

Office for
**Budget
Responsibility**

Welfare trends report

January 2019



Office for Budget Responsibility: Welfare trends report

Presented to Parliament by
the Exchequer Secretary to the Treasury by
Command of Her Majesty

January 2019



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Foreword

The Office for Budget Responsibility (OBR) was created in 2010 to provide independent and authoritative analysis of the UK's public finances. In December 2013, the Government asked the OBR to take on additional responsibilities in relation to its newly announced cap on a subset of welfare spending. This request was in two parts: to assess the Government's performance against the welfare cap and to "*prepare and publish information on the trends in and drivers of welfare spending within the cap*", so as to facilitate open and constructive debate. Parliament formally included these requirements in the October 2015 edition of the *Charter for Budget Responsibility*.

In our first *Welfare trends report (WTR)*, we presented a broad survey of historical trends and our latest judgements on the prospects for benefits and tax credits spending. Our second considered the UK's public spending on social protection – a broader definition of welfare spending – in an international context. Our third looked at how policy changes affected welfare spending over the 2010 to 2015 and the then-planned 2015 to 2020 Parliaments relative to a counterfactual in which spending increased in line with demographics, state pension age changes and pre-existing uprating policy. It included a particular focus on disability and incapacity benefits. Our fourth provided transparency around the complex and uncertain effects of universal credit on welfare spending.

This year's report again focuses on disability benefits – payments that contribute to the extra costs associated with daily living and mobility for people with disabling conditions. It has two purposes. First, to explain the evolution of spending on disability benefits over the past fifty years, with more emphasis on recent years. In particular, we look at trends in spending on working-age adults, where the system has been undergoing major reform as disability living allowance (DLA) is replaced by personal independence payment (PIP). Second, it evaluates the effects of PIP on the public finances, which have differed significantly from those envisaged at the inception of the reform, leading to systematic under-forecasting of PIP and working-age DLA spending since the former was introduced in 2013. Looking back at why our forecasts proved inaccurate enables us to reduce the chances of making similar errors in the future. By documenting our findings, and placing them in the public domain, we also ensure future policymakers and forecasters can draw upon them.

Reflecting the remit given to us by Parliament, our focus here is on the implications of these benefits for the public finances, not on their distributional impact, the efficiency of their delivery, their value for money or their contribution to government policy objectives, important though these are.

The analysis in this report represents the collective view of the OBR's Budget Responsibility Committee. We take full responsibility for the judgements that underpin it and for the conclusions we have reached. We have, of course, been supported in this by the full-time staff of the OBR, to whom we are enormously grateful. As we note in the report, we have not been able to draw upon all the information we would have liked to in preparing it, but no information has been withheld and we

Foreword

are grateful to the small number of officials in the Department of Work and Pensions that have fielded our requests and have provided their help and expertise.

We are also grateful to external stakeholders who gave their time and shared their expertise. In particular, we would like to thank Ben Baumberg Geiger at the University of Kent and Professor Roy Sainsbury at the University of York.

As with all our reports, the WTR remains a work-in-progress. We have refined and modified our other reports in response to feedback from users and we would be very keen to hear suggestions on the scope and format of this report.

We provided the Chancellor with a final copy of the report 24 hours in advance of publication.



Robert Chote



Sir Charles Bean



Andy King

The Budget Responsibility Committee

Executive summary

Introduction and overview

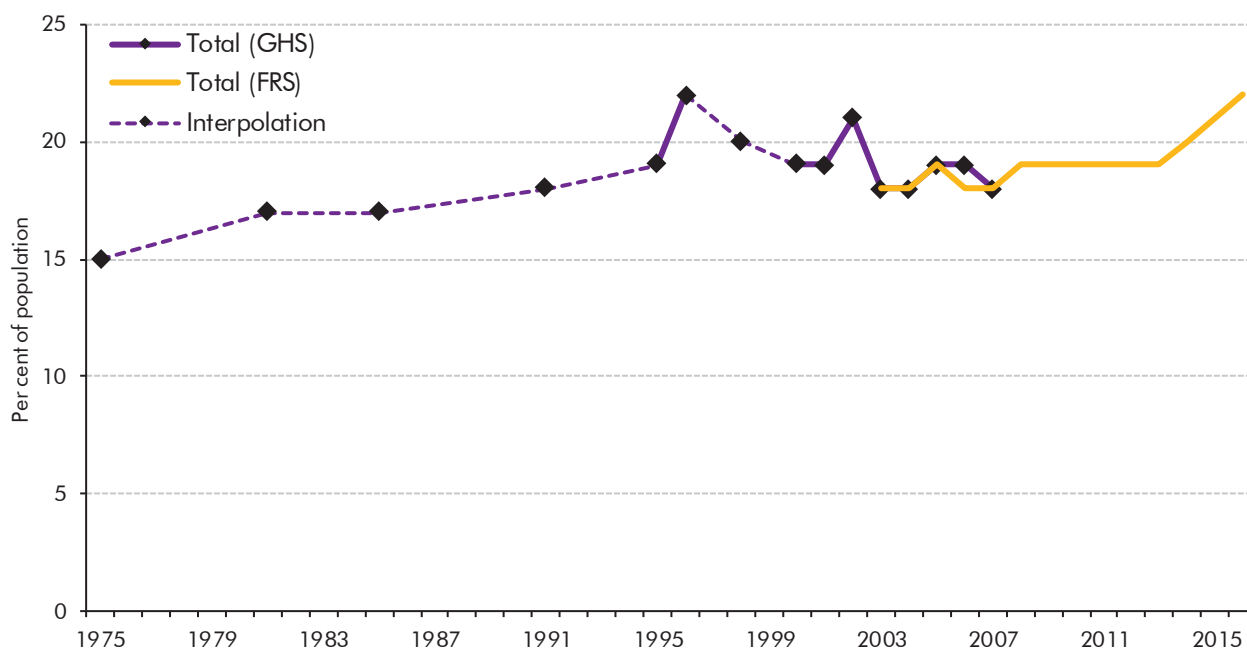
- 1 One of the main functions of the welfare system is to support people having difficulty supporting themselves due to ill health or disability. This role stretches back more than a century – at least as far as the National Insurance Act of 1911. The financial support provided by today’s welfare system can be split into those benefits that cushion the incomes of people unable to work for health reasons – principally employment and support allowance (ESA) and, in the future, universal credit (UC) – and those that help to meet extra costs associated with disability – disability living allowance (DLA), personal independence payment (PIP) and attendance allowance (AA). This ‘extra-costs’ disability benefits system cost £23.6 billion in 2017-18 and is expected to cost £30.5 billion in 2023-24. Its evolution and the effects of reforms to it on public spending are the focus of this report.
- 2 Survey-based measures of disability prevalence have been increasing gently in recent decades, with mental health problems in particular reported to affect a growing proportion of children and working-age adults. But spending on disability benefits has risen faster, thanks to a more rapidly rising share of the population in receipt of them. In large part, this reflects policy decisions to support a higher proportion of disabled people with the extra costs associated with their disability, first with the introduction of such benefits in the 1970s, then via the deliberate expansion of their coverage in the 1990s. Growth in disability benefits spending has continued in recent years, despite attempts to cut spending on working-age adults significantly through the replacement of DLA with PIP. The Government assumed initially that PIP would be rolled out by 2015-16 and that it would cost 20 per cent less than DLA would have done. In fact, by 2017-18 it was costing around 15 to 20 per cent more, with rollout only around two-thirds complete.

The prevalence of disability in the population

- 3 Two concepts are relevant when considering the population that might be eligible for support from the disability benefits system: physical and mental ‘impairments’ – the medical conditions that people have; and ‘disability’ – the effect of those impairments on people’s ability to enjoy the same quality of life as the rest of society. The disability benefits system focuses on the latter which is subjective in the sense of being affected by society’s views of the quality of life it should support and the environment within which people live and work.
- 4 The primary measure of disability prevalence in the UK at present comes from the *Family Resources Survey (FRS)*. It asks survey respondents whether they have a longstanding illness, disability or impairment that causes substantial difficulty with day-to-day activities. The FRS data on disability only extends back to 2003. Prior to that, the primary measure came from

the *General Household Survey (GHS)*, which covered Great Britain.¹ Chart 1 uses these two sources to illustrate the gently rising trend in the reported prevalence of disability among the population over the past 50 years. Given this pattern, all else equal we might therefore expect the cost of providing disability benefits also to have risen modestly over time. But in fact it has risen relatively rapidly.

