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The take-up of Carer's Allowance: A feasibility study

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a feasibility study

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Non-technical summary

About 500,000 people in Britain receive Carer's Allowance (CA), because they provide high-level care for a disabled or elderly person, and have limited earnings of their own. A further 400,000 are recorded as having an 'underlying entitlement' to CA which may be of value to them if they are able to claim the carer premium to means-tested benefits. Since there are more than three million people receiving the relevant components of the Disability Living Allowance or Attendance Allowance, the question arises whether all the carers who might be entitled to CA are in fact claiming it.

The initial conclusion is that measuring the take-up of CA is made difficult by the immense complexity of the benefit rules – which are arcane even by the specialist standards of the social security system. This means, first, that it is not even clear when the benefit has been successfully claimed, and second that an accurate answer to a whole series of questions is needed before eligibility can be established.

The analysis of the FRS reported here suggests a take-up rate of 65 per cent for the core group of within-household carers without overlapping benefits. Measurement error probably means that this is an under-estimate of the true figure. A better estimate for this group can, and should, be obtained using the linked FRS/WPLS data set. This should be done even if it was concluded that estimates for other types of potential claimant could not (yet) be obtained.

Promising options have been identified for measuring the take-up rate of CA for out-of-household carers, and the take-up rate of the associated premium for those with overlapping benefits. These options should be pursued and evaluated.

A central difficulty for take-up research is that it relies heavily on the accuracy of data reported in surveys, both on the receipt of the benefit under consideration, and on the eligibility conditions. Random errors in either or both of these areas will tend to lead to under-estimate of take-up rates. There are strong signs in this report that such errors affect measurement of the CA take-up rate. A wider implication is that similar errors may affect the measurement of the take-up rate of other benefits.

The Take-up of Carer's Allowance: a feasibility study

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Abstract

The Department for Work and Pensions committed itself to exploring the take-up of Carer's Allowance at the House of Commons Public Accounts Committee in May 2009. This study was commissioned as a first step in that enquiry. The report summarises the questions and discusses possible research approaches, with a view to considering more detailed investigations. In-depth analysis of the Family Resources Survey (FRS) and a review of previous research and current statistics helped to formulate the study conclusions.

Key words: Carers Allowance, Take-up, Family Resources Survey

JEL:H55, I38

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The Family Resources Survey is collected under the auspices of the DWP, and distributed by the UK Data Archive. Thanks to Barbara Menara of ISER for her preliminary work on the data.

I am also grateful to Kimberly Fisher, Caroline Glendinning, Ruth Hancock, Linda Pickard and Roy Sainsbury for comments on the issues raised.

None of these people or organisations necessarily endorses the conclusions of the research or the opinions expressed.

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Introduction

Aims

About 500,000 people in Britain receive Carer's Allowance (CA), because they provide high-level care for a disabled or elderly person, and have limited earnings of their own. A further 400,000 are recorded as having an 'underlying entitlement' to CA which may be of value to them if they are able to claim the carer premium or addition to means-tested benefits. Since there are more than three million people receiving the relevant components of the Disability Living Allowance (DLA) or Attendance Allowance (AA), the question arises whether all the carers who might be entitled to CA are in fact claiming it.

The National Audit Office recently reported on the DWP's support for carers (NAO 2009) and asked what evidence was available about the rate of take-up. The House of Commons Public Accounts Committee asked the DWP (HoC 2009):

> *If you do not know what the take-up rate is, how do you know that you are reaching these people and you are doing the job, and helping them to do the caring which takes the burden off the state?*

The Department agreed 'to look again, at whether we can make a better estimate of take-up and whether we can do some further research'.

This report was commissioned by the Department as the first step in that enquiry. Its objectives are:

- to review existing evidence about caring and CA which may have a bearing on the question of take-up.
- to undertake new analysis which will both provide a first estimate of current take-up rates, and assess the accuracy of take-up measures based on existing data.
- to assess options for new data collection which might provide more accurate measures.

Outline of the scheme

Carer's Allowance (CA) is a non-contributory benefit paid at a standard rate of £53.90 per week.[1] The scheme was introduced (as the Invalid Care Allowance) in 1975. Coverage was extended to married women in 1986, and to over 65s in 2002.

[1] All rates are those applicable between April 2010 and March 2011. Although benefit rates are always defined in pence, most of the text of this report refers to them in round pounds

The main conditions of entitlements are:

- The claimant is providing informal (ie unpaid) care to an elderly or disabled person, for at least 35 hours per week.
- The disabled person is receiving AA, or the middle or higher rate of the care component of DLA.[2]
- The claimant is earning less than £100 per week, net of tax and other deductions, and is not in full time education.
- Only one carer can claim for helping any disabled person; and a carer can claim for helping only one disabled person.

If the claimant fulfils these four main conditions (and also is 'resident' in Britain[3]), s/he will be 'entitled' to CA. But s/he will not actually be paid any allowance, if s/he is also receiving 'overlapping' earnings-replacement benefits (mainly the state Retirement Pension, Jobseeker's Allowance or the Employment and Support Allowance). In that case, s/he will be treated as having an 'underlying entitlement'.

People entitled to CA (whether receiving a payment or not) are also entitled to the carer premium in Income Support, Housing Benefit or Council Tax Benefit, or the carer's addition to Pension Credit, worth up to £30.05 per week. But people with underlying entitlement whose family income exceeds the various means-test thresholds will gain no increase in weekly income.

If the disabled person lives alone and receives the severe disability premium for means-tested benefits, the carer cannot receive CA. And vice versa. One of these entitlements can be claimed, but not both.

Policy context

The Chairman of the HoC Public Accounts Committee, quoted above, wanted to know whether 'you are doing the job, and helping them to do the caring'. A primary question, but one not addressed by this analysis of take-up, is whether the Allowance actually 'does the job' of helping people to care, even if everyone entitled had claimed it. The big policy issues are concerned with whether this is an appropriate form and

[2] The care component of the Disability Living Allowance is sometimes referred to as DLAc in the following text

[3] This report has assumed that almost all members of households taking part in social surveys fulfil the residence criterion. The issue is not discussed further.

level of support. These issues are outlined here simply as background to the current enquiry into take-up, but will not be discussed any further in this report.

CA was set up (as ICA) as one of two earnings replacement benefits aimed at people who were unable to work for legitimate reasons, but who were not covered by the national insurance scheme. (The other was the Severe Disability Allowance, originally called Non-Contributory Invalidity Pension.) The rates of both benefits were set at about 60 per cent of the rates for other long-term benefits (such as the Retirement Pension), in order to maintain a preference for insured cases.

Some organisations argue that the rate of CA (currently £53.90 per week) should be higher. Some of the arguments behind this proposal are:

- Caring should be treated as an insurable risk, and should be paid at the same rate as other long-term insurance benefits which are currently about £95 for a single person.
- It is argued by some organisations that carers' personal incomes are so low that they are left in poverty, and/or dependent on the incomes of the people they care for.
- Although CA is constructed as an earnings replacement benefits, its objectives are often represented, by policy commentators and by carers themselves, as a payment in recognition of their caring role. It is argued that the social value of the work that informal carers do should be recognised in a higher rate of allowance (Carers UK 2007). This idea is often discussed in the context of the cost that would have to be borne by the state if the informal carer was not available or willing to help the disabled person (NAO 2009).

An alternative policy would be to encourage and enable more carers to continue in employment, combining work and caring responsibilities (Vickerstaff and others 2009).

Another view is that an allowance within the income maintenance system should not be the main vehicle by which carers are supported. One of the key issues here is whether the policy objective is simply to (partly) compensate non-working carers for their loss of earnings (a social security response) or whether the aim is to encourage more people to become carers, and/or improve the care available to disabled or elderly people in need (a social services response).

- Some schemes (IBSEN 2007) have experimented with 'packages' of care that include payment to friends and relatives as well as to care workers . Note that

payment by the hour from social services sources is quite different in principle from a fixed allowance to the carer from social security sources. On the other hand the common use of disability benefits (AA or DLA) as contributors to such funding tends to blur this distinction.

- An alternative view (eg Wanless 2006) is that carers' main need is for help – that is, additional sources of regular or respite care should be provided, to relieve the continuous burden placed on informal carers.

Research issues and approach

The current research does not ask whether CA should be changed, but whether the existing policy is reaching the target group. The central issue addressed by this report is, what proportion of people fulfilling the eligibility criteria have claimed, and are receiving, their entitlement? This is an issue of practice, not of policy.

The main research concern has been about the availability, and accuracy, of data about CA payments and entitlements, and about potential claimants. There are some explicit and some implicit issues about the effectiveness of the administrative procedures by which CA entitlement is adjudicated and communicated.

Although the research has reviewed a range of previous research and current statistics, the main line of approach has been a detailed analysis of the main source of data that comes closest to providing all the information required to estimate take-up – the Family Resources Survey (FRS, described on the next page). The survey has been used to describe and assess each of the four main stages in the identification of eligibility for the Carer's Allowance. This is followed by a prototype attempt to use the FRS to measure take-up. It was never expected that this attempt would be successful, but the prototype has clearly identified where the problems lie.

The report concludes that take-up estimates for the single most important group of potential claimants could be obtained by new analysis of the data-set linking the FRS with administrative data, and recommends that this should be set in train. Estimates for other groups of potential claimants could be obtained by making fairly modest adjustments to data collection procedures, and the report recommends that these routes should be investigated.

Data sources

Some of the statistics quoted in this report are based on the self-contained databases for CA, AA and DLA available online via the DWP's excellent tabulation tool (DWP 2010). Figures for earlier years have been accessed either from the archive of standard tables available on the same website, or from the earlier series of Social Security Statistics (eg DSS 1985).

Figures about combinations of benefits received by the same person (or family) are derived from the Work and Pensions Longitudinal Study (WPLS), combining information about all benefits (and taxes) linked by national insurance number (DWP 2010). The WPLS data have been analysed by the Department, and none of the information reported here has been based on direct analysis of the database.

