

Nevertheless, any reform is likely to involve three major changes in the flow of resources to disabled people.

1. Care, rather than cash

This is the central objective of the proposal – money that is now going directly to disabled people to spend on the exceptional costs of living would now be spent mainly on paid for care services. Those few who already spend most of their benefit on paid-for care will not be much affected. Many people would presumably receive more care than they do now, and probably an increase in their overall resource allocation. Many people would receive less cash than they do now. The assumption is that the net gainers are at the more severe end of the disability scale (whose needs are, in the official phrase, “substantial or critical”), the net losers at the less severe end. The overall number of losers could exceed the overall number of gainers.¹¹

2. A carer test

Local authorities take account of support from carers and family members such that having a carer may disqualify a disabled person from eligibility for care services (DH 2003). Disabled people with a partner therefore tend to receive fewer services. Where other relatives are

¹⁰ Another detail, not discussed in this paper, is how the proportion of AA/DLAc entitlements to be diverted to the care system will be separated from the proportion to remain in support of extra costs.

¹¹ The Wanless report (2006) suggests transitional protection to prevent immediate losses of income at the point of reform. This would make the exchange of resources less painful for current recipients (and so for politicians) but does not deal with the underlying equity questions for following generations of claimants and clients.

available, either to live in or to provide help on a daily routine, negotiations often arrange a small package of services to support and encourage the informal care provision. Most of the money is spent on people without close family care. This is likely to be an outcome of any reallocation of funds into the care provision system. The gainers would be disabled people without informal carers; the losers would be those with informal, and especially live-in, carers. Couples are a readily identifiable group of potential losers.¹²

3. Means testing

AA and DLAc are not means tested, though there are also provisions within the mainstream system of means tests to boost the incomes of disabled people. Local authorities apply means tests in their charging arrangements. The basic care financing model proposed by the Wanless review is said to involve no means testing for care. However, it does involve a user “co-payment” and the review acknowledged that some financial help with this co-payment might be needed for those on the lowest incomes – in other words some means testing would continue. Entitlement to care would still, therefore, be less universal than AA/DLAc. The review also suggested that financial help with other disability-related costs might be better dealt with through pension credit. It can be assumed, therefore, that a switch of resources from AA/DLAc to services would be associated with at least some increase in means testing. The general advantages and disadvantages of means testing are well known. In principle, it concentrates public funds on those with the lowest economic resources (vertical equity), but is less effective at targeting on variations in need (horizontal equity). Means-tested benefits tend to be subject to lower rates of take-up and so may not reach all of those for whom they are intended. Means testing of state support, whether in the form of cash benefits or care services, may act as a disincentive to private provision for old age. Other things being equal, the main group of losers under this third option would be recipients of AA/DLAc on higher incomes. As we have seen, AA and DLAc tend to go to people in the lower parts of the income distribution anyway, so there is a degree of targeting in the system without means testing. These outcomes look likely to result in more funds dedicated to care for the most severely disabled people, who lack care at the moment, and who have no spare income to pay for services. But the costs are likely to be borne by moderately severely disabled people with a partner, especially if their income is above the means-test floor.

Social services, or social security?

One way of thinking about how these three reallocations might work is to ask whether we could achieve them by changes within the benefit system, rather than by transferring money to social services departments. For example:

- A disability care benefit could be made conditional on the money being spent on paid-for care services. The working tax credit has just such a provision to support parents with the costs of childcare services.
- A disability care benefit could be restricted to single people, or to people who live alone (unless all members of a household were disabled).
- A disability care benefit could be means tested, or added into the mainstream means-test network as a premium. (One possible scenario is that the savings from increased means

¹² AA and DLAc are paid to disabled people regardless of their living arrangements and existing care arrangements. The severe disability premium is largely limited to means-test recipients who live alone, and this can be interpreted as a carer test.

testing in the benefit system might be used to pay for a reduction of means testing in the care system!)

Reanalysing the Wanless plan in terms of a self-contained social security reform helps to identify the distributional issues more clearly.

There are other differences between social services and social security, besides the allocation of resources. Differences in approach and tradition have to be taken into account too. Three particular considerations are: “discretion” versus “entitlement”; budgetary control; and independence.

1. Discretion versus entitlement

People are “entitled” to “claim” their social security benefits, including AA and DLA. This means that there is a published set of rules establishing eligibility; a body of decision makers adjudicating the outcome on the basis of the evidence and in the light of case law; and a right of appeal to an independent tribunal. Social services departments are moving towards more open and formal eligibility criteria but retain considerable discretion to determine what services to offer on a case-by-case basis. A social worker assesses need by applying professional judgments to all the circumstances. A client disappointed by the outcome can ask for reconsideration, but cannot argue on the basis of legal entitlements.

There are arguments in favour of both approaches, and room for discussion about which is best for assessing the need for care. Disabled people’s needs may be difficult to characterise in hard and fast rules. Discretion means that eligibility can be sensitive to individual needs. But discretion can result in inconsistencies of treatment and/or the exercise of social control by the decision maker. Even though these problems may actually occur rarely, a disgruntled client can never be sure that they have not occurred on any particular occasion. It seems quite likely that the effect on individuals of a transfer of resources from the social security budget to local authorities would vary across local authorities – a “postcode lottery”. We are not arguing that entitlement is intrinsically better than discretion or vice versa, but the issue needs to be addressed in the development of alternative policies.