Chart 1: Reported disability prevalence in the UK



Source: DWP, ONS, OBR

Historical trends in disability benefits spending

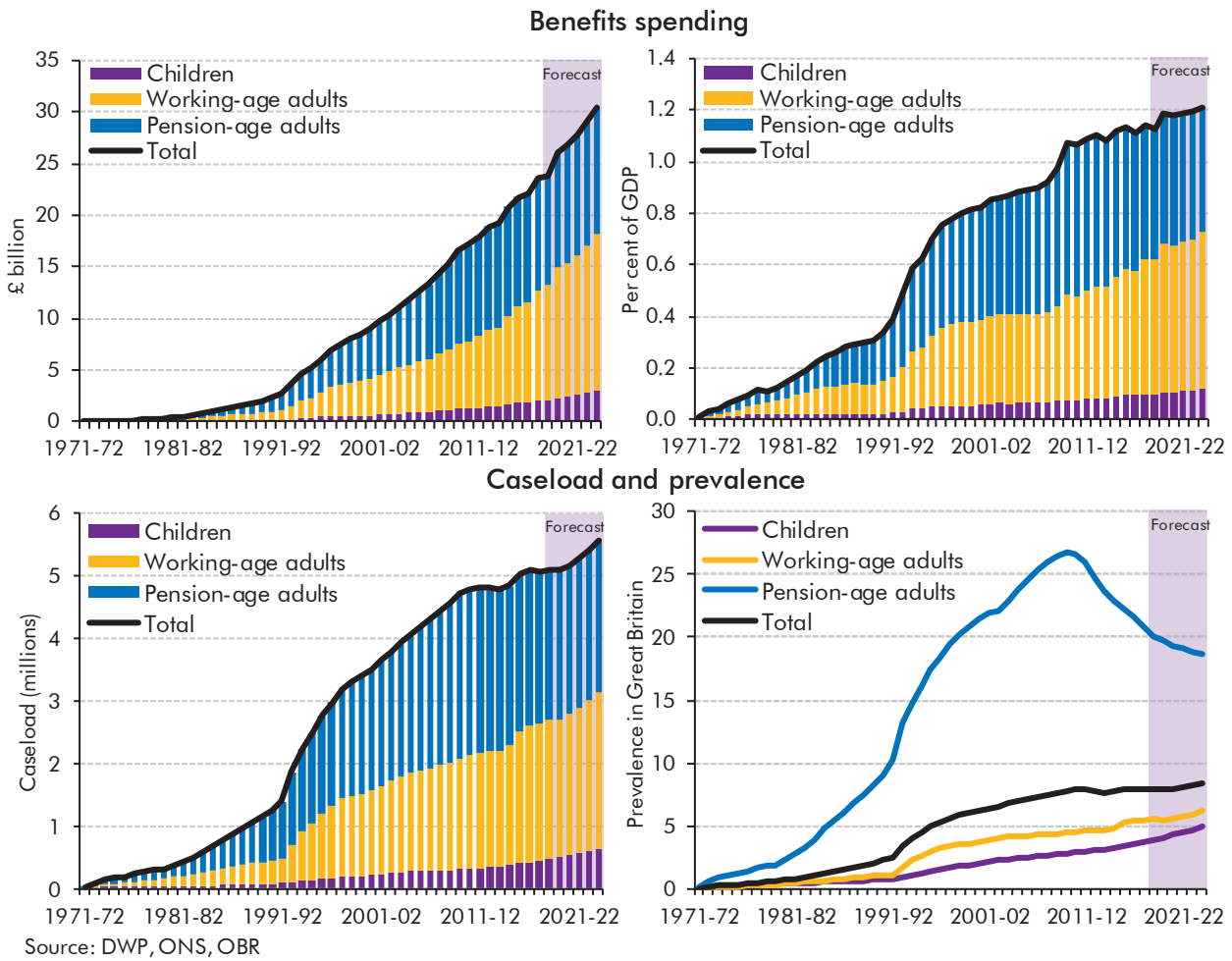
- 5 Attendance allowance (AA) was introduced in 1971 and mobility allowance in 1976, so spending on the 'extra costs' disability benefits system was first incurred in 1971-72. Over the next two decades, the cost of these benefits increased steadily as a greater share of the population received them. In part this simply reflected a rise in the caseload to its steady state, reflecting the fact that this is a benefit that on average people claim for many years. But it also reflected policy decisions to expand eligibility – for example, the extension of AA at a lower rate in 1973.
- 6 In 1992 the system underwent its first major reform with the introduction of disability living allowance (DLA) for children and working-age adults. One objective was to extend eligibility to people with less severe disabilities, so spending was expected to rise further as result. But in the event, it rose by considerably more than originally expected. Initially this appears to have reflected an underestimate of the rise in the caseload from moving to a primarily self-assessed system for claiming. Over the two decades that DLA was the principal disability benefit for working-age adults, it also reflected the lengthening average duration of benefit receipt across

¹ In the absence of UK disability prevalence data prior to 2003, we assume that the GB prevalence rates recorded in the GHS are a good approximation for UK prevalence rates over the period in which the survey was in operation.

the caseload, including continuing claims among pension-age adults, and policy changes that further expanded eligibility modestly.

- 7 In 2010 the next major reform to the system was announced, with the introduction of what was billed as “*an objective medical assessment*” for new and existing working-age claims, which was intended to reduce the caseload by 20 per cent over three years. DLA began to be replaced by personal independence payment (PIP) in 2013. Far from significantly reducing spending as planned, the introduction of PIP appears to have raised it – for reasons set out below.
- 8 Chart 2 shows the consequences of these developments for disability benefits spending and caseloads, both in absolute terms and relative to GDP and the size of the population respectively:
- **From 1971-72 to 1991-92**, disability benefits spending increased gently to reach £2.8 billion (0.4 per cent of GDP) in 1991-92, the year before DLA was introduced. As of 1991-92, 57 per cent of spending was on pension-age adults, 36 per cent on working-age adults and just 7 per cent on children. The prevalence of disability benefit receipt increased for all age groups, but particularly so among pensioners.
 - **From 1992-93 to 2012-13**, spending increased rapidly in the wake of the 1992 DLA reforms. In cash terms, spending rose five-fold. Relative to GDP, it doubled in the first five years, more-than doubling again by the end of this period (the step up towards the end merely reflects the sharp fall in GDP following the financial crisis). The caseload continued to rise as a share of the population and across all age groups.
 - **From 2013-14 to 2017-18**, following the introduction of PIP for working-age adults, cash spending has continued to rise steadily, but it has remained around 1.1 per cent of GDP. The caseload has also been reasonably stable as a share of the population, as declining prevalence among pension-age adults has been offset by rising prevalence among children and working-age adults. Indeed, the latter accounted for the largest share of spending in 2017-18 – for the first time since 1980-81. As discussed below, we expect spending to continue rising in cash terms and versus GDP.

Chart 2: Disability benefits spending and caseload



Prospects for disability benefits spending

- 9 Cash spending on DLA, PIP and AA combined is expected to rise by 29 per cent between 2017-18 and 2023-24 to reach £30.5 billion. This is slightly faster than growth in nominal GDP, so that spending rises by 0.1 per cent of GDP over the forecast period. With the exception of a small step up in 2019-20, this steady rise in spending relative to GDP would continue the trend observed between 2010-11 and 2017-18.
- 10 As regards spending by age group, expenditure is expected to rise fastest among children (by 53 per cent between 2017-18 and 2023-24), then working-age adults (by 41 per cent), with spending on pension-age adults rising more slowly (by 13 per cent). These trends largely reflect our assumption that recent increases in the prevalence of disability benefits receipt among children and working-age adults will continue.
- 11 The caseload across the three benefits is expected to rise by 9.7 per cent between 2017-18 and 2023-24. This takes the prevalence of benefit receipt up from 7.9 to 8.4 per cent of the population. By age, over this period we expect:

- the proportion of **children receiving DLA** to rise from 3.7 to 5.0 per cent – i.e. prevalence to rise by a third in six years, a somewhat faster rise than over the preceding six years;
- the proportion of **working-age adults receiving DLA or PIP** to rise from 5.4 to 6.2 per cent – continuing the pace of increase observed in the preceding six years;
- the proportion of **pension-age adults receiving DLA or PIP** to fall from 8.5 to 6.7 per cent – a faster pace of decline than observed over the preceding six years; and
- the proportion of **pension-age adults receiving AA** to fall from 12.3 to 12.0 per cent.

12 Changes in the composition of the caseload by rate mean that average AA and DLA awards rise by 3.0 and 0.1 per cent above inflation uprating, respectively. But real average PIP awards fall by 1.3 per cent. By age group, real average awards increase for working- and pension-age adults – by 9.9 and 6.0 per cent respectively – while child average awards fall by 2.1 per cent. The large increases for working- and pension-age claimants are partly driven by the shift towards PIP, where average awards are significantly higher than for DLA.

Risks and uncertainties

13 Our disability benefits forecasts are subject to a range of risks and uncertainties that can affect both the prevalence of benefit receipt and average awards. Our caseload forecasts assume that the upward trend in the prevalence of child and working-age claims and receipt will continue over the medium term. Our average awards forecast is determined by the proportion of claimants in each award group. For new claims, we assume that these proportions stabilise following the end of the PIP rollout. All else equal, a 10 per cent increase in either prevalence or average awards relative to our central forecast would increase spending by 10 per cent (e.g. from £15.2 billion to £16.8 billion in 2023-24).

14 The main sources of risk to our forecast include:

- **Legal challenges** have redefined the boundaries of eligibility and policy reform itself has created the space for legal challenges to new sets of rules. There is clearly a risk that future challenges to the Government's interpretation of benefits legislation could expand coverage of the system further.
- The **average duration of awards** under the PIP system is highly uncertain as we have no information on claims that are more than six years old. The effect of a higher number of fixed duration awards and more frequent reviews is not known at longer durations, and cannot necessarily be inferred from the shorter-term data.
- Average awards depend on the **composition of the caseload**, and how this changes as people join and leave it. The relationship between the composition of exits and average awards is not currently modelled explicitly, and, even if it was, would be particularly uncertain for longer durations where there are no outturn data.