Administrative statistics are necessarily confined to the limited information provided when people claim benefits, and of course provide no data about those who have not claimed. A main source for the current enquiry has been the Family Resources Survey (FRS) (DWP 2009). This is an annual survey of about 25,000 households conducted under the auspices of the DWP. All household members are interviewed (or information obtained from another household member as a proxy). Among many detailed questions asked about employment, earnings, taxes and benefits, are two series especially relevant to this enquiry, one on impairments, and one on care provided and received. The latter sequence is asked of one household member only, who is requested to record which members of the family care for which disabled members of the family. The same household representative also records any care provided by each household member to people outside the household, and any care received by each one from people outside the household. A shortcoming of the survey for the study of the care of disabled people is that it excludes those living in residential care.

Three consecutive years of the FRS have been analysed directly for this project: 2005/06, 2006/07 and 2007/08, omitting data for Northern Ireland. All figures have been weighted using the grossing up factors provided in the database (divided by three to take account of adding three surveys together) and so should be representative of the population by such factors as age, sex and region. The grossing factors are used to

estimate the total number of people in Great Britain with each characteristic. The grossed up total population of 57,766,000 is based on a sample of 167,643 individual respondents (including children). This means, for example, that where the analysis says that 380,000 people are shown by the FRS to be receiving CA, this is based on the actual reports of 1,160 respondents.

An issue highlighted in the following pages is the potential mismatch between benefits reported by survey respondents and what they are actually receiving. This is critical for all take-up research, but is of special importance for CA for which eligibility is determined by three other types of benefit.[4] The Department has addressed this issue by linking the answers provided by FRS respondents to administrative data contained in the WPLS, so that the two versions can be directly cross-compared (DWP 2009, page 138). This matching was undertaken experimentally in 2006/07, when about 40 per cent of survey respondents agreed to have their answers linked. Results so far available are based on this 2006/07 sample, and are quoted on pages 13 and 25 below. But the experiment has been repeated in 2008/09, with an improved permission rate of about 60 per cent. Although the latter has hardly been analysed yet, and requires validation, considerable weight will be placed, in the conclusions of this report, on the linked data-set as a potential solution to the take-up measurement problem.

Measuring 'informal care'

Alternative survey methods[5]

There are essentially two ways of finding out how much time people spend on particular activities. The most detailed, and potentially the most accurate, is to ask survey respondents to keep a diary of everything they do for a whole day or a whole week, and add up the number of minutes spent on the activity in question. As far as

[4] Qualifying benefits, overlapping benefits and income-related benefits

[5] A review of survey questions on informal care provision and receipt is currently in progress in a study, funded by the Department of Health and the Nuffield Foundation, entitled *Developing Improved Survey Questions on Older People's Receipt of, and Payment for, Formal and Informal Care.* The study is being carried out jointly by the Personal Social Services Research Unit (at the London School of Economics and the University of Kent), the University of East Anglia and the National Centre for Social Research (NatCen). . The important issue for the current study is whether the FRS care questions, on which much of the analysis relies, provide an appropriate measure..

using time diaries to measure care is concerned (see Bittman and others 2005, Nissel and Bonnerjea 1982), my colleague Kimberly Fisher comments as follows:

> 'Defining care to measure it is a difficult task. There is significant overlap with other activities. Nevertheless, carers can often estimate their total care commitment. The reason for this is that fitting care into the daily schedule is a complex process that can require a lot of forethought, and hence as the tasks are on people's minds, they have a reasonable sense of the total time the care takes.'

In practice, time diaries are too complex and expensive to be used to measure activities undertaken by small minorities of people in large population surveys. It has been shown (Kan and Pudney, 2008) that 'stylised' questions in large-scale surveys, in which respondents provide a simple estimate of the time spent on various activities, provide at least a reasonable approximation. The Census and at least four regular British surveys ask about the provision of or receipt of care – the General Household Survey, the Family Resources Survey, the English Longitudinal Study of Ageing and the British Household Panel Survey – although the sample size of carers in the latter is too small for detailed analysis. These sources provide rather different estimates of the total number of carers, and the implication is that the exact question asked in a survey makes a difference to the results (Pickard 2007, 2008) – although note (see below) that only a minority of carers spend enough time on this activity to come anywhere near qualifying for CA.

Types of care

A distinction is often made between personal care, and practical help. Personal care refers to assistance with (often intimate) activities which non-disabled people almost always do for themselves – getting in and out of bed, dressing, eating, bathing, going to the toilet. Practical help refers to tasks which people who live in the same house often do for each other, or share, in any case – driving, shopping, cooking, cleaning, gardening, dealing with paperwork, looking after children and so on. (Many of these are also tasks which a wealthy family might delegate to a servant, and guests in a hotel would expect to be done by the staff.) Practical help is treated as 'care' when the disabled person cannot do the tasks on their own, so that the assistance is essential rather than mutual. A difficulty both for benefit adjudication and for research is that it is not always possible to distinguish between things like housework that the carer

would have done in any case, and those additional tasks undertaken because of the disabled person's impairments. This distinction is especially difficult to make when close family relationships (husband and wife, parent and child) are involved. Gender issues also arise, as men and women in couples typically have different patterns of housework and childcare activities in ordinary circumstances, and so may have different adaptations when their partner or child needs disability-related care.

Various considerations suggest that the need for personal care is a more important policy issue than the need for practical help:

- the intimate nature of the tasks makes disabled people more reluctant to receive personal care, and carers more reluctant to provide it;
- fewer disabled people need or accept personal care than practical help – and those who do are reported to have more severe impairments; and
- the need for personal care is the primary issue in deciding on entry to residential care.

As far as benefit entitlements are concerned, the eligibility criteria for the CA qualifying benefits (AA and the higher and middle rates of the care component of DLA) are summarised as:

> • needing help with things such as washing, dressing, eating, getting to and using the toilet, or communicating your needs; and
> • needing supervision to avoid you putting yourself or others in substantial danger.

These conditions are clearly weighted towards a requirement for personal care, rather than for practical help, without necessarily excluding a need for the latter.[6] But the eligibility conditions for CA itself make no distinction between personal care and practical help: the requirement is simply that the claimant provides the disabled person with at least 35 hours of 'care' per week, with no definition of what 'care' means.

[6] Inability to prepare a cooked main meal is a criterion for the lower rate care component of DLA; but the lower rate does not confer eligibility to CA

Hours of care

How many hours of care are provided? For co-resident carers it must be very difficult to work out how much time is spent caring, especially when the tasks under consideration fall into the 'practical help' rather than the 'personal care' category, or when the care consists of 'being there' either to avoid the disabled person putting themselves in danger, or in case s/he needs the toilet.

This difficulty in estimating the number of hours spent on care is equally relevant to benefit adjudication and to research.

- The CA claim form simply asks the carer and the disabled person each to report that at least 35 hours of care is provided, and there is no independent procedure for validating these reports. Since the disabled person has already shown (in his/her claim for AA or DLAc) that s/he needs support throughout the day or supervision during the night, it is straightforward to assume that a main carer is involved for at least five hours per day.
- The issue for the measurement of take-up is how the carer will estimate the amount of time involved when asked about it in a survey (such as the FRS).

The distribution of hours reported by *within*-household carers is shown in Table 1. (Between-household carers are covered in the following section.) Note that respondents replied directly in terms of a range of hours – they did not give a precise number of hours which was grouped into bands later. As discussed above, it can be imagined that it is not easy to estimate one's contribution accurately, so the allocation of carers to these time-ranges may not be very precise. It will also be shown (in the next table) that low levels of care may be most difficult to identify with any precision. This would be an important problem if low levels of care were among the main issues of concern. But in the present context, we are not interested in low and medium levels of care; CA is available to people providing at least 35 hours per week. These are the 951,000 listed as 'full-time' within-household carers in Table 1.[7] But there is no natural boundary at 35 hours in people's minds, and it is relevant also to consider the position of the 254,000 'high-level' carers reporting at least 20 hours per week. But the 610,000 low and medium level carers are not really relevant to this enquiry – so the accuracy with which they may have calculated their hours is not really an issue.

[7] The term 'full-time' has been used to cover 35 hours per week or more, on the analogy of the definition of 'full-time' work – a concept clearly relevant to CA policy. As the table shows, some provide care literally all the time – in the sense that they are almost never off duty

Table 1 Number of hours reported by within-household carers

❖	Detailed answers	'Variable' amounts added back*	Summary	Thousands	
0-4 hours per week	9	10	Under 10	376	'Low'
5-9 hours per week	10	11	10-19	234	'Medium'
10-19 hours per week	11	12	20-34	254	'High'
20-34 hours per week	11	14	35 plus	951	'Full-time'
35-49 hours per week	8	12			
50-99 hours per week	9	13			
100 or more hours per week	20	28			
Varies - under 20 hours per week	3				
Varies - 20-34 hours per week	3				
Varies - 35 hours a week or more	16				
Total	100	100		1815	
Sample size	*5406*				

Source: new analysis of FRS
*'Variable amounts added back' means that, for example, the 16 per cent with variable hours over 35 have been redistributed among the three categories 35-49, 50-99, 100+ in proportion to the original sizes of those three categories

Care received and care supplied

Many years ago it was reported that a survey of disabled people had identified four million people as providing them with care; while a survey of the general population had identified as many six million care providers (HoC 1990, para 11). This suggests either that people understate the amount of care they receive, or that people overstate the amount of care they provide, or both.

The Family Resources Survey, the main source of data for this report, resolves this issue in part by linking the care *received* by one member of the household with the care *provided* by another member of the same household.[8] On the assumption that the household representative answering this question is more likely to be a care-giver than a care-receiver, this may favour the giver's perspective, but at least the arithmetic balances.

[8] This requirement to link the carer to the care-recipient within the household may help to explain why the FRS provides a lower estimate of the total number of carers than the GHS or the BHPS.

Where care is provided by a member of one household to a member of another, this automatic balancing does not apply. The FRS suggests that nearly three times as many people say they are providing care to someone in another household, as say they are receiving care from someone in another household (Table 2). However this discrepancy is much stronger for reports of low and medium levels of care (below 20 hours per week) than for high levels of care (20 hours or more). An interpretation of these figures is that the survey data on high levels of care is more reliable (in the sense that two estimates provide a similar answer) and therefore more accurate.

Table 2 Transfers of care between households (estimated numbers, in thousands)

	Providing informal care to someone outside household	Receiving informal care from someone outside household	Ratio of providers to receivers
Less than 20 hours per week	2,846	874	3.3
20-34 hours	213	139	1.5
35 plus	144	113	1.3
Total	3,203	1,126	2.8
Sample size	*9,471*	*3,443*	

Source: new analysis of FRS

One important consequence of this analysis is that the great majority of between-household carers (by either report) provide low or middle levels of care, and are well below the commitment required to claim CA. This means that the difficulty of estimating the take-up rate for between-household carers is less important than it might have been.

