# Response to consultation "Modernising Support: The Health and Disability Green Paper"

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*Responses to questions Q1, Q16, Q20-Q22, and Q26.*

***Q1. What are your views on an assessment that places more emphasis on condition rather than the functional impact of a condition on the person?***

The current assessment process for PIP is a 'functional' one, based on what activities an individual is unable to do because of their health condition. DWP are considering whether to move to a new or hybrid approach based entirely or partly on what condition the individual has been diagnosed with.

This proposal to shift the focus of assessment towards the condition rather than its functional impact is to some extent a return to DLA assessments. Under DLA, individuals with certain health conditions or impairments were automatically entitled to specific rates of benefits without a comprehensive assessment of their functional capabilities.[2] This approach had its merits, particularly in simplifying the process and ensuring that those with clearly defined conditions received support promptly. As the government now considers moving back towards condition-based assessments, it may be valuable for DWP to revisit the reasons for moving away from this in the 2010s, and to consider the lessons learned from the DLA system. This could help inform the potential implementation of any new assessment criteria.

The effectiveness of an assessment based on conditions rather than functionality will largely depend on the government's ability to 1) precisely identify health conditions, and 2) accurately map those health conditions to additional living costs.

Here we focus on this second requirement. Naturally a condition-based assessment does not account for any variations in how individuals experience and manage their conditions. Two individuals with the same condition might have different capabilities based on the severity of their condition, their personal circumstances, and the resources available to them. These factors will not be included at all in a purely condition-based approach, and only partly included in a hybrid approach.

To illustrate this point, we analyse data from the English Longitudinal Study of Ageing (ELSA), a survey of a representative sample of the 50+ population in England. This allows

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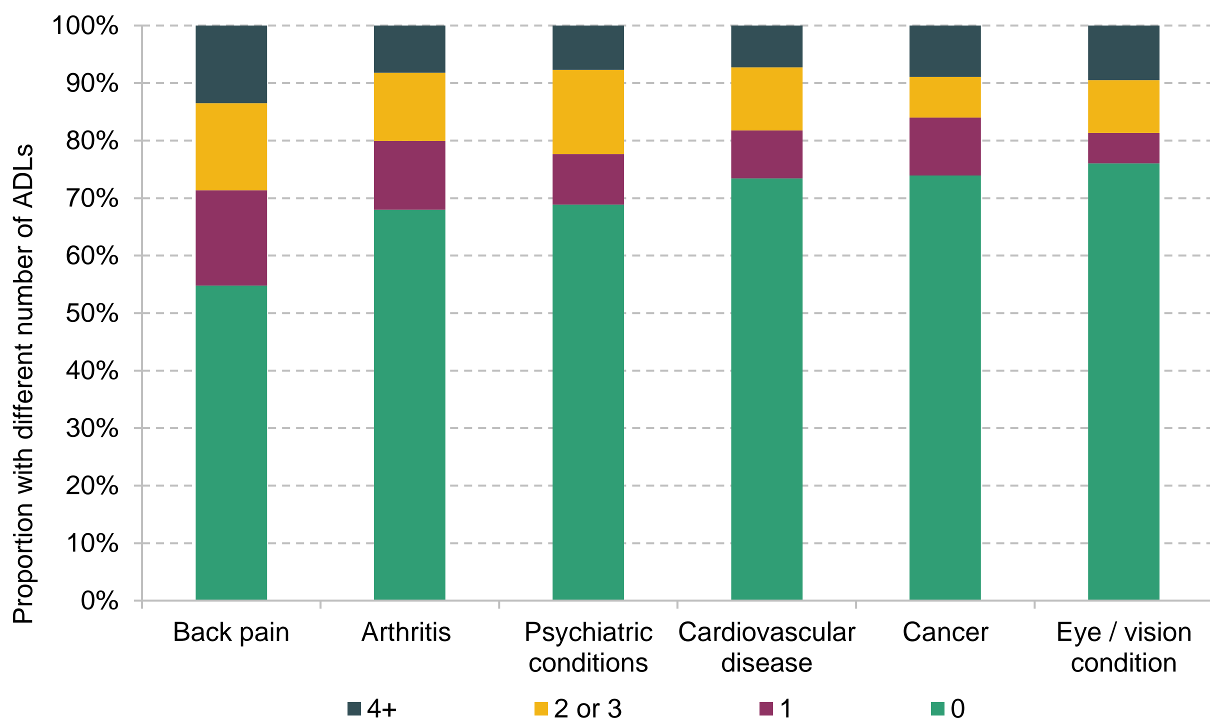
[2] https://assets.publishing.service.gov.uk/media/5a7abb8640f0b66a2fc026aa/dla-reform-consultation.pdf

us to compare the diagnosed conditions people report, to Activities of Daily Living (ADLs) that they report struggling with. The ADLs are closely associated with the categories of function that form the PIP test, such as determining whether the person has difficulties with bathing, preparing a meal, and using the toilet. However, unlike the PIP test, the ADLs are a simple yes / no indicator and do not take into account the level of difficulty the individual faces.