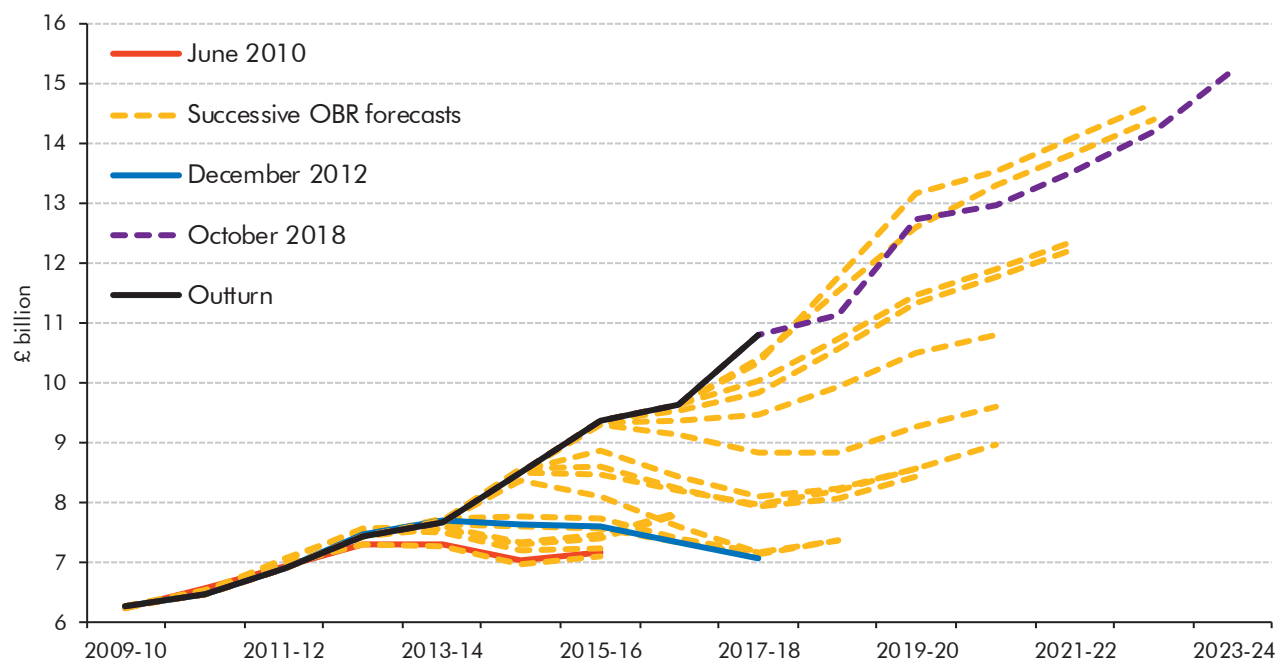
- Changes in **operational performance** can affect claims, awards, outflows and benefit amounts. The associated risks include those affecting underlying spending, for example where operational pressures lead to more generous decisions on awards than would otherwise have been the case, and timing effects, if arrears build up that move spending between years. A key operational risk relates to whether there are sufficient healthcare professionals available to providers, which is particularly pertinent given the significant increase in capacity required to complete the rollout of PIP.

The transition from DLA to PIP

Development of PIP and the putative savings

- 15 Reform to DLA for working-age adults was announced in June 2010 and PIP was introduced in April 2013. The original announcement stated that it would *“ensure support is targeted on those with the highest medical need. The Government will introduce the use of objective medical assessments for all DLA claimants from 2013-14 to ensure payments are only made for as long as a claimant needs them.”* This was assumed to reduce the caseload and spending by 20 per cent once fully rolled out, saving £1.4 billion a year by 2015-16.
- 16 Policy development progressed over the following two years, culminating in the Welfare Reform Act 2012. The main structural difference between PIP and DLA was the absence of a lower rate in the care (renamed ‘daily living’) component. Otherwise the focus was on the more transparent and objective assessment, and greater use of fixed-term awards. Greater recognition of certain types of condition, including fluctuating conditions, was also new.
- 17 Spending on PIP and DLA for working-age adults has been one of the biggest sources of difference between our welfare spending forecasts and outturns. Chart 3 shows successive forecasts of spending on these benefits. Since the introduction of PIP, every outturn has exceeded the corresponding forecasts, often by large amounts. The savings anticipated in June 2010 were revised up substantially in December 2012, although pushed back as the migration of existing DLA claimants was delayed. But these have not been realised. Indeed, PIP appears to cost more than a continuation of DLA would have done.

Chart 3: Successive OBR working-age disability benefits forecasts since 2010



Source: DWP, OBR

- 18 Our December 2012 forecast doubled the expected savings, from moving to PIP to £2.9 billion a year by 2017-18 (the final year of that forecast). This followed tests of the draft assessment criteria with a sample of 900 people who were claiming, or had previously claimed, DLA. This test was not designed with analytical use in mind, but it was virtually the only evidence available to underpin the December 2012 estimated saving. After allowing for mandatory reconsiderations and appeals, the sample results suggested that the overall effect of PIP relative to DLA would be to reduce the working-age caseload by 28 per cent (600,000 claimants) by May 2018 and spending by £2.8 billion.² The success rate for new claims to PIP was expected to be 35 per cent after reconsiderations and appeals (considerably lower than for DLA), with 74 per cent of claimants remaining eligible when their claims were reassessed as part of the migration of existing cases from DLA to PIP.
- 19 At the time of its use in our December 2012 forecast, the results from the 900-person sample appeared the best available guide to the assessment process. But hindsight has revealed several issues with the nature and use of the results, including: the voluntary nature of participation; the hypothetical nature of the assessment; subsequent changes to assessment criteria; and a sample that was unlikely to be representative of new PIP claims. It is now clear that the results were biased rather than merely uncertain.
- 20 PIP assessments were contracted to two outsourced providers, following the model used for employment and support allowance (ESA) work capability assessments. PIP significantly increased the medical assessment capacity required by DWP, at a time when problems were already apparent in the ESA contract. PIP added a further 60,000 assessments a month on top of the 110,000 being undertaken for ESA, but at the height of managed migration 95,000

² The savings are marginally lower than those estimated for 2017-18 due to the interaction of managed migration, the reconsiderations and appeals processes, and the timing of cash payments.

assessments a month would need to be undertaken for PIP. In the event, these volumes have not been achieved and the reassessment of DLA cases continues.

PIP in practice

- 21 PIP was introduced for new claims between April and June 2013. The number of claims proved to be higher than for working-age DLA (which has remained the case) and providers struggled to keep pace with the demand for assessments. Outstanding claims jumped, peaking at 240,000 in July 2014, before being addressed by mid-2015. These delivery challenges meant that early PIP data provided little information on how spending was performing relative to the savings that were ultimately expected.
- 22 The rollout of 'natural migration' from DLA to PIP was delayed in most areas and eventually occurred from October 2013 to August 2015. Our December 2012 forecast assumed that managed migration would run from October 2015 to September 2017. A small amount of this was brought forward to July 2015 (under the 'controlled start'), but it is not now expected to be complete until 2020-21. The delays initially postponed anticipated savings, but more recent ones have had little effect as we no longer expect PIP to generate savings.
- 23 As information accrued on the application of PIP in practice, we repeatedly revised up our spending forecasts, sometimes significantly. This reflected:
 - **Volumes of new claims to PIP being higher than for DLA.** DLA claims had been falling prior to PIP introduction, so we did not expect an increase in claims. But they have continued to increase over the past five years.
 - **Success rates for new claims being higher than expected.** Success rates for 'normal rules' claims³ were initially between 50 and 60 per cent, but as administrative processes stabilised they fell less than expected, to around 45 per cent. That was substantially higher than the 35 per cent assumed in the December 2012 forecast on the basis of the results from the 900-person sample of DLA claimants.
 - **Reassessment volumes being lower than expected,** initially from fewer natural migrations, but later from the successive delays to managed migration. Since PIP was originally expected to cost less than DLA, this increased forecast spending.
 - **Success rates at reassessments being higher than expected.** Natural migration success rates averaged 78 per cent in 2015-16, after reconsiderations and appeals. They have since fallen to just below the 74 per cent assumed in December 2012 for all reassessments. For managed reassessments, they have settled at around 82 per cent.
 - **Outflows initially being lower than expected,** despite PIP having a higher proportion of short-term awards than DLA. Greater use of fixed-term awards may have discouraged

³ Claims that are not from terminally-ill people, almost all of which are awarded under the accelerated 'special rules' claim process.

claimants from reporting changes of condition, instead awaiting their next renewal date. Outflows caught up once award review outcomes started to come through.

- **Average awards being significantly higher than expected**, for both new claims (by around £10 a week) and reassessments (by around £14 a week).

- 24 There were few substantial changes to PIP policy following its introduction, other than those arising from legal challenges. Following substantial upward revisions to our forecast in November 2015 and March 2016, Budget 2016 announced a reduction in the number of assessment points awarded for needing to use an aid or appliance to carry out two of the 'daily living' activities. This was expected to reduce spending by £1.3 billion in 2020-21, but the proposed change was withdrawn five days after its announcement in the Budget.
- 25 As with DLA before it, interpretation of the PIP legislation has been subject to several legal challenges. The most significant of these increases our forecast by around £400 million a year in steady-state, but will also involve an exercise to identify eligible claimants and backdate benefit payments to the date of the original judgement.