Total number of high level carers.

Discussion of CA often quotes estimates of the total number of carers in Britain – for example the six million cited by the NAO report (2009). Tables 1 and 2 have shown that the great majority of these provide less than 20 hours per week. Valuable though these services are to disabled people, they come nowhere near the eligibility threshold for CA. The FRS records 1.1 million who say they are caring more than 35 hours per week, plus a further 0.5 million between 20 and 34 hours. These are the 1.6 million people who might possibly claim CA

Stages in the identification of eligibility for Carer's Allowance

The four main conditions leading to eligibility for CA are as follows:

1. The disabled person is in need of care (as established by receipt of AA or DLAc)
2. The CA claimant provides care for at least 35 hours per week
3. The CA claimant does not work (or earns less than £100 per week), and is not in full time education.
4. The CA claimant does not receive other ('overlapping') earnings replacement benefits

This chapter discusses the four conditions in turn, reviewing FRS and/or administrative data relevant to the identification of entitlement.[9] The next chapter considers all four conditions together, to see whether it is possible to use survey data to identify eligible non-claimants and measure take-up

Condition 1: Disabled person is in need of care

The first condition offering entitlement to CA is that a disabled person needs care. If the disabled person is in receipt of AA, or the middle/higher rates of DLA (care), then s/he has been judged in need of support throughout the day, or supervision during the night, or both. These are referred to as the 'qualifying benefits'. His or her carer satisfies the first condition for CA.

Note that eligibility for DLAc and AA is determined by the disabled person's *need* for care. It is not necessary to demonstrate that he or she is actually *receiving* care at the time of the claim, nor that such care will be provided if the disability benefit is awarded. It is often assumed that disability benefits are intended to be used to pay for care, but in fact the benefits are equally intended to help meet other additional costs of disability - eg special diet, extra heating and so on (see Berthoud and Hancock 2008 for a discussion). The pattern will depend on the relative importance ascribed by the disabled person (and perhaps his her family) to the provision of care and meeting other priorities

[9] CA can be paid to only one carer in respect of any disabled person, and to any carer in respect of only one disabled person. The FRS would allow some assessment of the scale of multiple caring relationships, but no attempt has been made to address this issue in the current preliminary analysis.

The recent series of FRSs has a set of questions about impairments which suggests that 10.6 million people in Britain are impaired, if only slightly. The risk of impairment ranges from 3 per cent of under 4s, to 63 per cent of over 80s. The specialist Health and Disability Survey (Grundy and others 1999), which followed up FRS respondents in 1996/97, used a stricter definition of impairment, and concluded that there were 5.7 million disabled adults, with a risk ranging from 6 per cent at ages 16-19 to 84 per cent above the age of 85.

Returning to the recent FRS data series, 2.4 million disabled adults were reported to be receiving at least some care (formal or informal) of whom 1.5 million had high-level care of more than 20 hours per week Not surprisingly, receipt of care depended on the number and nature of the individual's impairments (Table 3). The most important predictors of high-level care (ie more than 20 hours) were difficulties in moving about, and inability to recognise when one is in danger. Perhaps surprisingly, incontinence had a relatively small additional influence on the receipt of care. Even though the survey contains no indication of the severity of the impairments reported, the regression equation is effective at predicting who does and who does not receive care, with a pseudo R^2 of 43 per cent. For any given set of impairments, women were more likely to be receiving care than men, and older people more than younger people, with a steep gradient above the age of 65.

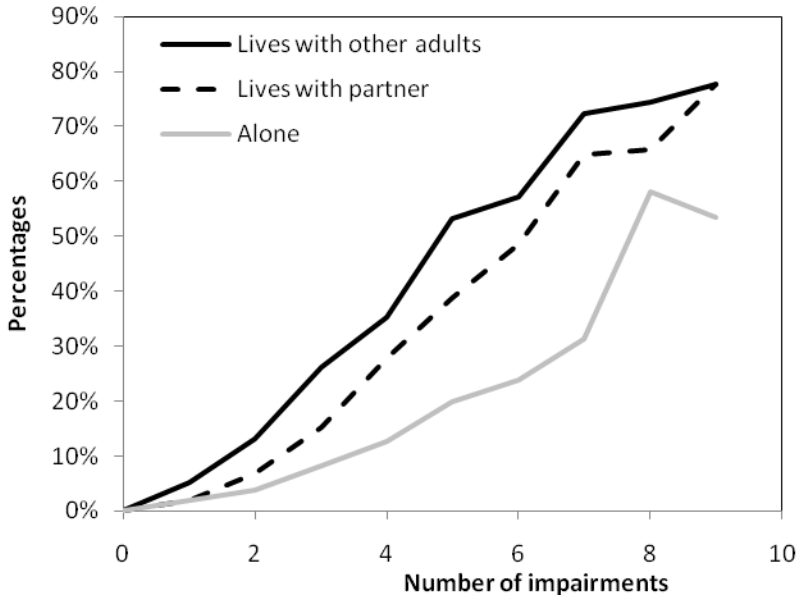
Table 3 Logistic regression equation predicting the probability of receiving at least 20 hours of care per week

	Probability of receiving at least 20 hours of care
Locomotor	1.84
Danger	1.34
Learning	0.97
Other	0.92
Lifting	0.83
Coordination	0.65
Dexterity	0.54
Communication	0.51
Continence	0.45
Age 16-65 (per five years)	0.06
Age 65-90 (per five years)	0.21
Woman	0.22
Lives with partner (base case)	0
Lives alone	-0.90
Lives with other adults	0.58
Constant	-6.50
Pseudo R^2	42.3%
Sample size	*126,948*

Source: new analysis of FRS

Less obviously, the receipt of care also depended on the disabled person's living arrangements. Those with a partner can be presumed mostly to have married or formed a union before they became disabled, and it can also be assumed that their care needs are largely met by their partner. This suggests that partnered people are likely to have their needs met. Those living with no other adults in the household were much less likely to receive high levels of care (for any given set of impairments), and it is possible that their living arrangements mean that they receive less care than they need. Those living with at least one adult (other than a partner) had a strong probability of receiving high-level care, and it seems likely that in many cases the decision of the disabled person and the other adult to live together was driven by the need for care. This variation in the supply of care is clearly illustrated in Figure A.

Figure A Proportion of disabled adults receiving at least 20 hours of care, by household living arrangements



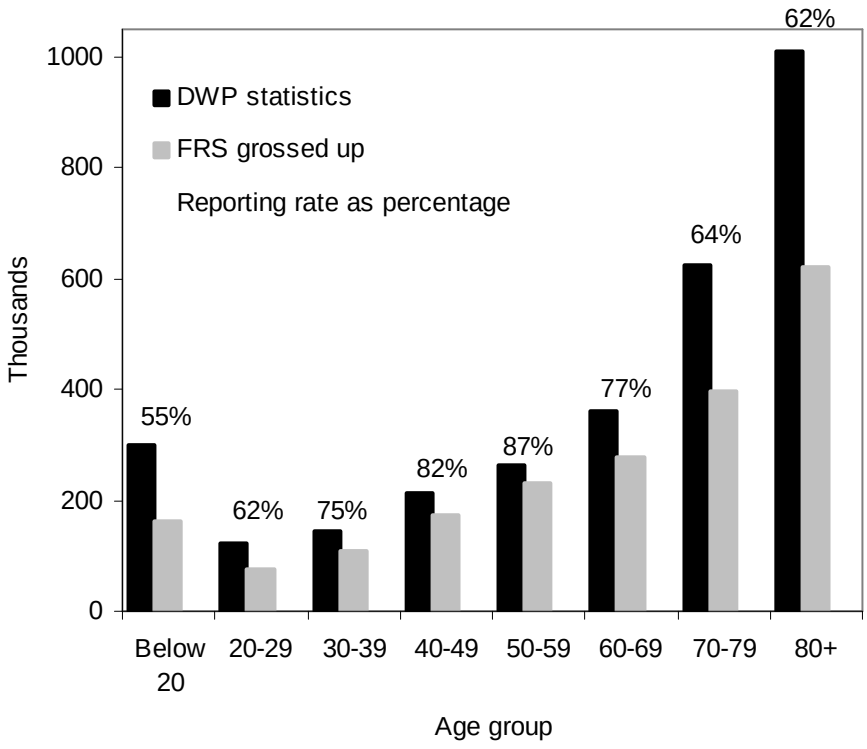
Source: new analysis of FRS

The hours of care actually received by the disabled person, or their (possibly unmet) need for care, are not directly involved in determining a carer's eligibility to CA. As far as the characteristics of the disabled person are concerned, the only criterion is whether they are receiving the qualifying benefits - AA or the higher/middle rates of DLA (care component). DWP statistics record that 3.3 million people received one or other of the qualifying benefits in July 2009, but the figure in November 2006 (about the middle of the period covered by the FRS data), was nearer 3.0 million. The FRS data for Great Britain, grossed up, suggest that 2.0 million people reported getting these qualifying benefits.[10] Comparing the two sources, the FRS reporting rate seems to have been about 67 per cent. Figure B breaks this comparison down by age group, to show that the overall reporting rate seems to have been more than 80 per cent in the middle age ranges, but younger and older people were less likely to record AA and DLAc. Some of the under-reporting among older people will refer to those still claiming AA while in residential care (and so not appearing in the sample of households covered by the FRS[11]). Nevertheless, there are some uncertainties about the accuracy with which the qualifying benefits are reported by FRS respondents.

[10] For a much more detailed analysis of the FRS data on Attendance Allowance (conducted independently of this brief overview, see Pudney (2010)

[11] There seems to be no estimate of the number of people receiving AA or DLAc while in residential care. This is an important policy issue, and filling in this information gap should be a priority

Figure B Number of people receiving qualifying benefits, by age



Source: WPLS, new analysis of FRS

Bear in mind that the total number of people reporting receipt of benefits in the FRS might be about right, even though some over-reporting and some under-reporting misallocated individuals. According to the experimental project in which DWP analysts matched the survey results to administrative data about the same respondents (DWP 2009, page 136), there was some mismatch between the two sources. Of those said to be receiving DLA (either the care or the mobility component) by either source of information:

- 11 per cent were identified by the survey but not the administrative data (false positives in the survey)
- 11 per cent were identified by the administrative data but not the survey (false negatives in the survey)
- 78 per cent were identified by both sources (correct).