2. Budgetary control

Eligibility criteria for benefits are set in advance and payments have to be made to as many people as apply and turn out to be eligible. Expenditure on benefits can be controlled in the long run, but only by changing the rules of eligibility. Local authorities are encouraged to review their eligibility criteria each year by reference to their budgets: an annual budget is allocated and decision makers are required to ration services as they go. In public finance language, social security benefits are “demand-led”, whereas social care services are “cash-limited”. The keepers of the purse naturally prefer controlled budgets to demand-led expenditure. But if the person assessing need is also the agent of budgetary control, there may be strong pressure to underestimate the extent of need. It would in principle be possible to separate these functions: an independent assessment of need, with budget holders deciding how much of that need should be met. This is ideal, but politically uncomfortable, because the amount of unmet need would become explicit. Arguably this is happening anyway through individual budgets.

3. Independence

Recipients of disability benefits are free to spend the money on anything they choose. Historically, support for care needs from local authorities was in the form of free or subsidised services, over which the client had little choice and no control. There has been a strong trend over the past 10 years towards “direct payments” (cash paid to the disabled person who arranges and pays for their personal assistance in the open market) and, more recently, pilot schemes of “individual budgets” - resources from social care and other funding streams are combined to finance an individually tailored package of services or equivalent-cost direct payment (IBSEN 2007). These more transparent allocations of funds have been intended to give disabled people greater choice over how their needs are met, and therefore a sense of independence – but they are limited to regular expenditure on care-related services. A transfer of funds from social security to local authority budgets could work against the trend towards greater flexibility and independence.

Discussion

Our intention in this paper has been to analyse the likely impact of the proposed reforms of cash and care, not to recommend that they should or should not be adopted. One theme of our analysis has been the acute scarcity of systematic research on the current interactions between cash and care. Another has been lack of clarity about how the proposed reforms would work.

Nevertheless, we can identify some probable consequences in broad terms. The Wanless and other similar proposals would probably deliver more care to severely disabled people, especially those living alone. We have shown that many disabled people, especially those living alone, do not at present have access to care. So these outcomes would be in line with the policy objectives.

There are some differences between social care allocation procedures and social security benefit adjudications that also need to be taken into account. A transfer of resources to local authorities would imply a trend from entitlement to discretion, and from demand-led to cash-limited cost control. Given the move towards direct payments and individual budgets, it is harder to say what the effect would be on the degree of independence enjoyed by disabled people. Transferring resources from benefits to social care may speed up the move within social care towards greater choice. But if the aim is greater control, the logic might be for more money to be delivered through the benefit system and less through social care. The pros and cons of these aspects of the relationship between the state and its citizens cannot be quantified, but they should not be ignored.

We have emphasised that the precise effect of transferring AA/DLAc resources to local authorities will depend on the future policies and practices of social services departments, after the proposed reforms. In the past, they have been associated with the six characteristics listed on the left of figure 2. The direction of travel (arrow 1) is already away from those characteristics, towards the six characteristics hitherto associated with AA/DLAc. New proposals outlined by Wanless and other commentators are likely to move social services further in the same direction (arrow 2). The question is whether AA and DLAc’s resources should be moved in the opposite direction (arrow 3), to the position in the middle of the spectrum, eventually adopted by social services.

Figure 2 Stylised representation of policy differences between AA/DLAc and social services departments

| Social services | | | AA/DLAc |
|------------------------------|----|---|-------------------------------|
| Provision of formal care | | | Cash for extra costs |
| Informal carer test | | | Independent of family |
| Means tested | 1 | 2 | 3 |
| Discretion | ▶▶ | | Entitlement |
| Cash limited | | | Demand-led |
| Controlled by social workers | | | Controlled by disabled person |

A major reform needs to be evaluated on the basis of its costs as well as its benefits. It is likely that the proposal will lead to a loss of cash income for a large proportion of disabled people claiming AA or DLAc. We have shown that most of them have modest incomes. Standard of living indicators suggest that the present benefits do little more than compensate disabled people and their families for the extra costs associated with disability. A reduction in cash incomes is likely to lead to an increase in deprivation.

Outline of attendance allowance and disability living allowance

Attendance allowance (AA) is paid to over-65s at rate of £64.50 per week (2007/2008 rates) if they need *both* help throughout the day *and* supervision during the night; they receive £43.15 per week if they meet *either* the day *or* the night condition, but not both. The same rules govern access to the care component of the disability living allowance (DLAc) for under-65s; but here there is a third rate of £17.10 per week for people who need help only part of the day, or who cannot cook a meal. DLA also has a mobility component for under-65s who cannot walk, or need assistance when walking outdoors, but DLAm is largely left out of the current analysis.

People who receive either element of DLA before their 65th birthday continue to receive it, rather than AA, after 65.

All these benefits are based solely on the identified needs of disabled people, and are neither means-tested themselves, nor treated as income in means-test calculations. But recipients of the main means-tested benefits (income support, pension credit, housing benefit and council tax benefit) can add the severe disability premium of £48.45 per week to their needs assessment if they are receiving AA or the middle/higher rate of DLAc, live alone (or live with another disabled person) and have no one getting carer's allowance for their care.

AA/DLA and the severe disability premium can be taken into account in local authority means tests for home care but only if part is disregarded to allow for disability-related expenditure. A 2003 survey (Thompson and Mathew 2004) found that most local authorities did take these benefits into account, but there was considerable variation in how disability-related expenditure was allowed for. AA/DLA and the severe disability premium are taken into account in determining whether a care home resident is entitled to local authority help with fees. If a resident is so entitled, AA/DLA and severe disability premium cease to be payable and the local authority contribution is accordingly larger. Different procedures apply in Scotland, which has introduced a version of "free" personal care.

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