The public spending impact of PIP

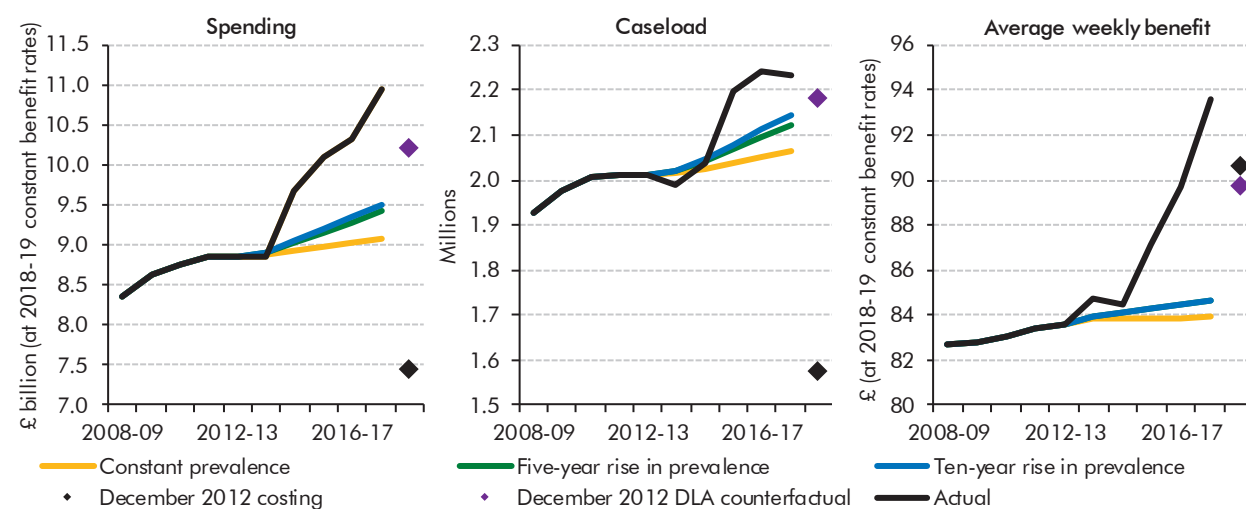
- 26 To gauge the effect of PIP's introduction on welfare spending – and to compare it with the savings assumed in the June 2010 Budget and in the December 2012 costing – we need to estimate what sticking with DLA would have cost. This is not straightforward, as it would depend on how the prevalence of DLA receipt would have evolved. Rather than making a single assumption, we look at three alternative scenarios and compare the cost of continuing DLA on that basis with the latest outturn data for 2017-18. We also compare the December 2012 costing assumptions for May 2018 with recently published outturns for that month. Under each scenario, far from generating significant savings, PIP has cost more than a continuation of DLA.

Alternative scenarios

- 27 We generate our three alternative scenarios for the cost of working-age disability benefits by controlling for changes in spending arising from demography and uprating statutory benefit rates, and projecting the cost forward using plausible assumptions regarding the prevalence of benefit receipt. The three prevalence scenarios are: constant at 2013 rates for DLA; rising in line with the trend from 2008 to 2013; and rising with the trend from 2003 to 2013.
- 28 These scenarios are shown in Chart 4. With the introduction of PIP, spending at 2018-19 benefit rates rose from £8.9 billion in 2012-13 to £10.9 billion in 2017-18. That is significantly higher than in all three of our alternative scenarios, by between £1.5 billion (16 per cent) and £1.9 billion (21 per cent). While the December 2012 costing, based on more detailed modelling, judged that DLA spending would have increased by more than any of these alternatives, outturn spending was still £1.4 billion (15 per cent) higher than assumed DLA spending.

- 29 Based on these comparisons, PIP appears to have increased spending on disability benefits significantly, by perhaps £1 to £2 billion a year as of now. That compares with intended savings of around £1.5 billion in 2015-16 when originally announced. Spending in 2018-19 is £4.2 billion higher than the annualised estimate of spending in May 2018 made in December 2012.
- 30 Rather than having been reduced by 600,000 (28 per cent) as assumed when PIP was fully costed, outturn caseloads are higher than in the alternative scenarios, by around 90,000 to 170,000 (4 to 8 per cent), and marginally higher than the DLA counterfactual estimated in December 2012.
- 31 Average awards explain most of the growth in spending we have seen between 2012-13 and 2017-18, rising by almost £10 a week (12 per cent) in 2018-19 benefit rate terms over those five years, and by a further £2 a week by May 2018. The alternative scenarios suggest the upward drift in average amounts, relative to uprating alone, would have been only around a tenth of that size. The December 2012 forecast included a substantial increase in amounts under the DLA counterfactual, by around £6 a week (7 per cent), and a further £1 (1 per cent) increase from reform, but the May 2018 outturn shows that average awards were around £5 a week (5 per cent) higher than that forecast.

Chart 4: Forecasts and projections of PIP and DLA spending



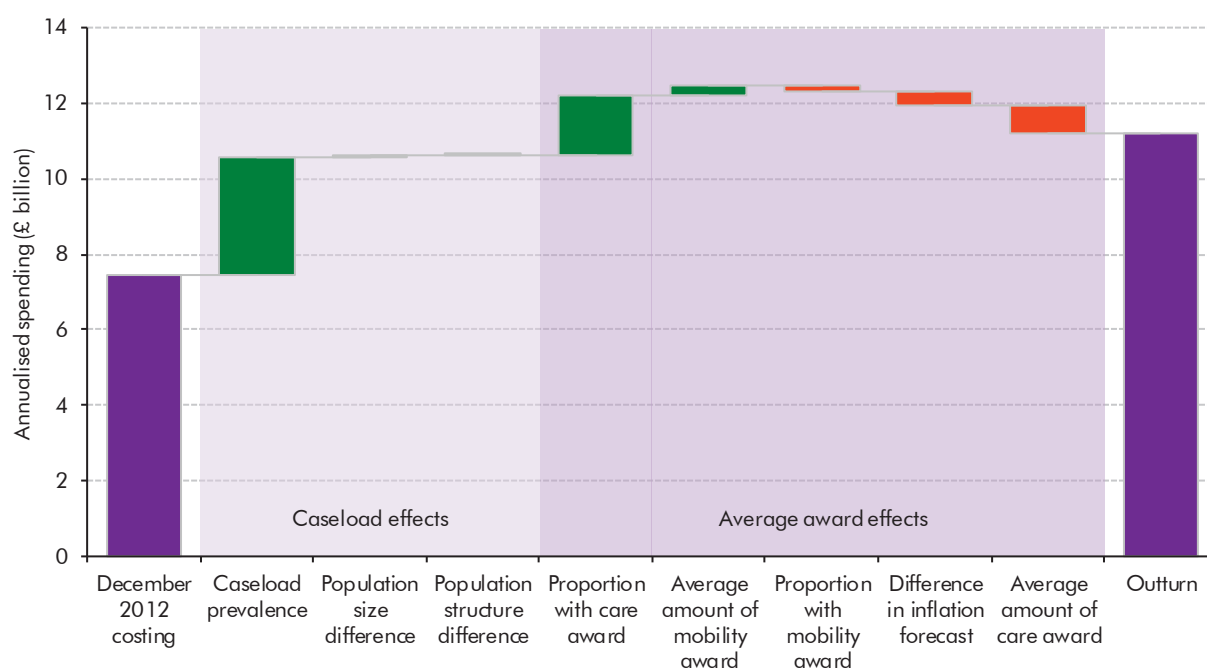
Source: DWP, OBR

Comparison with the December 2012 costing

- 32 The December 2012 PIP costing included detailed forecasts of the PIP caseload in May 2018, which can be compared to outturn data. (Although the December 2012 estimates assumed PIP would be fully rolled out to 16-64-year olds by May 2018, whereas in fact 665,000 claimants were still in receipt of DLA then.) Chart 5 decomposes the differences between the costing and the outturn for annualised spending in May 2018:

- **Caseload differences** account for around 85 per cent of the spending difference, almost all of which reflects unexpectedly high prevalence of benefit receipt. PIP was expected to reduce the caseload substantially. In fact it has risen.
- **Differences in average amounts** account for only 15 per cent of the spending difference. PIP was expected to result in slightly higher average amounts, for a much smaller caseload, but in the event average amounts were around £5 a week higher than assumed across a significantly larger caseload.

Chart 5: Sources of difference between December 2012 costing and outturn



Source: OBR

Conclusions and lessons learnt

- 33 The cost of the ‘extra costs’ disability benefits system has risen significantly over time, and both major reforms to the system – the introduction of DLA in 1992 and of PIP in 2013 – have ended up costing much more than expected. With DLA, that involved a deliberate expansion in coverage yielding a greater increase in the caseload and cost than had been predicted. With PIP, a reform intended to reduce spending has actually increased it. The Government assumed initially that PIP would be fully rolled out by 2015-16 and that it would cost 20 per cent less than DLA would have done. In fact, by 2017-18 it was costing around 15 to 20 per cent more, with rollout only around two-thirds complete.
- 34 Historical trends in spending and the experience of major reforms to the system yield several lessons for anyone trying to forecast the medium-term cost of PIP:
- Prevalence of disability benefit receipt varies considerably by age, so **changes in the size and age profile of the population are key drivers** of disability benefits spending.

- When a new disability benefit is introduced, **it takes many years for the average duration of claims to reach steady state**. This means that there is uncertainty over trends in the prevalence of benefit receipt for an extended period.
- **Changes in caseload composition have typically pushed average awards higher** than can be explained simply by uprating policy. This could reflect claimants (and their advisors) learning how to navigate the system better – a factor accentuated by the rise of the internet and social media.
- Echoing conclusions reached in each of our previous *Welfare trends reports*, **the effects of major reforms on spending are hard to predict and subject to the risk of optimism bias**. This was true of the early years of DLA and has been true again of the transition from DLA to PIP for working-age claims described in Chapter 4.

35 The substantial revisions to our forecasts of the fiscal effects of PIP since its introduction have also provided important lessons – many of which have already been acted upon:

- **The effects of a policy change should only be ‘scored’ and factored into our forecasts when there is a clear and credible plan for implementation**; mere aspirations are not enough. We would no longer certify the scorecard cost or yield of policy proposals where the detail is as sparse as it was for PIP.
- The need to **look more deeply at the nature and interpretation of key pieces of underpinning evidence**, testing for bias, applicability and sensitivity to key assumptions, and avoiding as far as possible reliance on a single source of evidence. This is particularly important where the information was not collected with subsequent analytical use in mind.
- Be sceptical of any **improbable ramping-up of operational activity** (especially where it requires putting many more trained staff in place quickly), interrogate delivery plans more thoroughly, and monitor performance more closely. This is now routine in our scrutiny of policy costings and in our forecasts in respect of ESA, PIP and UC.
- **Distinguishing news from noise in early vintages of administrative data** can be a major challenge, but the PIP experience suggests we were too slow to abandon prior forecast judgements in the early years of PIP, which ultimately led to large revisions when that inertia was overcome. This experience has influenced our approach to forecasting universal credit, where we have focused on extracting forecast-relevant information from early vintages of corresponding administrative data.