The equivalent figures for AA were 4 per cent false positives, 20 per cent false negatives and 76 per cent correct. So AA had a balance of under-reporting, where DLA seemed equally affected by under and over-reporting.[12]

Another source supports the view that survey interviews do not always correctly record receipt of the relevant benefits. Among respondents to the English Longitudinal Study of Ageing (ELSA) who reported that they were receiving AA at their first interview (and who were interviewed again at waves 2 and 3), the proportions reporting AA at waves 2 and 3 were 60 per cent and 50 per cent respectively.[13] Since it is thought that AA is an 'absorbing status' (ie people enter, but rarely leave unless they die or enter residential care paid for by their local authority) these findings suggest either some over-reporting at wave 1, or some under-reporting at waves 2 and 3, or both

So there is substantial uncertainty about the FRS record of qualifying benefits.

Table 4 repeats the regression equation predicting disabled people's receipt of high-level care (copied from Table 3), and then compares it with a parallel equation predicting reported receipt of the qualifying benefits. The two formulae are very similar to each other, so in broad terms it can be seen that the *types* of people (characterised by their impairments, age, sex and household arrangements) who received care were the same as the types of people who reported qualifying benefits. In detail, the impairments labelled Learning and Lifting were rather less predictive of benefit receipt than of care actually received, whereas increasing age (above 65) was more predictive of benefits than of care. Disabled people who lived alone were more likely to have the benefits (though they were less likely to have the care). But those living with other adults were slightly less likely to have the benefits, than their profile of care might have suggested.

[12] This enquiry is concerned with the take up of CA. But a general comment on take-up methodology derived from these figures is that the FRS would estimate non-take-up of DLA at 14 per cent, and of AA at 23 per cent, simply through false negatives, even if the actual take-up was 100 per cent.
[13] Thanks to Marcello Morciano for undertaking this analysis.

Table 4 Logistic regression equation predicting the probability of receiving at least 20 hours of care per week, and of receiving qualifying benefits

	Probability of receiving at least 20 hours of care	Probability of receiving qualifying benefits	Difference
Locomotor	1.84	1.83	-0.01
Danger	1.34	1.26	-0.08
Learning	0.97	0.70	-0.27
Other	0.92	0.87	-0.05
Lifting	0.83	0.52	-0.31
Coordination	0.65	0.53	-0.12
Dexterity	0.54	0.54	0.00
Communication	0.51	0.52	0.00
Continence	0.45	0.44	0.00
Age 16-65 (per five years)	0.06	0.07	0.01
Age 65 -90 (per five years)	0.21	0.42	0.21
Woman	0.22	0.14	-0.08
Lives with partner (base case)	0	0	0
Lives alone	-0.90	0.33	1.24
Lives with other adults	0.58	0.46	-0.12
Constant	-6.50	-6.11	0.38
Pseudo R^2	42.3%	43.2%	
Sample size	*126,948*	*132,050*	

Source: new analysis of FRS

If the FRS data suggests that the types of people who successfully claimed benefit were similar to the types of people who received or needed care, the match between the two at the individual level was far from perfect. Getting on for half (41 per cent) of those who received at least 20 hours of care were not recorded as having the qualifying benefits. Getting on for two-thirds (63 per cent) of those receiving the benefits were not observed to receive high-level care. 754,000 people are estimated to have had both care and benefit, but 1.3 million had the benefits without the care, and 518,000 the care without the benefit.

A potential substantive and policy interpretation of these figures might be that AA and DLA (the QBs) are less than efficient – many people seem to be in need but have no QB, and many have a QB but do not seem to need high-level care. As discussed, we would not expect an exact match between the need for care (the QB eligibility

criterion) and the receipt of care (which may depend on the availability of informal care and/or the disabled person's spending priorities). But in the context of CA, it is expected that the disabled person is receiving at least 35 hours of care (from the CA claimant).

But there is an important methodological issue. The interpretation depends on whether each of the measures (of care and of benefits) is strictly accurate, or whether it should be considered broadly indicative of the construct under consideration. There is a very strong statistical relationship between the probability of needing care and the probability receiving benefit, even though it is not precise when the two outcomess are compared at the level of individuals.[14] From the point of view of take-up research, the methodological problem is that we have to identify individuals who were or were not entitled (in need), and cross-analyse them with individuals who were or were not receiving benefits. Any misclassification of individuals on either of the two variables would lead to apparent misallocation of benefits, interpreted as poor targeting (on the one hand) or as non-take-up (on the other).

The simple conclusion of this analysis of the first CA criterion is that there are two or three million disabled people (depending on the data source) receiving the qualifying benefits, who could therefore entitle a carer to claim CA. The more complex conclusion is that many of them do not seem receive the care that they need, while many other disabled people are receiving care, but do not have the qualifying benefits which would entitle their carer to CA. The next section examines a similar set of questions from the point of view of carers.

One issue concerns the take-up of the qualifying benefits (AA and DLAc). Two very different research programmes are currently attempting to measure the take-up rate – one using the same FRS data as is being analysed for this report (Pudney 2009) and another using an experimental approach in which entitlement is modelled more directly (Kasparova and others 2007). If disabled people have not claimed their AA or DLA, their carer is not entitled to CA, so, strictly speaking, the case cannot be

[14] The correlation between *predicted* care and *predicted* qualifying benefits (derived from the two equations in Table 4) is 0.91. The equivalent correlation between *actual* care and *actual* benefits is 0.45.

considered as unclaimed CA, contributing to the CA non-take-up rate. It can be argued, on the other hand, that unclaimed QBs should be counted against the take-up rate of CA (to the extent that the carer would have qualified on other eligibility criteria).

The disabled person's receipt of the qualifying benefits is not the end of the story. The severe disability premium (SDP) is an addition to means-tested benefits payable to individuals receiving the QBs who live alone, or to couples both of whom receive QBs and have no other adults in the household. But the SDP is not payable if the carer receives CA. It is one or the other. Since the severe disability premium for a single person is £53 per week, and CA is £54, it may be a nice judgement whether the disabled person should claim the SDP, or the carer the CA – depending on whether the welfare of either of them takes priority over the combined income of the two together. It can be argued that take-up will be achieved if either of the two benefits is claimed and paid, but there are clearly serious measurement difficulties.

The FRS suggests that of about 143,000 disabled people with QBs, reporting the receipt of at least 20 hours of informal care from outside the household, three quarters (76 per cent) live alone. Of these, nearly two-thirds (64 per cent) receive means-tested benefits. So there are about 70,000 disabled person/carer pairs for whom the choice between SDP and CA might be difficult.

Condition 2 Providing care

Carers are entitled to CA if they are looking after a disabled person (who receives the qualifying benefits) for 35 hours a week or more. The focus of the analysis switches here from the disabled person to the carer.

If the disabled person receiving care is a member of the same household as the person providing it, both of them will have taken part in the FRS, and it is possible to cross-analyse the characteristics of the disabled person and the carer. If they are not members of the same household, there is no information about the other party. Much of this section therefore describes the position of in- and out-household carers separately, focussing especially on the former, who are more numerous and for whom more information is available.

Policy in general, and the Carer's Allowance in particular, are not particularly concerned with low or medium levels of care, and it is more relevant to report the numbers of people providing high levels of care – 20 hours per week or more. The analysis is based on the assumption that people providing more than 20 hours of care are potentially eligible for CA, on the grounds a) that survey questions cannot accurately make a distinction either side of the formal 35 hour criterion, and b) that the main carer for someone who needs help frequently throughout the day, or during the night (the conditions for the qualifying benefits) could legitimately argue that he or she was on duty at least 35 hours. The FRS suggests that:

- 1,205,000 people provide high-level care to others in their own household (see Table 1).
- 357,000 provide high-level care to someone outside the household (see Table 2). Nine out of ten of these are looking after a relative.
- 1,562,000 in total

Table 5 shows that the single most common care relationship is between husbands and wives or cohabiting partners. Wives (and female partners) are only slightly more likely to care for their husbands (male partners) than vice versa. These partnerships are typically between men and women of about equal age, with an average age in the mid 60s.

One in seven of the high-level carers were looking after their disabled child of dependent age. The carer was most often the mother, though it is surprising to find that a high proportion of the disabled children concerned were boys.

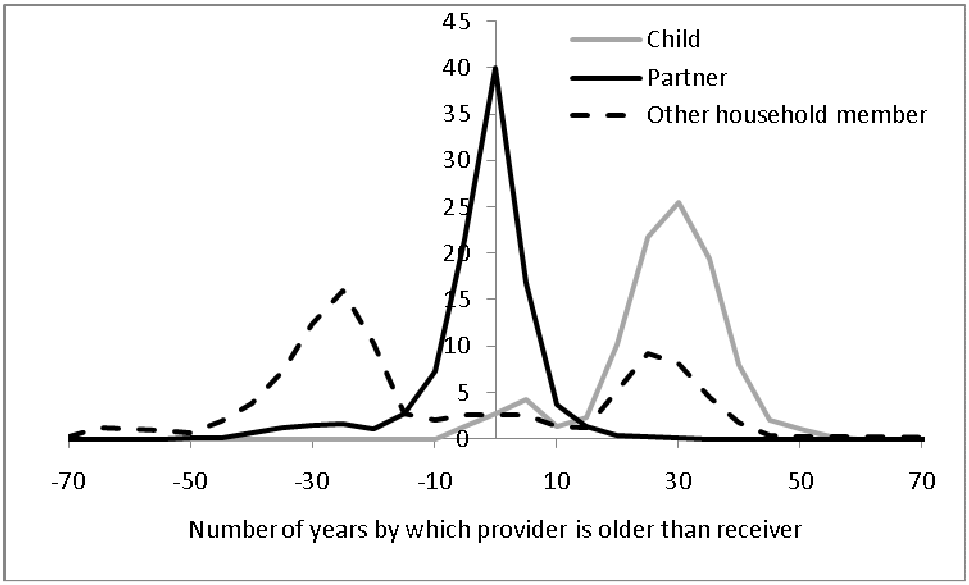
Table 5 Pairings of high-level care givers and care receivers

Position of care receiver	Partner	Dependent child	Other household member	Outside household	Total
Proportion of all high-level care relationships	42%	14%	21%	23%	100%
% of care providers who are women	52%	72%	61%	73%	61%
% of care receivers who are women	49%	32%	63%	70%	38%
Median age of care provider	64	39	53	52	44
Median age care receiver	64	10	55	71	43
% of providers who are of pensionable age	53%	1%	25%	24%	29%
Sample size	*2082*	*718*	*864*	*1079/ 757*	

Source: new analysis of FRS.
Notes:
1. Providers and receivers are matched pairs when they are members of the same household. They are independent samples when they are in different households
2. 'Dependent child' is defined by benefit rules as below the age of 16, or below 18 and in education. Adult children would appear as 'other household members', even though possibly 'dependent' on care.
3. Median ages are calculated by interpolation across 5-year age bands.