Figure 1 shows the number of ADLs among the ELSA sample of those aged 50 to 64 with different self-reported diagnoses of health conditions. It is clear that among each of these conditions, there is a large degree of variation in the level of functional limitations that people face. This analysis suggests that under an approach where PIP entitlement is purely based upon health condition, PIP might not be very closely targeted to those with the most functional limitations.

**Figure 1. Number of ADLs among ELSA respondents aged 50 to 64**




Source: Authors' calculations using ELSA wave 9.

Of course, some of the conditions in Figure 1 are quite broad (especially psychiatric conditions), and basing entitlement on a more precise diagnosis of conditions might enable the government to target PIP to those whose conditions more strongly limit functionality. But this approach presents another challenge, as the more granular the definition of a condition, the more difficult it will be to map it to functionality, due to limited data on how these finer distinctions affect individuals' daily lives. For example, if PIP entitlement was to vary with degree of arthritis, ideally one would have detailed data on how each degree impacts daily living – but this may not be readily available.

In addition, even among those with exactly the same condition, the impact on daily living is likely to vary due to non-health factors. As an illustration, we examined ELSA respondents aged 50-64 who have arthritis and none of the other health conditions shown in Figure 1. Those in the top wealth quintile were 20 percentage points less likely to have any ADLs than those in the bottom quintile. Among those with some ADLs, the number of ADLs among those in the top wealth quintile was also on average 1.3 less than among those in the bottom wealth quintile. This shows how individual's wider circumstances will affect the mapping between conditions and functionality, which a purely condition-based approach would be unable to take into account.

How might a shift to a condition-based approach affect the number of claimants to PIP? Naturally this would be dependent upon which conditions were included as generating PIP eligibility. It is possible that if entitlement is automatically linked to specific conditions, individuals whose conditions do not significantly affect their daily lives might qualify, increasing the number of claimants and the associated costs among that group. Focusing the test on conditions would also create incentives for people with disabilities to seek specific diagnoses to help benefit claims. This means that current estimates of the prevalence of conditions might not be a perfect guide to the number of people that would end up on PIP under a condition-based approach.

In summary, while a condition-based assessment could simplify the process and ensure timely support for individuals with clear diagnoses, it also presents significant challenges. The mapping of conditions to functionality is complex and varies between individuals, influenced by factors such as age, socio-economic status, and the severity of the condition.

***Q16. What are your views on changing the length of the current three-month qualifying period for PIP which is used to establish that the functional effects of a health condition or impairment have been present for a certain time period before entitlement can start?***

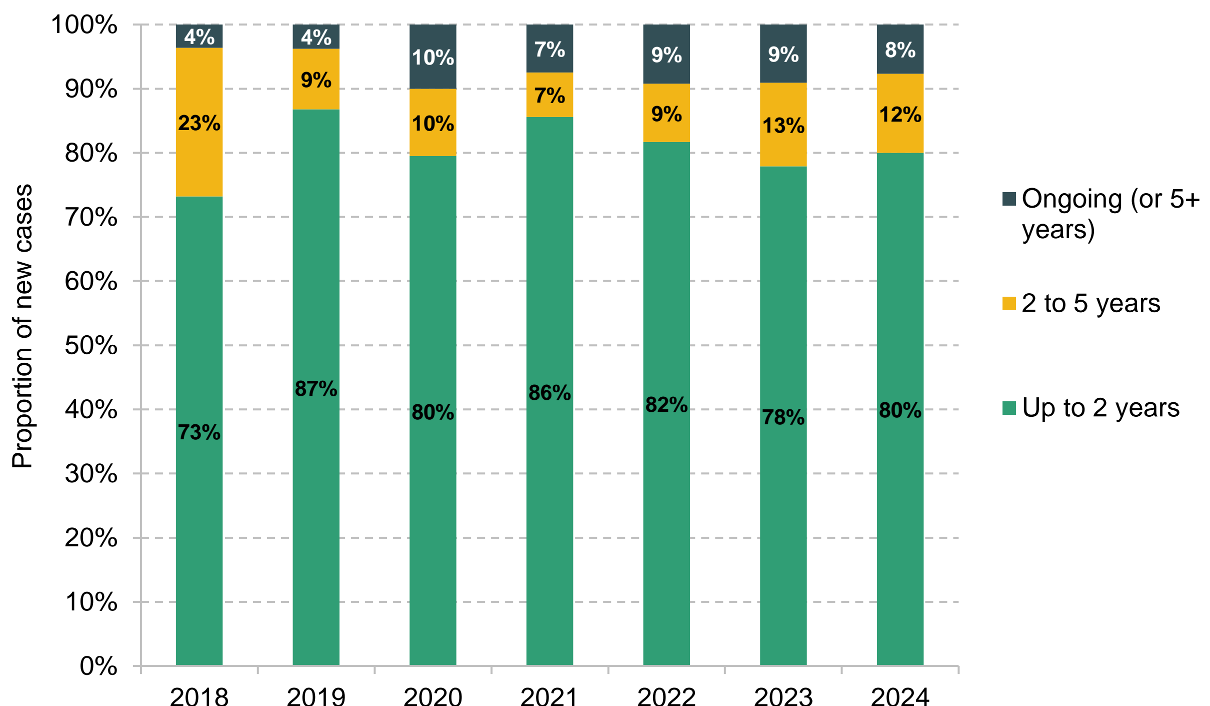
The current three-month qualifying period for PIP serves as a mechanism to ensure that the functional effects of a health condition are likely to be long-term before PIP is awarded.