1 Introduction

- 1.1 'Welfare spending' means different things to different people. At its broadest, it could cover any public spending that plays a part in the provision of the welfare state – including health, social care, education and social housing, as well as social security benefits and tax credits for people of all ages. Our *Welfare trends reports (WTRs)* focus on benefits and tax credits, which transfer cash from some parts of the population to others who are eligible.
- 1.2 This year's *WTR* focuses on benefits designed to support disabled people with the extra costs faced in daily life (as distinct from those designed to replace income lost from finding it harder to work). In particular, we focus on support provided to people of working age. This part of the welfare system has undergone major reform in recent years, with the switch from disability living allowance (DLA) to personal independence payment (PIP) that started in 2013. It is also an area where spending has been rising relatively quickly and where our forecasts have been revised up significantly as the effects of moving to PIP became clearer.
- 1.3 In this chapter we introduce the metrics and methodological approach that we use to analyse the evolution of welfare spending over time. We then introduce DLA and PIP, putting them in the context of related benefits and of the broader welfare system.

Welfare spending

How we measure welfare spending

- 1.4 Our *WTRs* focus on those elements of benefit and tax credit spending that are financed by central government as part of what the Treasury calls 'annually managed expenditure' (AME). Most are administered by three central government organisations:
 - the **Department for Work and Pensions (DWP)** for most benefits in Great Britain;
 - **HM Revenue and Customs (HMRC)** for the personal tax credits, child benefit and tax-free childcare systems across the United Kingdom; and
 - the **Department for Communities** for most benefits in Northern Ireland.

In addition, under the terms of the fiscal framework agreed between the UK and Scottish Governments, responsibility for some benefits paid to people resident in Scotland is being transferred to the Scottish Government. So far only carer's allowance has been transferred.

- 1.5 Housing benefit and local council tax support are administered by local authorities. Most of the cost of housing benefit in Great Britain is met by DWP.

1.6 Due to the administrative separation of the benefits system between Great Britain and Northern Ireland, we tend to focus on Great Britain for DWP-administered spending, while HMRC-administered spending is considered on a UK-wide basis. Disability benefits are administered by DWP in England, Scotland and Wales and by the Department for Communities in Northern Ireland. We focus on trends in Great Britain in this WTR.

1.7 Figure 1.1 shows how the definition of welfare spending used in this report relates to total public spending and to other possible definitions of welfare spending. It shows that AME spending on social security and tax credits accounted for 28 per cent of the £789 billion of total public spending in 2017-18 and 45 per cent of a broader definition of spending on the 'welfare state'. The Government's 'welfare cap' applies to 54 per cent of welfare spending as defined here and 15 per cent of total public spending. All disability benefits spending is subject to the welfare cap. It makes up 19.5 per cent of capped spending.

Figure 1.1: UK welfare spending in context (2017-18)



Not to scale
Source: DWP, ONS, OBR

1.8 In describing how welfare spending evolves over time, different metrics are appropriate for different purposes. The three we use most often are:

- **Spending in cash or nominal terms:** this is simply the cash amount spent in a given period. But without putting the cash amount into context – by asking what recipients could buy with it or how much national income is available to fund it – interpreting changes in cash spending is difficult, particularly over longer time periods.

- **Spending in real terms:** trends in cash spending can be adjusted for whole economy or consumer price inflation. This gives a sense of the volume of goods and services that could be purchased with that spending – either across the whole economy or in the hands of the recipients. For disability benefits, it is also useful to consider cash figures against an index of the price level used to uprate statutory rates each year.
- **Spending as a share of national income:** trends in cash spending can be related to the cash value of the economic activity that can be taxed to finance it. This is the metric most relevant when considering the sustainability of the public finances.

1.9 Other metrics include welfare spending as a share of total public spending (illustrating the trade-offs with other priorities within a given spending envelope), relative to revenues (a more direct comparison with the resources available to finance it) or in per capita terms (allowing it to be related more directly to individual incomes or living standards). For benefits like DLA and PIP, that contribute towards extra costs associated with disability, one might also wish to compare the value of per capita benefits with estimates of those extra costs. But this is not an area in which we have expertise and we do not seek to do that here.

How we analyse trends in welfare spending

1.10 Trends in welfare spending reflect many different drivers. We split these into:

- those that affect the number of recipients – **the caseload**; and
- those that affect the amount paid to each – **the average award**.

1.11 Total spending on each benefit and the average caseload through each year are derived from administrative data, with the average award calculated from the two. The average award is not necessarily the same as the statutory rate or rates for a given benefit, as it will usually depend on the composition of the caseload. This is true of disability benefits.

1.12 Changes in caseload can be affected by:

- **changes in the population eligible for a benefit**, due to demographic or economic factors – such as the rising number of people above the state pension age or changes in the number of people with disabilities or long-term health conditions;
- **the proportion of those eligible who take up their entitlement** – this could be affected by knowledge of the entitlement, by conditions placed on receiving it, or by perceived stigma that deter people from making a claim;
- **changes in income that affect entitlement** – especially earnings and changes in housing costs in means-tested benefits; and
- **policy changes that alter eligibility criteria** – such as raising the state pension age or revising the parameters that guide assessment decisions for new or existing claims.

1.13 Changes in the implied average award can be affected by:

- **Statutory (or default) uprating of benefits and the economic factors that affect the measures by which they are uprated.** For example, where rates are linked to prices, they would be affected if exchange rate or oil price movements led to higher or lower inflation or if the Government changed the measure used (as the Coalition Government announced in 2010, moving from the RPI to CPI measure of inflation).
- **Policy choices to uprate benefits by a discretionary amount instead of the default setting.** For example, in its 2009 Pre-Budget Report the Labour Government declared its intention not to freeze disability benefits in 2010-11, despite the negative rate of RPI inflation in September 2009, but instead uprated them by 1.5 per cent.¹
- **Changes in the composition of the caseload.** If different groups receive different amounts, such changes can alter the average award even when the overall caseload is stable. For example, a lower rate of employment and support allowance (ESA) is paid to those deemed to be in the 'work-related activity group' and a higher one for those deemed to be in the 'support group', so a shift towards one or other of these groups will affect the average award across the aggregate ESA caseload.

1.14 This approach is also useful when considering the effect of a new policy, which can be split into the number of recipients affected and the average amount they are expected to gain or lose. This is relevant to our discussion of the transition from DLA to PIP for working-age recipients – the reform was originally intended to reduce the proportion of the population in receipt of PIP relative to DLA, but in the event has increased it.

Disability benefits

What do we mean by 'disability benefits'?

1.15 The welfare system contains several benefits that aim to support people affected by various effects of sickness or disability. The largest of these are ESA, an income-replacement benefit for those unable to work due to sickness or disability, and DLA and PIP, which are 'extra costs' benefits that are designed to contribute towards the daily living and mobility costs associated with disability and long-term health conditions (regardless of whether the individual is working or not). For new claims among pensioners, attendance allowance (AA) performs the same role, although many pensioners have continuing claims for DLA or PIP.

1.16 We typically refer to AA, DLA and PIP spending as 'disability benefits' and ESA and its predecessors as 'incapacity benefits'. But there is a big overlap between the recipients – more than half the 2.5 million people in receipt of ESA in April 2016 were also in receipt of either DLA or PIP. The UK is relatively unusual in primarily supporting disabled people with the extra costs of daily living and mobility via a cash transfer rather than by providing goods

¹ Legislation did not allow for benefits to be reduced given the negative inflation figure, so the default uprating would have been zero.

and services directly as benefits in kind.² Extra support for disabled adults and children is also provided in the tax credits and universal credit systems.

- 1.17 In addition to benefits that directly support sick and disabled people, carer's allowance is available to individuals that provide at least 35 hours of care per week for someone in receipt of certain rates of DLA, PIP or AA. Trends in spending on carer's allowance are therefore closely linked to trends in spending on these qualifying benefits.