Where a carer was looking after a member of the household other than their partner or dependent child, there was again a majority of women, though the preponderance of female carers was not as marked as in some other types of pairing. Women were also over-represented among care receivers, no doubt because of their tendency to live longer. Although providers and receivers have similar average ages, detailed analysis of the differences within the pairings (Figure C) shows that the disabled person was either much younger than the carer (often an adult child) or much older than the carer (often an ageing parent.)

Figure C: Age differences between within-household care providers and receivers



Source: new analysis of FRS
Note: Age differences estimated by comparing five years bands

Among caring relationships between members of different households, a high proportion of both the givers and receivers of care are women. The receivers of out-of-household care are older, on average, than other disabled people in receipt of care.

It will become clear later that actual payment of CA depends on non-receipt of other earnings replacement benefits, especially the state pension. So it is important to note that about one third of high-level care providers are above pensionable age, ranging from hardly any when the care receiver is a dependent child, to about half when s/he is the carer's partner (Table 5, above).

As discussed, the qualifying condition is not directly whether the care receiver needs care, but whether s/he receives one of the qualifying benefits (QBs) (AA, or the higher middle rates of DLAc). Among within-household care pairings, the proportions of care receivers who reported one of the QBs were as follows:

- Carer provides less than 20 hours per week 35%
- 20 to 34 hours per week 48%
- 35 hours or more 62%

There was not much difference in this respect between receivers who were parents, dependent children or other household members.

This is one of several indications in the analysis of the FRS that people reported to need, and receive, high-level care, do not closely match the people reporting receipt of the qualifying benefits. This means either that the benefits are not getting through; or they are being under-reported in the FRS.

Condition 3: Economic activity

A third condition for eligibility for CA is that the claimant is not in work (or has earnings from employment of less than £100 per week at current rates), and is not in full time education.

The original intention was that the earnings replacement benefit should be offered to people who gave up work opportunities because they spent so much time caring; while those who would not have worked in any case should not be eligible. This gave rise to the exclusion of married women from eligibility to the original ICA scheme. While being a married woman may have been a fair predictor of not having a job when the scheme started in 1975, that assumption rapidly became out-dated, and married women were allowed to claim from 1986 onwards.

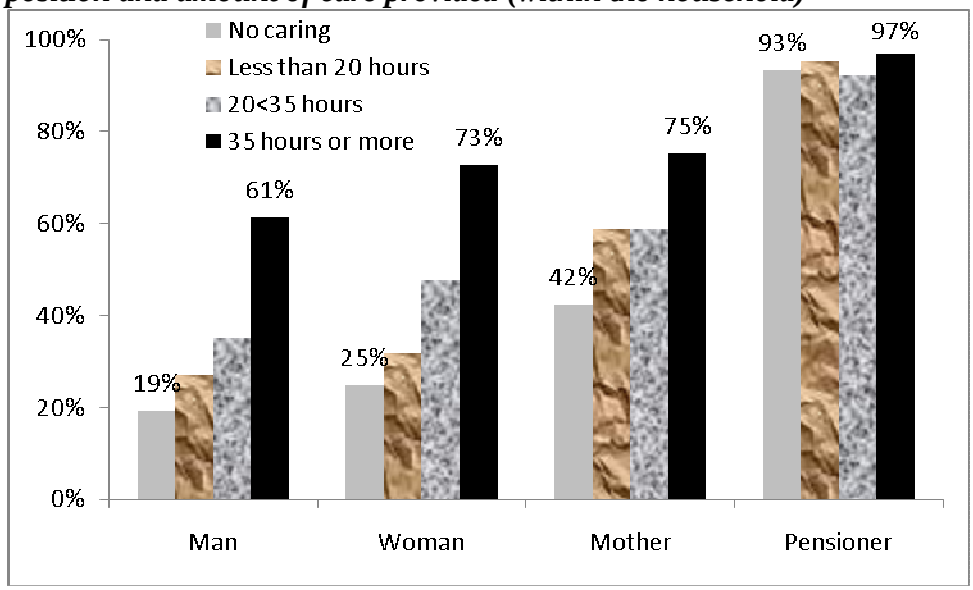
One potential issue concerns carers who work variable hours from week to week, and so earn more than the threshold some weeks, and less than the threshold (or nothing) other weeks. This is more likely to affect waged jobs (paid by the week) than salaried jobs (paid by the month) because monthly earnings will be averaged across 4.3 weeks. There may be some effect on take-up, where carers with fluctuating earnings do not claim at all because of this uncertainty, or effectively claim too much because they fail to report occasional weeks with non-trivial earnings. A more explicit procedure for averaging earnings over a period would help to clarify this confusion.

The FRS analysis defined this eligibility criterion directly for those without work (except students), and low-paid employees (reporting net earnings below the threshold for the relevant year). For the self-employed, whose earnings are reported unreliably,

those whose earnings were *probably* less than the threshold were identified indirectly, using an analysis of employees to predict the probability of low earnings.[15]

Figure D shows the proportion of all adults who were out of work, or with low earnings (as defined), cross analysed by family position and the number of hours of care they provided. As expected, men were less likely to be non-workers than women, and, among women, those with children under 16 were more likely than those without current parenting responsibilities. Most people over pension age would have qualified on the non-work criterion in any case.

Figure D Proportion of adults not in work (defined using the CA criteria), by family position and amount of care provided (within the household)



Source: new analysis of FRS
Note: men, women without children and mothers are all defined as those below pension age.

But among those below pension age, people who provide long hours of care are much more likely to be non-workers, according to this criterion. The difference between non-carers and 'full-time' carers is strongest for men, and weakest for mothers. This means that variations by family position are much weaker for full-time carers than for non carers.

[15] The prediction was based on a logistic regression equation predicting the probability of employees' earning below the CA threshold, on the basis of hours worked, age (and age-squared) and sex. The equation had a pseudo R^2 of 35%, indicating quite a strong relationship between the prediction and the outcome. Self-employed people with characteristics that would have given an employed person more than a 50% chance of low earnings were judged to have low earnings themselves.

It follows that among people who would qualify for CA on the disabled person's receipt of AA or DLAc, and also on number of hours of care they provide, only a minority would be disqualified by the fact that they earn more then the threshold level (or are studying). Clearly, most of those disqualified are below pension age, with male carers slightly more likely to be disqualified than female carers.

Table 6 Carers who qualified on the AA/DLAc and care-hours criteria, who would be disqualified by the economic activity criterion

	Number qualifying before this stage (thousands)	Percent disqualified at this stage
Man	182	39
Woman without children	136	29
Mother	108	23
Pensioner	272	3
Total	697	21

Source: new analysis of FRS

Note: 'qualifying before this stage' means caring more than 20 hours for someone (in the household) who receives qualifying benefits

Condition 4: Overlapping benefits

People who fulfil the first three eligibility criteria (QBs, 35 hour care, below earnings threshold) are judged to be 'entitled' to CA. But they may not actually receive any CA if they receive other earnings replacement benefits such as the state pension, incapacity benefits and so on. These are known as 'overlapping benefits'. The principle is that individuals cannot be compensated twice for the same lack of a job.[16]

Where a carer fulfils the basic entitlement criteria but is affected by the overlapping benefit rules, s/he is said to have an 'underlying entitlement' to CA. No CA is paid, but the carer may claim the carer's premium on Income Support, Housing Benefit and Council Tax Benefit, or the carer's addition on Pension Credit. This premium/addition is worth up to £30.05 at current rates, if the claimant meets the other qualifying conditions (notably a low family income) for these means-tested benefits.

Because the state pension is the main overlapping benefit, most CA payments are made to people below pension age, and most of those with underlying entitlement are

[16] In theory, some CA can be paid if the total of OBs is less than the CA entitlement. But since CA is the least generous benefit in the social security system, this happens very rarely in practice.

above pension age (Table 7). People of pensionable age were not entitled to CA at all (and therefore not to the carer's premium/addition) until 2002.

Table 7 Carers Allowance payments and entitlements (thousands), by pension age: DWP statistics.

	Under pension age	Over pension age	Total
CA in payment	373	59	432
Underlying entitlement	30	478	508
Total	403	537	940

Source: WPLS

An analytical complication is that statistics on CA are often meaningless unless this four-way split by age and type of entitlement is maintained. Some DWP statistics do not make it clear whether it is claims in payment, or all 'entitlements' that are being counted. It is also doubtful whether respondents to surveys, such as the FRS, would record CA among the benefits they are receiving, if the entitlement is only 'underlying'.

The CA claim form asks for details of the overlapping benefits (without making it very clear what the impact will be on the outcome). The decision maker then checks the central record to make sure the claimant is not receiving any of the OBs. It is not difficult to imagine how claimants react to the letter from the Carer's Allowance Unit (CAU) which tells them that they are entitled to CA, but are not actually going to receive any money. This issue was raised many years ago by McLaughlin's survey of claimants (1990), and again, trenchantly, by the House of Commons Public Accounts Committee (2009).