For many individuals, particularly those experiencing a sudden onset of a disability, the three-month waiting period can already be a considerable duration to live without the additional support. Extending this period could exacerbate the challenges that those with a rapid onset of disabilities face. However, delays can also serve as a device to target support on the neediest, whose conditions are likely to last for longer. This presents a difficult trade-off when setting the qualifying period.

One way to deal with the difficulty of knowing whether a condition is long-lasting would be to give shorter awards with more frequent reassessments. However, this could put pressure on the limited capacity of the reassessment system. In fact, Figure 2 shows that already around 80% of new PIP awards (under normal rules) are awarded for the relatively short period of up to 2 years.

Looking at Figure 2 in more detail, we can also see that there has been little change in the number of people getting a short award over time. This suggests that the recent rise in conditions has not been driven by those with short awards. (While Figure 2 shows this across all conditions, the same is also true when focusing on psychiatric conditions only).

**Figure 2. Award length of new awarded PIP claims (new claims only, those below state pension age, normal rules only)**




Source: Authors' calculations using Stat-Xplore.

***Q20. What are the benefits and disadvantages of moving to a new system for PIP claimants? A catalogue/ shop scheme. Please explain your answer and provide evidence or your opinion to support further development of our approach.***

***(Same response applies to Q21 for voucher, and Q22 for receipts-based systems)***

A catalogue, voucher, or receipt-based system could help target help towards those who face higher costs due to disability that are tangible and easily identifiable. In particular, if there are specific items and services that those with higher living costs due to disability are much more likely to need, then using these approaches would help target support towards them, and away from those whose health does not generate higher living costs in the same way.

However, with a catalogue, voucher, or a receipt-based system, there is a central trade-off between making the list of allowed expenditures more comprehensive, or making it more restricted. If the list of allowed expenditures is too broad, the vouchers effectively become a cash transfer as people can use it for most of the types of activities they would have used it on anyway.

On the other hand, if the list of approved activities and costs is too narrow, this will prevent individuals from spending money on things that might most effectively improve their quality of life. For example, reimbursing taxi fares but not rent could force individuals into spending on transport when they might prefer better housing conditions, ultimately making them worse off. It may also be difficult for disabled households to illustrate that certain types of spending are due to a disability – for example mobility issues restricting movement may increase the need for an individual to heat their home, but it can be difficult to tell this apart from general heating costs that all households face.

If the government wants to move towards a system such as a voucher, catalogue or receipt based system, there may be a compelling case for treating one-off costs and ongoing costs through different systems. For example, providing one-off support for home adaptations such as installing rails via vouchers, receipts-based support or a catalogues could be more easily implemented as those costs can be easily verified and linked to specific conditions and functional limitations. In fact, this type of system would have the potential to much more effectively provide support for those who have large one-off costs, who may not benefit as much from the smaller periodic PIP payments.

***Q26. Are there specific groups of people whose needs are not being met by the current PIP provision and have a need for a greater level of support? What form should this support take (eg. help with specific extra costs, access to improved healthcare such as mental health provision or enhanced local authority support such as care packages and respite)?***

PIP currently provides disabled individuals with cash transfers to compensate them for the higher costs arising from their disability. Despite this cash support, previous IFS research[3] shows that disabled individuals, and those receiving PIP (or DLA) have higher rates of poverty and material deprivation (a measure of whether a household is able to afford a number of basic items and activities) than other working-age households.