The focus of this report

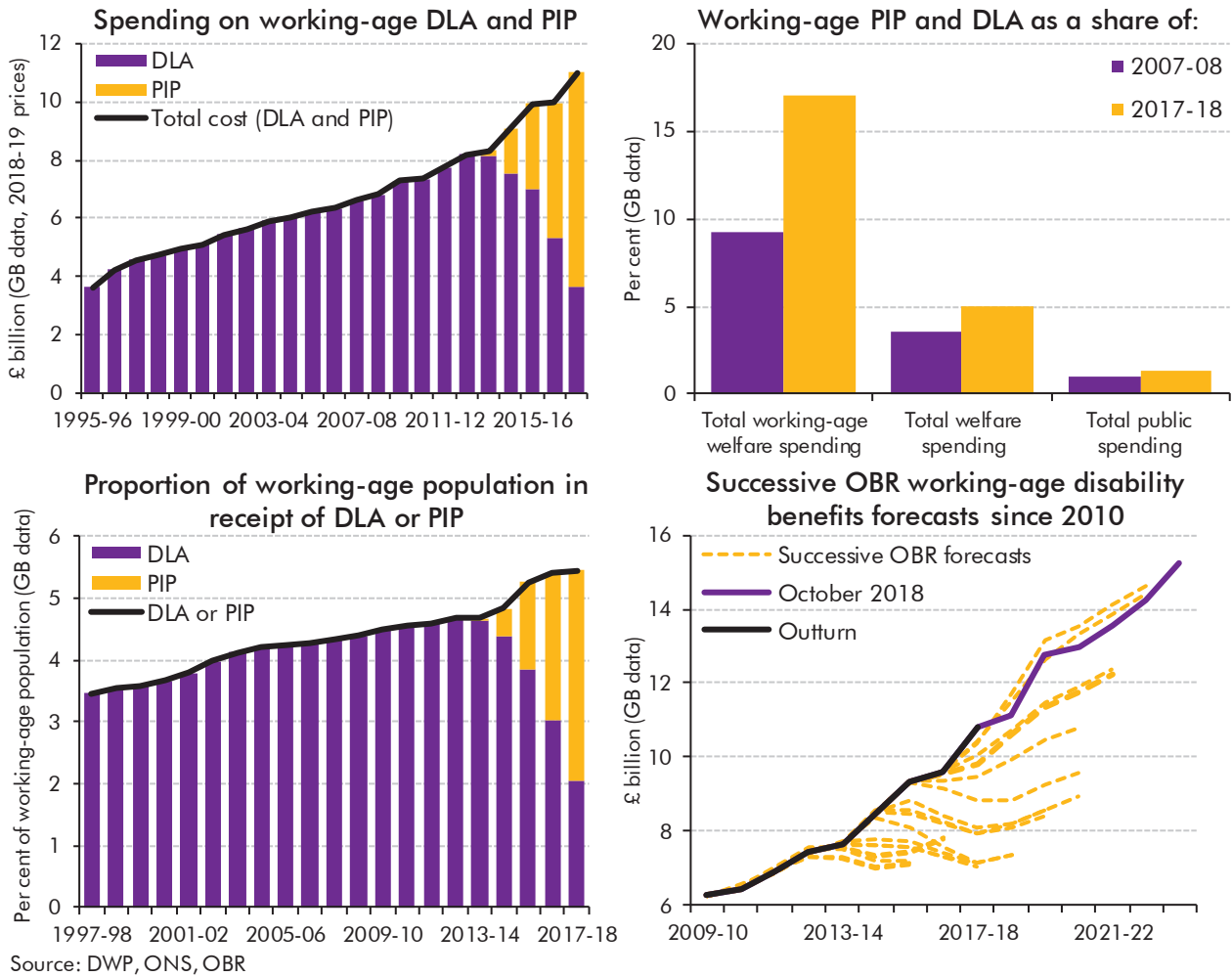
- 1.18 In this report we discuss all the main components of disability-related welfare spending, but focus especially on DLA and PIP for working-age adults. Of course, there is much that could be said about the trends in other elements of disability-related welfare spending, including the impact of different health conditions on the cost of DLA for children, the effect of reforms to other parts of the welfare system on spending across different age groups, and the effects of an ageing population on the cost of attendance allowance. But several factors have encouraged us to focus in particular on working-age DLA and PIP, including:

- **The rising total cost:** as the top-left panel of Chart 1.1 shows, spending on DLA and PIP for working-age adults has risen by 66 per cent in real terms (relative to the GDP deflator) over the past 10 years and by 141 per cent over the past 20 years. That has pushed it up from 0.3 per cent of GDP in 1997-98 to 0.4 per cent in 2007-08 and 0.5 per cent in 2017-18.
- **The rising relative cost:** the top-right panel shows how spending on DLA and PIP for working-age adults over the past decade has risen as a share of working-age welfare spending, total welfare spending and public spending as a whole.
- **The rising prevalence among working-age adults:** the bottom-left panel shows that the proportion of working-age adults in receipt of DLA or PIP has risen from 3.5 per cent in 1997-98 to 4.3 per cent in 2007-08 and 5.4 per cent in 2017-18.³ This trend includes a notable step up in 2015-16 as the transition from DLA to PIP took effect.
- **The scale of historical forecast revisions:** the bottom-right panel shows successive forecasts for spending on DLA and PIP for working-age adults. It shows that, more often than not, spending has risen faster than we expected. In part, this reflects the disparity between initial intentions and subsequent reality for the replacement of DLA with PIP, where the Government originally intended the introduction of "objective medical assessments" to reduce the caseload by 20 per cent over three years.

² See MacInnes *et al*, *Disability, long-term conditions and poverty*, New Policy Institute for the Joseph Rowntree Foundation, July 2014. We discussed incapacity and disability benefits spending in international context in Chapter 3 of our 2015 *Welfare trends report*.

³ We refer to the proportion of the population with a reported disability or in receipt of a disability benefit as 'prevalence' – a stock concept. The proportion that is newly classified as disabled or newly receives a disability benefit is referred to as 'incidence' – the flow.

Chart 1.1: Working-age DLA and PIP spending in context



Structure of the report

1.19 The report is structured as follows:

- Chapter 2 discusses trends in different **measures of the prevalence of disability** in the population and some of the associated challenges;
- Chapter 3 reviews **historical trends in spending on disability benefits**;
- Chapter 4 explores the **transition from DLA to PIP** and how actual experience has differed from initial expectations;
- Chapter 5 describes **our latest disability benefits forecast** and the risks and uncertainties to which it is subject; and
- Chapter 6 concludes the report by estimating **the effect of the introduction of PIP on welfare spending** and compares that with earlier estimates of the amount it would save relative to DLA.

2 Trends in disability

Introduction

2.1 In this chapter we discuss trends in disability in the population and how they might influence our forecast for disability benefits spending. In doing so, we discuss:

- overall **trends in survey measures of disability prevalence**, including possible drivers of age-group specific trends and methodological limitations;
- **differences between measures of disability prevalence and measures of disability benefits receipt** and what they might signify; and
- **implications for forecasting** spending on disability benefits.

2.2 In discussing trends in different measures of disability in the population, we do not address different conceptions of disability or impairment. How disability should be conceived is still a subject of debate, though there has been a general movement towards the ‘social model’.¹ This view sees *disability* as being generated at the point of interaction between an individual and their physical, social or economic environment whereas *impairments* are the limitations that the individual faces related to any conditions that they may have. Under the social model, the extent to which an individual’s impairment is disabling depends on the environmental factors at work – for example, accessibility of information or transport. This debate is fundamental to measuring disability as it defines what surveys are attempting to measure. It lies, however, beyond the scope of this report. Given our focus on disability benefit spending, broader or narrower conceptions of disability would imply a smaller or larger proportion of disabled people receiving support from the welfare system.

Reported disability prevalence

Overall trends

2.3 Trends in disability prevalence – the share of the population with a reported disability – in the UK over recent decades are shown in Chart 2.1, which draws from the ONS General Household Survey (GHS) between 1975 and 2007 and from DWP’s Family Resources Survey (FRS) between 2003-04 and 2016-17.² In the years covered by the GHS, disability prevalence refers to the proportion of people in surveyed households reporting a longstanding illness that limits their activities in any way. In years covered by the FRS, it

¹ For further detail on the ‘social model’ of disability, see, World Health Organisation (2011), World Report on Disability.

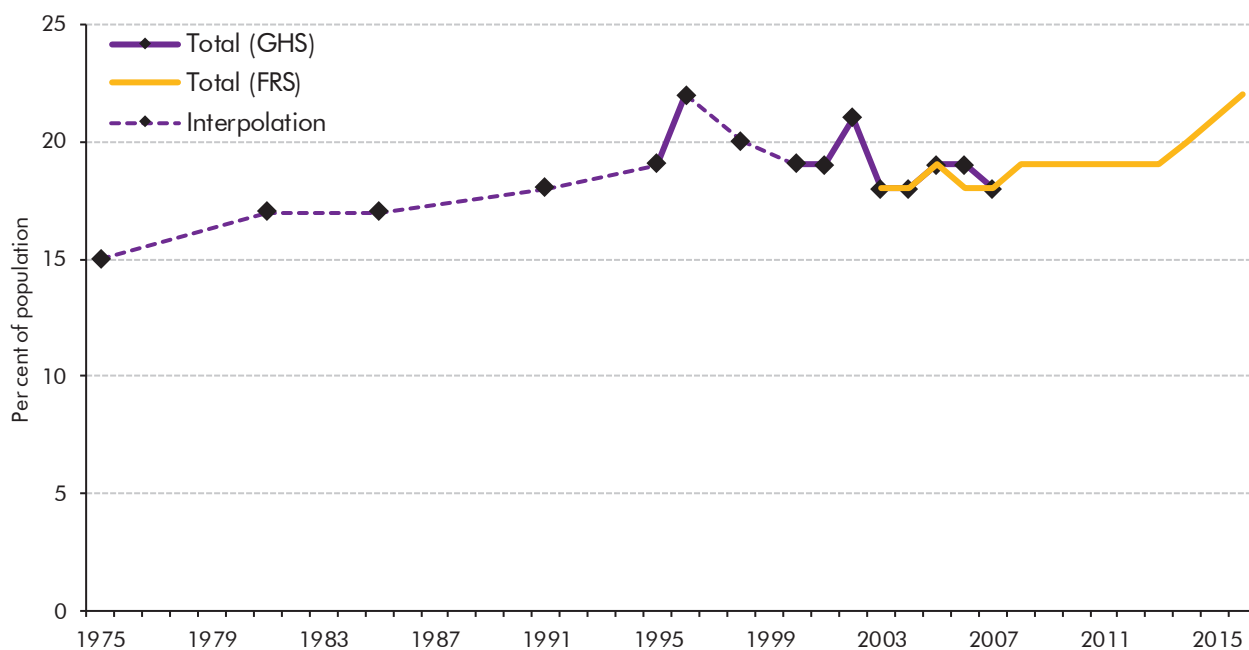
² Whilst the FRS covers the whole of the UK, the GHS only covered Great Britain during its operation. We therefore assume that the GB prevalence rates recorded in the GHS are a good approximation for UK prevalence rates over the period in which the survey was in operation.

Trends in disability

refers to people reporting a longstanding illness, disability or impairment that causes substantial difficulty with day-to-day activities. Differences in the prevalence measure due to the switch from the GHS to FRS surveys do not appear to be material to the historical trends, but methodological differences mean that it is possible to draw different conclusions for specific prevalence trends from each survey. We discuss this and wider issues around the accuracy of measures of reported disability prevalence in Box 2.1.