The CAU also reports this underlying entitlement to the relevant Income Support or Pension Credit office. The letter informing claimants implies that the premium will be awarded automatically. It is not clear what checks are in place to ensure that this happens. There seem to be no arrangements for the IS or PC administrators to report back to the CAU, and no statistics are collected to distinguish between CA claimants with underlying entitlement who gain from the carer's premium and those who do not. But even though the system is not closely monitored, it seems to work. Analysis of the administrative data-base undertaken specially for this enquiry (DWP 2010) shows

that 96 per cent of people entitled to CA and also receiving Income Support or Pension Credit had the carer's premium/addition added to their means-test assessment. The proportion was very similar for those with underlying entitlement, and those with CA in payment. (Table 8)

Table 8 Combination of national means-tested carer premium/additions with CA entitlement: DWP statistics

	CA in payment		Underlying entitlement	
	Number (K)	Per cent	Number (K)	Per cent
IS/PC with premium	190	37%	166	38%
IS/PC without premium	6	1%	9	2%
No IS/PC	324	62%	263	60%

Source: WPLS

Housing Benefit (HB) and Council Tax Benefit (CTB) are administered by local authorities. People receiving IS or PC are automatically entitled to 100 per cent rent and council tax rebates. For people claiming HB or CTB only (without the national income-related benefits) the CAU does not inform LA offices, but advises the claimant to get in touch with them. It seems likely that claimants with underlying entitlement will often miss out on the carer premium on HB or CTB unless they have a welfare rights adviser.

The FRS, which indicates the benefit positions of all potential CA claimants, confirms that the overwhelming majority of carers below pensionable age receive no overlapping benefits, whereas the overwhelming majority of pensioner carers are affected by the OB rules (left hand panel of Table 9). In a proportion of cases, the total OB payments are less than the CA rate, and the carer is potentially entitled to a small amount of actual CA. About a quarter of carers with OBs are also receiving means-tested benefits such as Income Support or Pension Credit, and are potential applicants for the carers premium/addition; but most are not in the means-test net, and so have nothing to gain from claiming CA. DWP statistics on the combination of CA and means-tested (income related) benefits (right hand panel of the table) provide a very similar picture.

It can be concluded that a significant minority of people with underlying entitlement stand to gain from the associated premium – but the majority do not.

Table 9 Receipt of overlapping benefits, and means-tested benefits: FRS and WPLS compared

FRS: Potentially entitled carers (see note 1)	Below pension age	Above pension age	**WPLS: CA cases**	Below pension age	Above pension age
No overlapping benefits	89	4	Claim in payment	89	8
OBs less than CA rate	1	6			
OBs and national means-tested benefits (JSA/IS/PC)	3	24	UE with national means tested benefits (JSA/IS/PC)	4	38
OBs and local means-tested benefits (HB/CTB) only	1	7			
OBs and no means-test	6	59	UE without national means-test	7	54
Sample size	*895*	*843*			

Source: new analysis of FRS; WPLS
Note:
1. The FRS analysis is based on people providing at least 20 hours of care to another member of their household who reports qualifying benefits, and who are not disqualified on the earnings rule
2. Means tests are defined in the FRS analysis to include PC, IS, HB and CTB. In the WPLS analysis, the definition is confined to PC and IS, because the WPLS has no record of HB or CTB (which are administered by local authorities)

For carers who may have underlying entitlement to CA, the take-up issue ceases to be do they or don't they claim. We have to consider the outcomes for two distinct sub-groups:

A. For those within the scope of income-related benefits, there are three possible outcomes
    a) No claim to CA
    b) CA underlying entitlement awarded, but no premium/addition received
    c) Premium/addition received
B. For those beyond the scope of income-related benefits, there are two possible outcomes
    a) No claim to CA
    b) CA underlying entitlement awarded, but no premium/addition entitlement

Outcome Ac is the target that should be measured for take-up analysis – premiums awarded as a proportion of all those entitled to them. It can be argued that outcomes

Ab (claim without correct award) and Bb (successful claim to a valueless benefit) should be counted against the system, rather than in its favour.

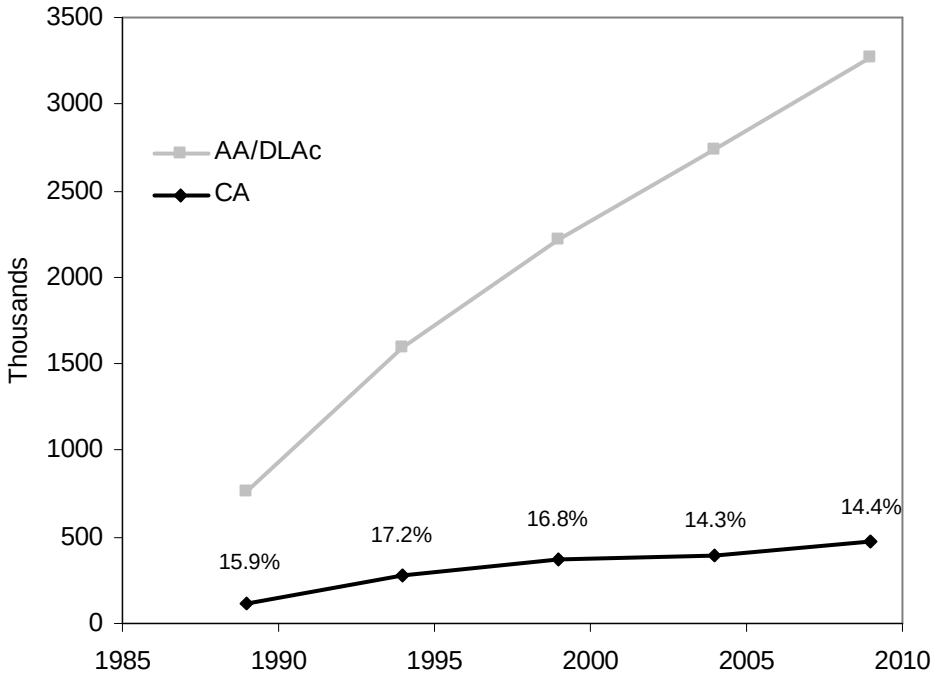
Reach of the Carer's Allowance.

The preceding sections have broken the CA entitlement criteria down into four steps, so that measurement issues relevant to each step could be discussed independently. It is now possible to address CA itself more directly, in an attempt to measure take-up – though there are measurement issues for CA itself which also need to be taken into account.

Reported numbers

As reported in Table 7 above, there were 432,000 CA claims in payment at the latest count (mostly to carers below pension age), plus a further 508,000 carers with underlying entitlement (mostly above pension age). Figure E plots the trend in the number of CA claims in payment over the last twenty years, compared with the trends in the number of disabled people receiving the qualifying benefits. The number of people receiving AA or DLAc more than quadrupled over the period (although the officially stated eligibility conditions did not change much). Since the prevalence of disability did not increase by anything like that rate, the rise in successful claims can be interpreted as a massive increase in take-up of the QBs. The ratio of CA payments to QB entitlements should *not* be interpreted as a direct measure of CA take-up (because QBs are not the only eligibility criterion) but the trend can perhaps be interpreted to mean that the take-up rate in 2000s has been rather lower than that observed in the 1990s.

Figure E Number of CA claims in payment compared with number of disabled people receiving the qualifying benefits.

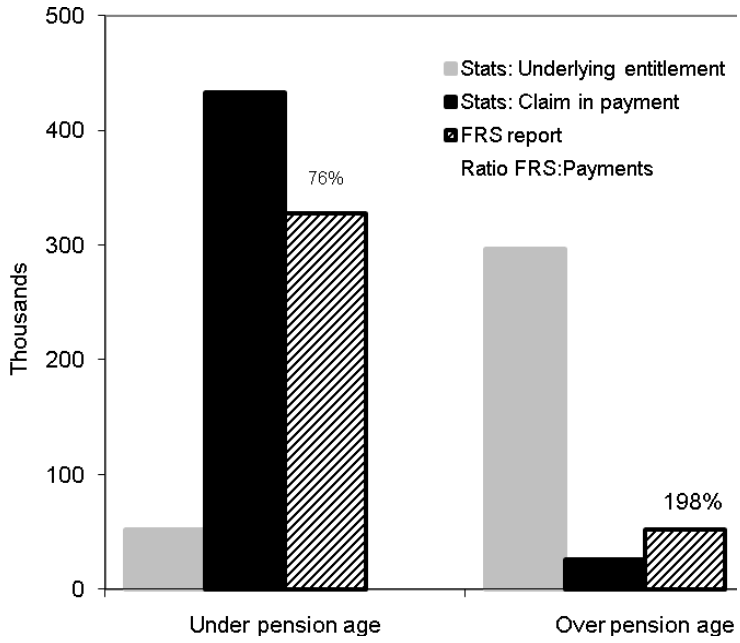


Source: DWP benefit statistics. The percentages represent the ratio of CA recipients to QB recipients.

A first step in using the FRS data to measure take-up is to consider the accuracy with which CA is reported by survey respondents. It is crucial to take account of the difference between claims in payment (which might possibly be well reported in the survey), and underlying entitlement (which might be omitted from the list of benefits received, since no money comes in directly). The distinction between claims in payment and underlying entitlement is not explicit in the survey questionnaire, but breaking the sample into those below and above pension age provides a fairly clear picture. Figure F shows that the FRS estimates a total of 328,000 people under pension age reporting receipt of CA, compared with 433,000 in that age group recorded y the statistics as having an actual payment. So about three-quarters (76 per cent) of the actual payments seem to have been reported. Among people above pension age, the FRS indicates 52,000 current cases, compared with only 26,000 claims in payment recorded at headquarters. This suggests that at least some of the underlying entitlements are being listed in the FRS.[17]

[17] Simultaneous equations applied to both age groups indicate a reporting rate of 74 per cent for claims in payment, and 11 per cent for underlying entitlement.

Figure F Comparison of CA receipt: grossed up FRS compared with DWP statistics



Source: new analysis of FRS; WPLS

This result is largely caused by treating underlying entitlement as positive in the administrative data. Unpublished analysis of the same data suggest that the great majority of those with underlying entitlement reported (understandably) that they were not receiving CA in the survey. If CA in payment is treated as a self-contained benefit (treating underlying entitlement as negative), then the unpublished analysis suggests a much better match between the administrative and survey reports, although the number of cases analysed is too small for accurate figures to be quoted.

So the accuracy with which survey respondents report that they are receiving the target benefit is an important consideration for take-up research, as well as the accuracy with which they report the eligibility conditions (qualifying benefits, hours of care and economic activity).

