

# Modernising support for independent living: the health and disability green paper

Submission by Professor Paul Spicker

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## The objectives of the consultation

This consultation is profoundly misconceived.

*The main social security benefits for people with disabilities are misunderstood.*

Social security benefits for disability have been used to meet many objectives. Those objectives include supplementing long-term low income (e.g. DLA); social insurance (Invalidity Benefit); support for carers (Carers Allowance); support for special needs (Mobility Allowance); support while out of work (ESA); compensation for injury (IIB); compensation for severe disability (Severe Disablement Allowance); support for independent living (Independent Living Foundation); promoting employment (Manpower Services Commission); rewarding desert (War Disablement Pensions), extra costs (Exceptional Needs Payments and Exceptional Circumstances Additions) and paying for social care (Supplementary Benefit before the Griffiths reforms).

Benefits can have several of these objectives all at once, but the primary purpose of Attendance Allowance, Disability Living Allowance and now PIP has always been the first: to raise persistently low income. That was explained in Parliament by Alf Morris, the first Minister for the Disabled: the aim was “improving the financial status, and therefore the dignity, of every one of our severely disabled fellow citizens”. That is why those benefits were to be assessed on the basis of the severity of the disability, and why they are not means tested.

*Personal Independence Payment is not designed to meet extra costs.*

There have been benefits which assess extra costs. PIP is not one of these benefits, and never has been. Nor were its predecessors: Disability Living Allowance, Attendance Allowance or Mobility Allowance. That is why none of these benefits made any assessment of extra costs.

There have been other benefits which were designed to meet extra costs. For example, two ‘extra costs’ benefits attached to Supplementary Benefit and Income Support: these took the form of “Exceptional Circumstances Additions” and “Exceptional Needs Payments” when they were part of Supplementary Benefit, and became ‘premiums’ when Income Support was introduced. ECAs were paid for recurring weekly expenses, ENPs for one-off needs.

Those purposes were subsequently met through the community care elements of what was the Social Fund, which in England have been transferred to local authorities and in Scotland are now part of the Scottish Welfare Fund.

*Personal Independence Payment does not and cannot duplicate the work of the social care services.*

The consultation document refers to tailored support for individual needs, joining up local services; and reviewing non-monetary options for support. These are the objectives of the social care system. They are totally inappropriate for a scheme intended to provide a stable income for millions of people.

It follows from these three points that the questions asked in chapters 2, 3 and 4 are inappropriate to any review of PIP. Chapter 2 is mainly concerned with tuning benefits to meet extra costs. Chapter 3 and 4 are concerned with individualised responses to community care needs, and the provision of social care services. These are the focus of the system of social care.

The assumptions embodied in the consultation questions are so ill-matched to the problems under review that the consultation cannot achieve its purpose. The Green Paper should be withdrawn and reconsidered.

### **The process of assessment**

Chapter 1 is mainly concerned with the process of assessment. The current system tries to assess the functional impact of conditions on everyone individually. The points system cannot adequately incorporate considered medical evidence. It cannot cope with the volume of applications. It is error prone, leading to huge numbers of appeals – most of which are successful.

According to the National Audit Office, the DWP had initially intended 75% of all claimants to undergo face to face assessments for PIP, but the actual rate has been 98%. Although repeated checks on people with long-term conditions have been acknowledged to be pointless, most of the assessments that remain are little better. They either confirm the obvious or they duplicate information that is already held.

Some assessments are necessary: many people with disabilities cannot say whether they are disabled or not, and have no idea whether or not their disability fits the criteria for benefits. Any general rule, no matter how sensitively it is administered, is going to have to deal with some grey areas. However, the administrative burden, and the effectiveness of the assessments, can be eased substantially, once a simple principle has been recognised: the same approach does not have to apply to everyone.

First, it is possible to identify certain conditions which should imply automatic entitlement, offering benefits on minimal or secondary evidence – either accepting on sight that the

person has a qualifying disability (double amputation, severe disfigurement) or passporting benefits on the basis of provision by other agencies (congenital disability, blindness).

Second, there are conditions which will have led to prolonged long term contact with health services, and certification from a consultant is sufficient to establish that the condition is there without requiring further detailed examination of personal circumstances. Examples are terminal illness, multiple sclerosis, MND, malignant neoplasms or brittle bones.

Third, there are conditions where existing services in long-term contact with the individual are far better placed to judge the impact of a condition than an independent assessor could be, and it would be appropriate to accept medical certification. Examples are continued psychosis, epilepsy, dementia and learning disability.

Only after these three categories are considered is it appropriate to think in terms of further individual assessment. The points scheme currently used in a range of benefits was initially developed from work by the Office of Population Censuses and Surveys to establish the range and severity of disabilities in the UK. That research validated the approach through a range of tests, but it pointed to an important conclusion: that once the primary disabilities had been identified, it was very rare for further disabilities to make any notable difference to the findings, and that information served no useful purpose. It follows that it is neither appropriate nor necessary to ask most claimants, for example, whether they can go to the toilet unaided. The assessment process should begin by asking people to identify their most important disabilities, ask questions only about those, and go further only in marginal or complex circumstances.

Finally, there will be a residual category of people who are not adequately dealt with by any of the four stages above, and who will require or ask for a more thorough comprehensive assessment. This category should be small.

*Paul Spicker is Emeritus Professor of Public Policy at the Robert Gordon University. His books on social security include Poverty and social security (Routledge, 1993), How social security works (Policy Press, 2011) and What's wrong with social security benefits? (Policy Press, 2017). This submission is written in an individual capacity.*