- 2.4** Reported disability prevalence across the population increased slowly in the two decades to the mid-1990s and has been reasonably stable at close to 20 per cent since then. That said, reported prevalence has increased by 1 percentage point in each of the past three years, taking the 2016-17 level back to the peak recorded under the GHS in 1996.
- 2.5** Between 1975 and 2016, the UK population grew by 17 per cent to reach 65.6 million. The latest rate of reported prevalence therefore suggests that 14.4 million people have a disabling condition that causes substantial difficulties with day-to-day activities. That is up from 8.4 million in 1975, with population growth accounting for just over a quarter of the 71 per cent rise over four decades while higher prevalence accounting for almost three quarters.

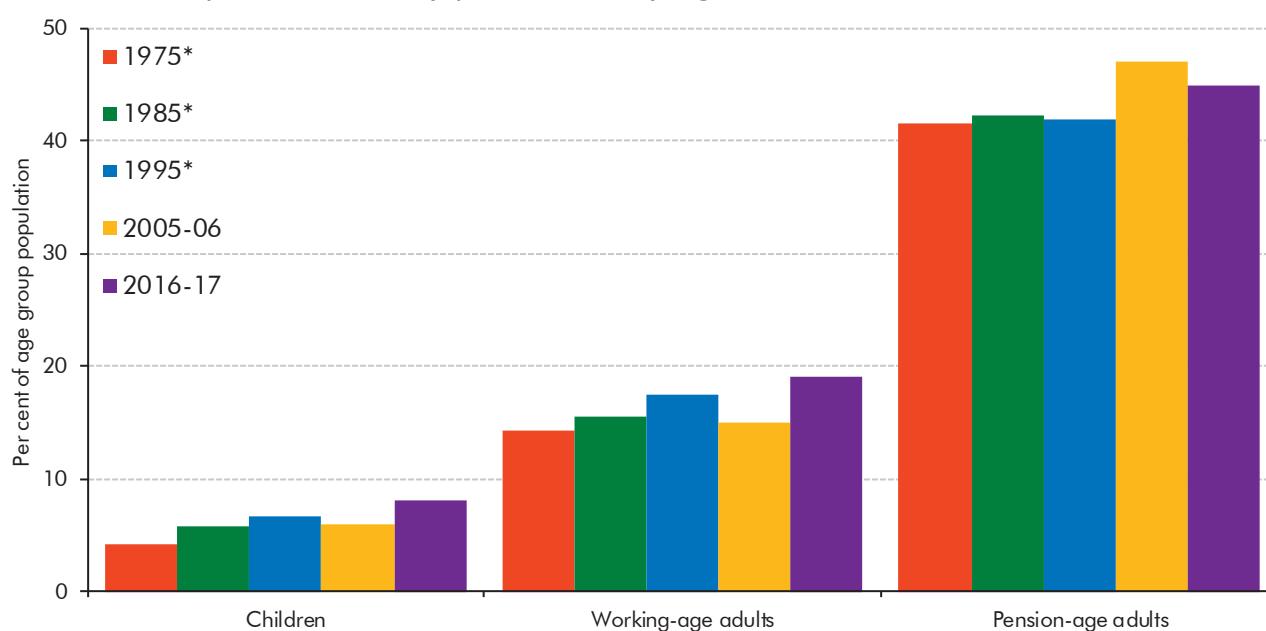
Chart 2.1: Reported disability prevalence



Source: DWP, ONS, OBR

- 2.6 Reported disability prevalence has risen among children, working-age adults and pensioners over the past four decades.³ The largest change, both proportionately and in absolute terms, has been among children, where it has roughly doubled since 1975 and has increased from 6 to 8 per cent over the past decade. Among working-age adults, it has increased from 15 to 19 per cent over the past decade. Among pension-age adults, it is much higher and has fluctuated over time but changed little over the past decade. Of the 14.4 million disabled people in 2016-17, around 7 per cent were children, around 56 per cent were working-age adults and around 37 per cent were pensioners.
- 2.7 The 7 percentage point rise in reported disability prevalence over the past four decades reflects changes in the age composition of the population and rises in age-group-specific prevalence. Holding population fixed at 1975 levels, rising prevalence in the working-age population accounted for 3.5 percentage points of the increase in overall prevalence over that period, while increases among children accounted for 1.6 percentage points and the modest increase among pension-age adults for 1.1 percentage points, the remainder reflects changes in the age composition of the population, in particular population ageing.

Chart 2.2: Reported disability prevalence by age



* Weighted average of relevant age groups reported in the ONS General Household Survey.
Source: DWP, ONS (GHS: 1975, 1985 and 1995, FRS: 2005-06 and 2016-17), OBR

³ As the GHS and FRS report different age groupings, we have calculated a weighted average prevalence rate for each age group in the years covered by the GHS in order to ensure comparability with the figures reported in the FRS.

Box 2.1: Measurement issues with reported disability prevalence

Measures of reported disability prevalence derived from surveys are often highly sensitive to the survey methodology on which they are based. So different surveys can yield different results.

For example, in their 2015 study of the disability employment gap in the UK, Baumberg *et al* found that the Labour Force Survey (LFS) and General Household Survey (GHS) yielded contradictory results for the trend in working-age disability prevalence between 1998 and 2012.^a In particular, the GHS reports a fall in working-age prevalence in that period, while the LFS reports an increase. The surveys use similar methodologies, but the authors see differences in the definition of disability used, the geographical area covered by each sample and how interviews were conducted as possible sources of the discrepancy. Even after controlling for these, the authors found that a discrepancy remained between the two prevalence estimates.

Methodological differences can also mean that even estimates *within* surveys are not fully comparable. For example, there have been several changes to the wording of the LFS disability questions since 2010. These harmonise the LFS definition with other household surveys, but mean that the pre-2010 series cannot readily be compared to the post-2010 series.

In November 2017, the ONS suspended publication of its LFS-derived *Labour market status of disabled people* statistical series for six months due to an apparent discontinuity between the second and third quarter releases in 2017. ONS analysis of the sudden increase in reported prevalence between the releases remains inconclusive, but it may be due in part to changes in respondent behaviour associated with mental health awareness campaigns. This hints at a broader problem in defining the underlying prevalence of disability in the population. Even if survey measures were consistent within and across surveys, the decision to self-report “a longstanding illness/disability/impairment that causes difficulty with day-to-day-activities” (necessarily) is the product of: (i) actual incidence of longstanding conditions; (ii) awareness of ‘disability’; and (iii) the perceived effect of impairments in interfering with everyday life. Changes in awareness and/or the demands of everyday life could therefore lead to changes in self-reported prevalence with no accompanying change in the underlying rate of conditions.

^a See Baumberg *et al* (2015), *Disability prevalence and disability-related employment gaps in the UK 1998-2012: Different trends in different surveys?*

Trends in types of conditions reported

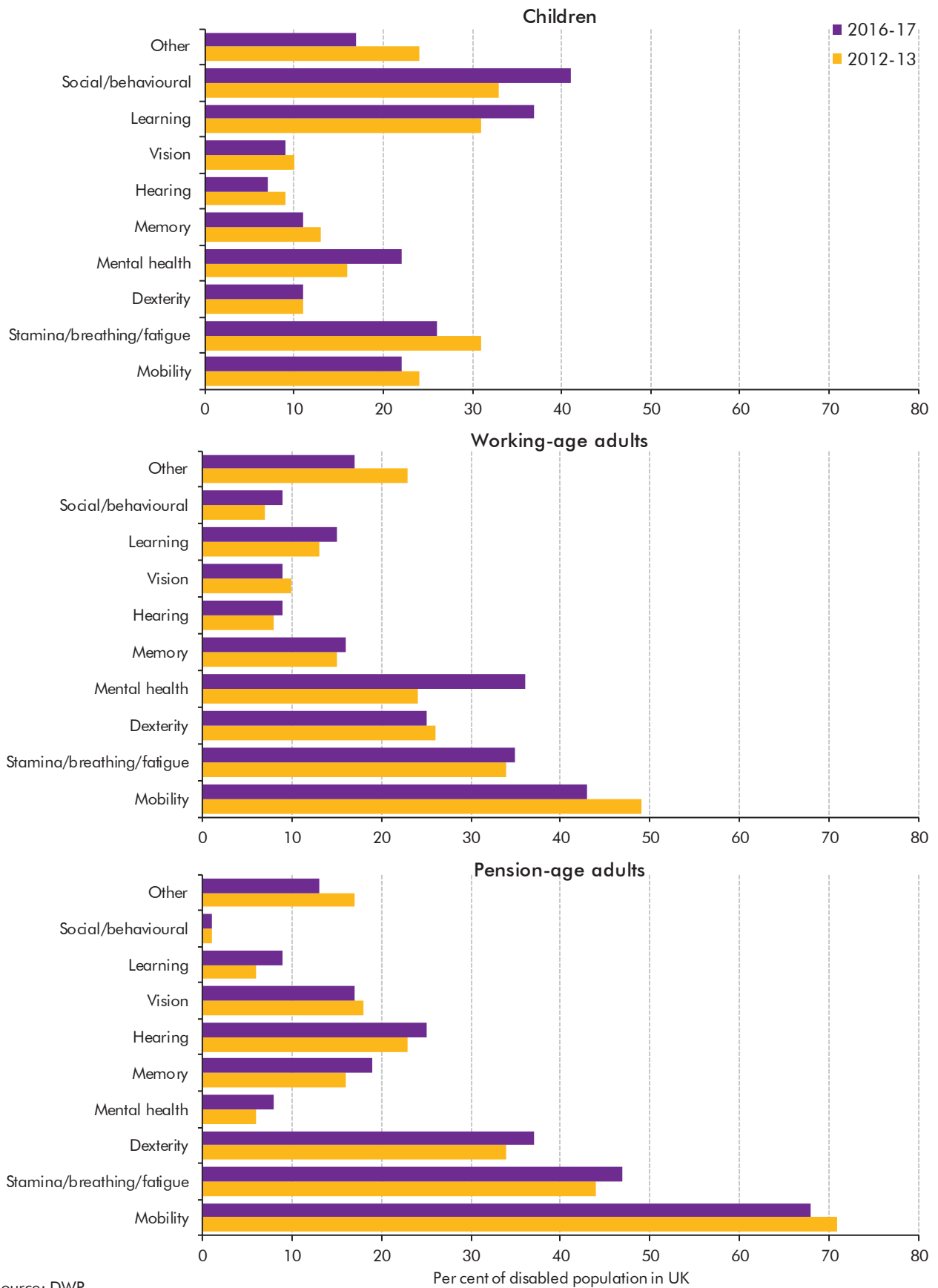
2.8 The modest upward trend in the proportion of the population reporting a disability that limits their day-to-day activities reflects some stronger and partly offsetting trends in the types of condition that are reported. The GHS and FRS data do not provide consistent breakdowns over the full period from 1975 onwards, so this section looks at recent trends reported in the FRS and then considers other evidence of trends over a longer period.