Estimating take-up

There seems to have been only one previous attempt to measure the take-up of CA. Lawton (1989, summarised in McLaughlin 1990) analysed the General Household Survey (GHS) of 1985. Some of the methodological problems around the accuracy of survey responses, discussed in this report in the context of the FRS, would have been

equally (or more) relevant to the GHS, but the SPRU analysis did not have mainly methodological objectives, and interpreted the survey data at face value.[18] It suggested that the take-up rate for the then Invalid Care Allowance was only 12 per cent. But the number of claims in payment shot up between 1985 and 1988, probably because of the huge publicity associated with Madeleine Drake's claiming a right to ICA even though the rules at that time debarred married women. Lawton and McLaughlin estimated the take-up rate to have risen to 80 per cent by 1989 – but warned that take-up was likely to decline again over the years as new cohorts of carers would be less likely to hear of the opportunity to claim.

The new analysis of the FRS undertaken for this project provides the nearest to an estimate of take-up as it is possible to achieve with existing data. The rows of Table 10 require careful explanation as they apply successive eligibility criteria to people below pension age.

- The first line is simple – it records that 46 million people in the age range do not provide high levels of care, either to someone in the household, or someone outside.
- The second line identifies people who report at least 20 hours of care (within the household on the left, outside the household on the right) but for whom the disabled person being cared for did not report receiving the qualifying benefits. In the case of care outside the household, the QBs could not be reported, because the disabled person was not interviewed.
- The third line identifies people who provide high-level care to disabled people with QBs (within the household), but the carer was in work (earning more than the current threshold) or a student.
- The fourth line refers to people who pass the three main eligibility criteria, but whose overlapping benefits meant that they would probably not receive an actual payment.
- The fifth line identifies people who appeared to qualify on all four criteria (within-household) or three criteria (out-of-household, where the receipt of QBs is not known).

The first column of each half of the table records the total number of people (below pension age) in this position, estimated in thousands. The second column records the number estimated to receive CA, according to the FRS reports; the third column records the CA reports as a proportion of the total.

[18] Lawton makes no mention of the distinction between claims in payment and underlying entitlement, and it is possible that she treated both together. But since over 65s were not entitled to claim (I)CA in any case before 2002, the issue was much less important then than it is now.

Table 10 Distribution of CA among people of working age, analysed by successive entitlement criteria

	Within household			Outside household		
	Total in pop (K)	N with CA (K)	% with CA	Total in pop (K)	N with CA (K)	% with CA
Provide less than 20 hours care	46,087	62	0.1%			
Provide 20 hour care, no QBs	329	51	15%	126	3	2%
20 hour care and QB, but in work	146	8	5%			
20 hour care, QB, not in work, but OBs	30	3	9%	18	0	2%
Apparently entitled to payment	266	172	**65%**	112	29	26%

Source: new analysis of FRS

At first sight, the table provides an estimate of take-up. Among people providing high levels of care within their own household, and who meet the other eligibility criteria, nearly two thirds (65 per cent) are receiving CA (figure emphasised in bold).
For people caring outside the household, the apparent take-up rate is lower, but that could at least partly be explained by the fact that the analysis has not been able to screen that group for qualifying benefits.

If the threshold of the care criterion is raised to 35 hours, the apparent take-up rates rise to 68 per cent for within-household carers and 44 per cent for out-of-household carers. The boost in the latter figure is probably caused by the 35 hour threshold acting as a better proxy for receipt of QBs by the disabled person.

Returning to the 65 per cent estimate for within-household carers, does this provide the answer we are looking for? It is certainly the closest we can get. But consider, first, the evidence reported, earlier in this section, that CA is under-reported in the FRS, compared with the DWP's record of the number of payments being made. If only three quarters of payments are reported in the FRS, then perhaps the true take-up rate is not 65 per but 87 per cent (65/0.75).

Consider, second, the number of people in Table 10 who report receiving CA, even though they appear not to be entitled to it. Of 328,000 working age reported recipients of CA, 127,000 – 39 per cent – are recorded in one of the first four lines of Table 10, mostly because they say they are not providing high-level care, or because the

disabled person they are caring for does not receive qualifying benefits. In that context, consider the evidence in previous sections that AA and DLA are also misreported in the FRS.

If it was assumed that anyone reporting receipt of CA must be entitled to it (and make no other adjustments)[19], the take-up rate for within-household carers rises from 65 per cent to 75 per cent. If we also applied the correction for under-reporting of CA (discussed above) the estimated take-up rate reaches 100 per cent. These are not serious alternative estimates – they simply illustrate how sensitive the answer is to some fairly obvious analytical issues.

Another way of illustrating the methodological issue is to imagine a perfect real world in which there were (say) 400,000 CA claims in payment. All of the claimants in this imaginary perfect real world, of course, satisfy all four of the entitlement conditions (hours of care provided, disabled person receives QBs, no work (or low earnings) and no overlapping benefits). Now imagine that we try to observe this perfect real world with imperfect survey measurements. Assume that for each of the five questions (receipt of CA and each of the four eligibility criteria), there was a 1 in 10 self-balancing error rate: 10 per cent of the true positives in the sample are turned into false negatives in the survey, and replaced by the same number of false positives, separately for each of the five questions. Analysis of each question would still show the correct proportions in each situation. But the requirement to consider all five questions in combination to measure take-up would yield a grossed up total of only 236,000 ($400{,}000 \times 0.9^5$) payments to fully eligible claimants. The other 164,000 cases in this imaginary perfect world would appear in these imperfect survey measurements either as payments to ineligible claimants, or as eligible non-claimants.

The combination of apparently too many and too few CA payments, predicted on the basis of multiple small measurement errors, is similar to the actual pattern reported in Table 10. Of course, the real world is not actually perfect, either, but the difficulty lies

[19] That is, the number of apparent payments to ineligible people is added to both the numerator and the denominator of the take-up percentage.

in distinguishing the imperfections of the survey, from the imperfections of the claim process, in reaching an estimate of the take-up rate.

Table 11 repeats Table 10, this time focussing on people above pensionable age. Because most people in the age-group have a pension, the overlapping benefits/underlying entitlement issue is much more important for them. But we have no confidence that pensioners in the FRS are reporting their underlying entitlements in answer to the question about receipts of CA, and the table is provided mainly for the record.

Table 11 Distribution of CA among people of pensionable age, analysed by successive entitlement criteria

	Within household			Outside household		
	Total in pop (K)	N with CA (K)	% with CA	Total in pop (K)	N with CA (K)	% with CA
Provide less than 20 hours care	10,135	16	0.2%			
Provide 20 hour care, no QBs	161	9	6%	6	0	0%
20 hour care and QB, but in work	9	0	0%			
20 hour care, QB, not in work, but OBs	237	17	7%	66	1	1.5%
Apparently entitled to payment	26	7	28%	10	2	15%

Source: new analysis of FRS

Implications for improved estimates of take-up.

Detailed consideration of official DWP statistics and survey data in relation to CA and its eligibility criteria has identified four types of potential claim, each with its own specific set of measurement problems:

Label	Definition	Weekly amount at stake
Within-household allowances	High-level care to fellow household members, without overlapping benefits	£54
Out-of-household allowances	High-level care to others outside their household, without overlapping benefits	£54
Underlying entitlement with means-test	High-level care, with overlapping benefits, but a potential gain from the carer premium	£30
Underlying entitlement without means-test	High-level care, with overlapping benefits, and no gain from the carer premium	nil

The take-up of *within-household allowances* is clearly the most important issue from the point of view of the volume of benefits potentially foregone. It is the group for which we have already a provisional take-up estimate (see Table 10), and, as will be argued in the following paragraphs, the group for which a more accurate estimate could most easily be obtained, by combining existing survey and administrative data

The take-up of *out-of-household allowances* is less important in the sense that fewer carers are potentially affected. But receiving the correct allowance is just as important to each of the carers concerned. And it could be argued that the provision of care across household boundaries (mostly between relatives for whom co-residence is not appropriate) is one of the most important policy issues. A take-up rate cannot even be approximated with current data, because members of two households are involved in establishing eligibility. New data collection is discussed below.

The take-up of *underlying entitlement with means-test* is less important than the core group of within-household allowances, because the amounts at stake are smaller. On the other hand, families on means-tested benefits have very low basic incomes, and the carer premium of £30 would make a substantial proportionate difference to their living standards. A combination of survey and administrative data might enable take-up to be estimated for this group, although it seems likely that this would require a change both in adjudication procedures and data recording.

The take-up of *underlying entitlement without means-test* does not matter at all, as the gain from a successful claim would be nil. The main issue here is to distinguish between underlying entitlements with and without means-tests, both in the administration of claims and in the analysis of take-up.

These four groups are discussed in turn in the following paragraphs.

Within-household allowances (high-level care to fellow household members, without overlapping benefits)

This is the core group, for which a take-up estimate is an over-riding priority.

In principle, the FRS provides all the data to enable a comparison to be made between entitlement to and payment of CA, case by case. The take-up rate directly estimated from the FRS is 65 per cent – well short of the rates estimated for other benefits, though massively better than the only previous estimate, of 12 per cent. But the same source appears to show that many people who do not provide high-level care, or whose dependent does not receive one of the qualifying benefits, nevertheless report receiving CA. This pattern of too little and too much is consistent with the possibility that some of the five crucial questions are not being answered accurately – and indeed there is direct evidence (quoted above) that CA, AA and DLAc are sometimes misreported (in both directions) by survey respondents. Such misreporting would tend to lead to an under-estimate of the take-up rate (if the errors were at random).

A solution would be to undertake an analysis of FRS data which relied as much as possible on administrative records, and on self-reported survey data as little as possible. This analysis would have to be confined to the 60 per cent of FRS sample who (since 2008) have agreed that their survey answers could be matched with benefit records. Only cases where both the disabled person and the carer had agreed to the link could be analysed (and this may raise questions about the extent to which 'informed consent' can be provided by disabled people with severe mental health problems).

Further work is probably needed to establish whether this is a representative sub-sample. In the present context, a comparison of the prevalence of disability and care (comparing within the FRS only) and of the penetration of AA, DLA and CA (comparing both base sources) would be essential, and might lead to an appropriate set of weighting procedures.

Of the five main information requirements:

1. Information about the hours of care provided would have to rely on respondents' reports in the survey interview. For within-household care these are thought to be fairly reliable, provided the analysis is not too strict about the exact number of hours reported.
2. Information about receipt of qualifying benefits by the disabled person would be obtained from the WPLS administrative data.

3. Information about employment and earnings would be obtained from the carer, and cross-checked against National Insurance records.
4. Information about overlapping benefits would be obtained from the administrative data.
5. Information about CA would be obtained from the administrative data.