We can see a strong link between material deprivation and disability in Figure 3, which shows the percentage of people in different parts of the material deprivation distribution with no disability, with a disability but not receiving disability benefits, and with a disability who are receiving disability benefits. The figure shows that among the least materially deprived 60% of our sample, only 12% reported a disability in 2019–20, whereas in the most materially deprived tenth, more than four in ten (44%) are disabled. This shows that disability, as well as PIP receipt, is strongly related to material deprivation.

Another critical point to draw from Figure 3 is also that there are a large number of materially deprived people who report being disabled but do not receive a disability benefit. Nearly a third of the most deprived tenth of the working-age population are in this category, equivalent to around a million people.

Some of the link between material deprivation and disability may be explained by the fact that disabled people have on average lower incomes than the rest of the working age population (for example due to the fact that a disability may affect ability to do paid work). However, studies have also shown that even for a given level of income, disabled people have higher levels of material deprivation (see e.g. Schuelke, Munford and Morciano, 2022[4]). This could be because disabled people have higher underlying costs associated with living with a disability. Alternatively, it could be because those with disabilities receive less income over their lifetime. This means that they have lower assets and expected future income than otherwise similar non-disabled individuals – meaning they cannot afford as high a standard of living. It is likely that all of these factors play a role in explaining the high rates of material deprivation among disabled people.

As a result, it is important for the government to consider impacts that any disability benefit system reform will have on low-income disabled households.

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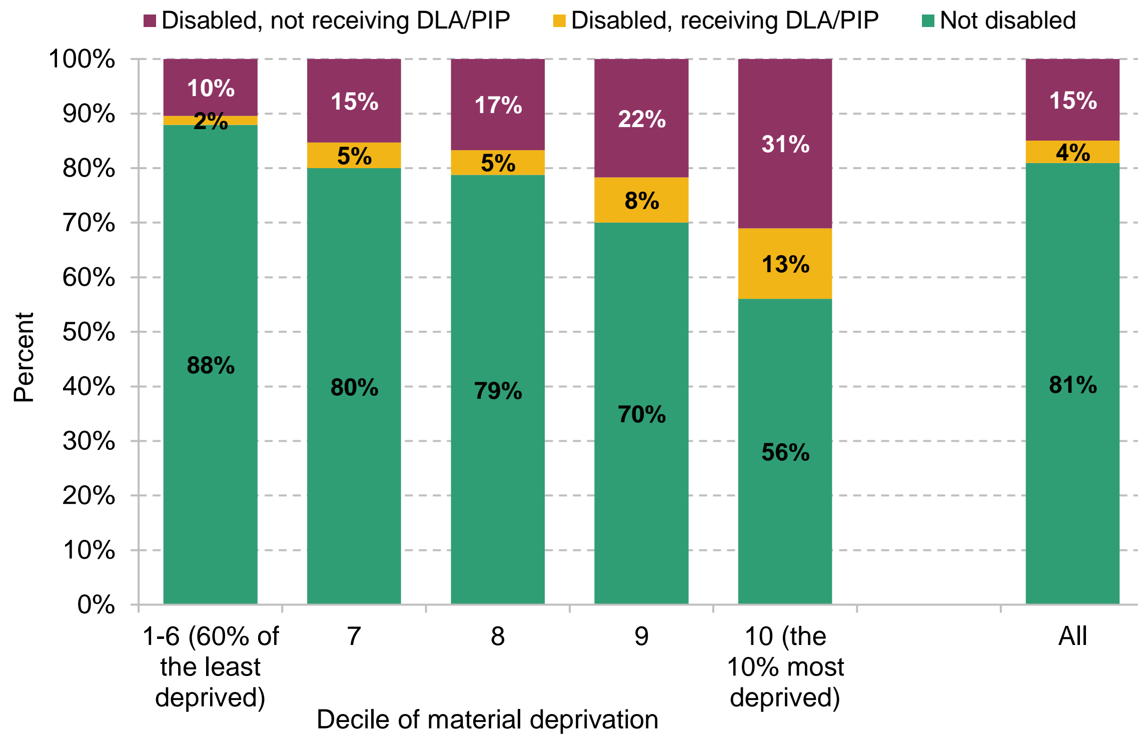
[3] Cribb, Karjalainen and Waters, 2022 (https://ifs.org.uk/publications/living-standards-working-age-disability-benefits-recipients-uk)

[4] https://link.springer.com/article/10.1007/s10198-021-01366-1

**Figure 3. Disability status, by material deprivation score in 2019–20**




Source: Modified from Cribb, Karjalainen and Waters, 2022.