Thus the strategy is to make use of the FRS, both to select a sample of interest, and to identify the household members providing care to disabled people. But the linked administrative data would be used to provide, or at least check, on benefits and earnings, thus avoiding the high sensitivity to measurement error of a definition that depends on five items of information.

If there is a weakness in this strategy, it is the doubt about the representativeness of the sample of families who have agreed to take part in FRS interviews in the first place, and then to allow their answers to be linked to the administrative records.

It is recommended that this analysis should be undertaken, including tests for representativeness. It would be valuable to have an estimate of the take-up rate for 'within-household allowances', even if was concluded that the other three sectors' take-up could not be measured accurately. A partial answer (for a key and clearly defined group) would be better than no answer.

The matched FRS/WPLS data set is subject to strict data security procedures to ensure that confidential information about households' personal circumstances cannot be accessed by unauthorised analysts. This means that the analysis should be undertaken within the DWP itself, by members of its own staff; or that the work should be commissioned from an independent analyst based in a university or research institute after careful vetting and explicit assurances of data security.

*Out-of-household allowances (*high-level care to others outside their household, without overlapping benefits)

Estimating this take-up rate is a high priority, because of the importance of the income to the carers concerned, and because of the relevance of this resource to disabled people living alone or with an equally disabled partner. It may be of lower priority

than the estimate for ‘within-household allowances’, because the number of potential claimants is much lower, and because it will cost more, and take longer, to obtain an answer.

The strategy recommended for within-household allowances, based on the matched FRS/WPLS sample, would work for out-of-household allowances, except for the impossibility of cross-checking the disabled person’s benefits with the carer’s benefits. This difficulty can only be resolved by adding cross-household data (and linkage permissions) to the existing survey method. The obvious alternatives are:

- Ask the carer (in a sampled household) questions about the benefits received by the disabled person (who is in another household). Many carers (including all those receiving the CA) will know whether the disabled person is receiving qualifying benefits (and may have helped them to claim). On the other hand, some carers (who have not claimed CA) will not know for sure. An ethical problem is whether the carer should be asked for information about a third party, and how to obtain the disabled person’s consent to data linkage
- Add a short interview with non-resident informal carers to the interview in households where a disabled person is identified (and reports high-level informal care from a non-resident). If the care is at all regular, the carer will be on the premises and therefore potentially available for interview. S/he can also provide permission for his/her own data linkage.

Although it might be possible to pursue both of these two options at the same time (and so double the sample of between-household care relationships) the latter version looks more appropriate. It also has the advantage of relying initially on the disabled person’s report of care received, which has been shown to be more conservative (and perhaps more reliable) than the carer’s report of care provided.

In all other respects, the strategy adopted for ‘within-household allowances’ can be applied.

This option, involving a change to the FRS questionnaires and fieldwork procedures, would take some time to bear fruit. Aside from the lead time for assessment of the options and design of the procedures, only about 450 people providing high-level informal care from outside the household would be identified in the sample each year, so several years’ data might be required to provide an accurate take-up measure

among the fraction of them who were judged eligible. The estimate would react only sluggishly to any changes in policy or practice designed to improve take-up.

It is recommended that this option should be investigated further by the team responsible for the FRS. The change in FRS procedures is quite small (and affects only a small number of households) and it might be concluded that the 'out-of-household allowances' take-up estimate should be pursued in this way. Alternatively, it might be decided that the information gain did not justify the additional costs. That could be a legitimate conclusion, if justified with figures after due consideration. It would not be a good reason for not investigating the option in detail in the first place.

Underlying entitlement with means-test (high-level care, with overlapping benefits, but a potential gain from the carer premium)

Identification of carers providing high-level care with overlapping benefits is in principle identical to identifying high-level care without overlapping benefits. The research would follow the two routes (analysis of the FRS/WPLS linked data for within-household care arrangements, with revised FRS survey procedures for between-household arrangements). Those with overlapping benefits are simply the converse of those without.

The important new point is to distinguish, among those with overlapping benefits, between those who do, or might, gain income via the carer premium/addition. The WPLS provides data about the centrally administered means-tested benefits, Pension Credit and Income Support, including a record of which additions and premiums have been included in the needs assessment. Among survey respondents shown to have underlying entitlement to CA, those eligible for the carers premium can be defined, approximately,[20] as individuals receiving PC or IS. Within that group, take-up of the CP can be measured directly. It is recommended that take-up should be estimated, using a modified version of the approaches described (above) for claimants without

[20] This procedure misses a) people eligible ofr PC or IS and not claiming it, and b) people with incomes close to the means-test threshold, who would become eligible if the CP was added to their assessment.

overlapping benefits. But take-up must be defined as including receipt of the premium/addition, not on the basis of an award of underlying entitlement (on its own).

The WPLS does not contain data about means-tested benefits administered by local authorities, mainly Housing Benefit and Council Tax Benefit. Our FRS analysis suggests that about one-third of carers with apparent underlying entitlement to CA are receiving any means-tested benefits; who split roughly 75:25 between those claiming a centrally-administered means test, and those whose only means test is LA administered. The FRS/WPLS data set will yield a take-up estimate for the former; it will not do so for the latter.

Underlying entitlement without means-test (high-level care, with overlapping benefits, and no gain from the carer premium)

Once carers who potentially gain from the premium/addition have been identified, those with underlying entitlement who have nothing to gain are simply defined as the remainder.

There is no point in attempting to measure take-up among those who would not gain from either a CA payment or a premium/addition. There is nothing to claim.

Indeed, it can be argued that the people who have been awarded a valueless entitlement should be recorded as having had their claim to CA rejected. That is not the legal position, but the current system effectively counts to the DWP's credit thousands of carers who have been encouraged to waste their time on a claim which has yielded no income.

It is recommended that more information should be kept about cases with underlying entitlement but no benefit, which should be clearly distinguished from statistics about claims in payment and premiums/additions. In the long run, regulations could be amended to make it clear both to claimants themselves, and to policy commentators, that these claims have effectively been rejected.

Alternative sources and approaches

This report has focused heavily on the FRS as a main source of immediate information, and on the FRS/WPLS linked data set as the most likely long-run solution to the measurement issue. There has been little explicit consideration of alternative sources.

The FRS is the most obvious candidate among the regular large-scale government-funded surveys. It is designed to measure benefits received, and the WPLS link greatly enhances the accuracy with which it can do this. The questions on impairment and on caring are at least as good as those available in other general purpose surveys. The FRS has the advantage of offering complementary perspectives on care provided by carers, and care received by disabled and elderly people. The main shortcoming, which it shares with all other household surveys, is that there is no direct information about the people in other households who exchange care with members of the sample – but this gap can potentially be filled.

There is often a long time-lag between a person becoming eligible for CA, and their hearing about it and claiming (McLaughlin 1990, NAO 2009). An element of take-up could be measured as the duration of a period in receipt of the benefit, expressed as a proportion of the duration of the period of eligibility. One line of approach might be to interview of people who had just successfully claimed CA for the first time, and ask detailed questions designed to find out when they first became eligible. The same survey could (like McLaughlin's earlier study, 1990) investigate the reasons for the delay. Administrative records could then be used to establish the eventual duration of the payment period. However, the FRS analysis has shown that it is difficult enough to establish current eligibility, so the chances of defining it retrospectively seem remote.

An alternative approach would be to make use of a survey dedicated to the analysis of carer's activities. There have been some surveys of carers over the years, mainly to investigate attitudes to the claim process (eg McLaughlin 1990, Carers UK 2007, NAO 2009, Byrom and others 2009), but these have mainly covered small scale samples of people who have claimed CA – so non-claimants have automatically been excluded.

It is understood that the Department of Health has commissioned a survey of carers in households to develop a better understanding of the support they provide and how it affects the carers' day-to-day lives. The key objective of the research is to update existing information that is held about carers. In particular the survey will provide information about:

- The prevalence of caring in England
- The commitment from carers and what this involves
- Carers' use of services and support organisations
- Carers' aspirations and thoughts about employment
- The health and well being of carers themselves

In the end a survey of carers has two linked weaknesses for this current purpose. It relies mainly on the carer's report of his or her activities, which has been shown to differ from the disabled person's report, possibly in the direction of overstating the amount of care provided. And there is no easy way of getting the additional and corroborating information from elderly or disabled people if they live in other households.

It is surprising how little use has been made of surveys of disabled people in the analysis of care – they are, after all, the ultimate objectives of policy in this area. The Health and Disability Survey (following up disabled people identified in the FRS of 1996/97) has hardly been analysed from this perspective (Grundy and others 1999), and could perhaps still yield useful findings if revisited. The Office for Disability Issues has commissioned a new longitudinal survey of disabled people, under the title Life Opportunities Survey (LOS). The new enquiry includes detailed questions on activities which disabled people can and cannot do without help; but astonishingly (given the current policy interest in social care) it has a very limited set of questions about care received. The LOS would require two substantial modifications before it could meet the requirements of the current objective: a question sequence identifying carers, and an interview with the carers themselves.

So the FRS remains the most likely source.

Conclusions

The initial conclusion of this project is that measuring the take-up of CA is made difficult by the immense complexity of the benefit rules – which are arcane even by the specialist standards of the social security system. This means, first, that it is not even clear when the benefit has been successfully claimed, and second that (as with many other benefits) an accurate answer to a whole series of questions is needed before eligibility can be established.

The analysis of the FRS reported here suggests a take-up rate of 65 per cent for the core group of within-household carers without overlapping benefits. Measurement error probably means that this is an under-estimate of the true figure. A better estimate for this group can, and should, be obtained using the linked FRS/WPLS data set. This should be done even if it was concluded that estimates for other types of potential claimant could not (yet) be obtained.

Promising options have been identified for measuring the take-up rate of CA for out-of-household carers, and the take up rate of the associated premium for those with overlapping benefits. These options should be pursued and evaluated.

A central difficulty for take-up research is that it relies heavily on the accuracy of data reported in surveys, both on the receipt of the benefit under consideration, and on the eligibility conditions. Random errors in either or both of these areas will tend to lead to attenuation - an under-estimate of take-up rates. There are strong signs in this report that such errors affect measurement of the CA take-up rate. A wider implication is that similar errors may affect the measurement of the take-up rate of other benefits.

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