Disabling conditions reported by different age groups

2.9 Chart 2.3 shows the nature of the impairment reported by those identifying themselves as disabled in the FRS over the five years from 2012-13 to 2016-17. The panels show that:

- **Among disabled children**, social/behavioural and learning impairments are the most common conditions reported and have been on an upward trend over the past five years (rising from 33 to 41 per cent and 31 to 37 per cent of disabled children respectively). The largest proportionate increase was in respect of mental health conditions, up from 16 to 22 per cent.
- **Among disabled working-age adults**, mobility impairments are the most common condition reported, but have been on a declining trend over the past five years. Much the largest increase over that period was the proportion of disabled working-age adults reporting mental health conditions, which increased from 24 to 36 per cent. Small increases in learning and social/behavioural impairments were also reported.
- **Among pension-age adults**, mobility impairments are by far the most common. Changes in the prevalence of different conditions have been less pronounced than among disabled children and working-age adults. The largest increases are in respect of dexterity, memory and learning impairments. Mental health conditions have risen, but only slightly and are still reported by only a small minority of disabled pensioners.

Chart 2.3: Recent trends in reported disability by impairment and age group



Source: DWP

Trends in mental health conditions

- 2.10 The rising proportion of disabled children and working-age adults reporting a mental health condition in the FRS in recent years is consistent with other indicators showing rising prevalence of mental health conditions in the wider population:
- **The NHS Mental Health of Children and Young People in England** survey shows the prevalence of any mental disorder in 5-to-15-year olds to have increased from 9.7 per cent in 1999 to 11.2 per cent in 2017.⁴ Emotional disorders show the greatest increase in prevalence for both girls and boys, with increases of 1.7 and 1.4 percentage points respectively. The reported rise was particularly large among girls aged 11 to 15 (up 3.5 percentage points).
 - **The NHS Adult Psychiatric Morbidity Survey** shows increases in the prevalence of mental health and associated conditions among working-age adults in England. Between 1993 and 2014 (the most recent year for which data were collected), the percentage of 16-to-64-year olds reporting having experienced a common mental disorder (CMD) increased from 15.5 to 18.9 per cent.⁵ The increase was somewhat larger among women than men, and was particularly large among young women (aged 16 to 24) and older working-age women (aged 55 to 64).
- 2.11 It is difficult to pinpoint specific causes of the increased prevalence of reported mental health conditions. As well as increases in underlying rates of mental illness, changing social attitudes towards mental health issues may have increased awareness of them and the willingness of individuals to report such conditions. In surveys on attitudes to mental illness over the past decade or so, more people now say they regard mental illness as ‘an illness like any other’, fewer report negative attitudes towards mental illness (perhaps reducing the stigma that might have deterred people from reporting such conditions) and more report that they would seek medical advice if they had a mental health problem. It is also possible that an increased tendency of medical professionals to diagnose mental health issues may have contributed to greater reporting of them by individuals in surveys.⁶
- 2.12 Increased provision of mental health services may also have contributed to increases in reporting. One study traces this back to the plan for increased spending on mental health announced in the then Labour Government’s 1998 *Modernising mental health services: safe, sound and supportive* White Paper.⁷ By 2000, mental health had become one of three clinical priorities for the NHS. This was followed by the introduction of the *Improving access to psychological therapies* (IAPT) programme in 2008 which focused on increasing access to therapy for those with common mental health conditions and which is still in operation.

⁴ In this survey, mental health conditions include: emotional disorders (comprised of anxiety and depressive disorders), behavioural disorders (oppositional defiant, unsocialised conduct, socialised conduct and other disorders), hyperactive disorders and other disorders.

⁵ CMD refers to: generalised anxiety disorder; depressive episodes; phobias; obsessive compulsive disorder; panic disorder; and other CMDs not covered by these categories. For further information, see ‘Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014’.

⁶ See successive editions of the ‘National Attitudes to Mental Illness’ survey.

⁷ For a history of mental health services policy, see Turner et al (2015), *The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research*, Medical History, vol. 59(4), pp.599-624.

More recently, the Coalition and Conservative Governments have published further strategies for mental health services, including *No health without mental health* in 2011, *Closing the gap: priorities for essential change in mental health* in 2014 and the child and adolescent focused *Future in mind* in 2015. Mental health services were again identified as one of the Prime Minister's five priorities for the NHS over the next ten years when announcing the significant increase in NHS funding in a speech in June 2018.⁸ The new NHS long-term plan states that mental health services provision will rise faster than the overall NHS budget to "enable further service expansion and faster access to community and crisis mental health services for both adults and particularly children and young people".⁹

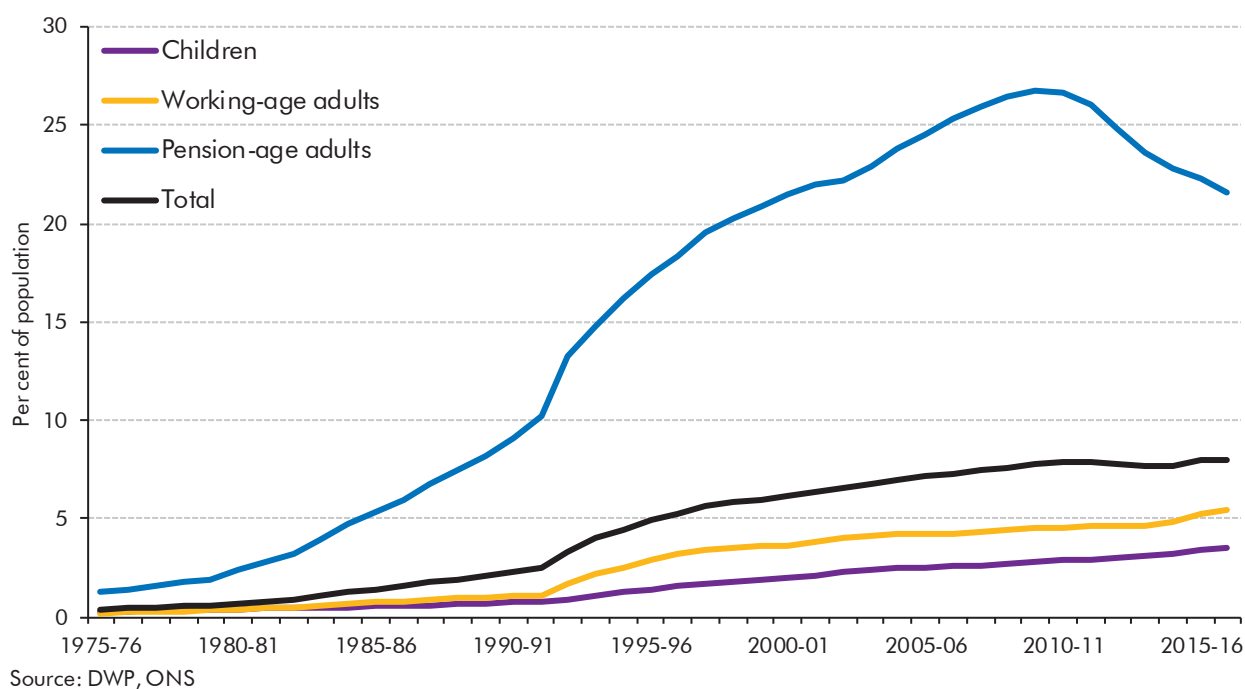
The prevalence of disability benefit receipt

- 2.13 There is greater certainty over the trends revealed by administrative data on receipt of disability benefits, since they are not subject to sampling variability. But the extent to which this provides insights into the prevalence of disability in the population is limited as it is greatly influenced by the extent to which the disability benefits regime aims to provide support for all disabled people and the extent to which disabled people are willing and able to take up what support is available. Disability captured by administrative measures reflects the eligibility regime at the time, which can change materially with reforms to the system.
- 2.14 Chart 2.4 shows how prevalence of disability benefit receipt has evolved since 1975. This includes receipt of disability living allowance (DLA), personal independence payment (PIP) and attendance allowance (AA). It does not include receipt of incapacity benefits, such as employment and support allowance (ESA). Trends in disability benefit prevalence are discussed in Chapter 3, but the largest changes over time are related to changes in the disability benefits system – most clearly the introduction of DLA in 1992 and the subsequent (and largely intended) rise in the share of the population receiving it. Trends in underlying disability prevalence (to the extent that they are effectively captured in survey measures) also have an impact, for example on the rising prevalence of benefit receipt among children.

⁸ Prime Minister's speech on the NHS, 18 June 2018.

⁹ The NHS Long Term Plan, NHS, January 2019.

Chart 2.4: The prevalence of disability benefits receipt in Great Britain



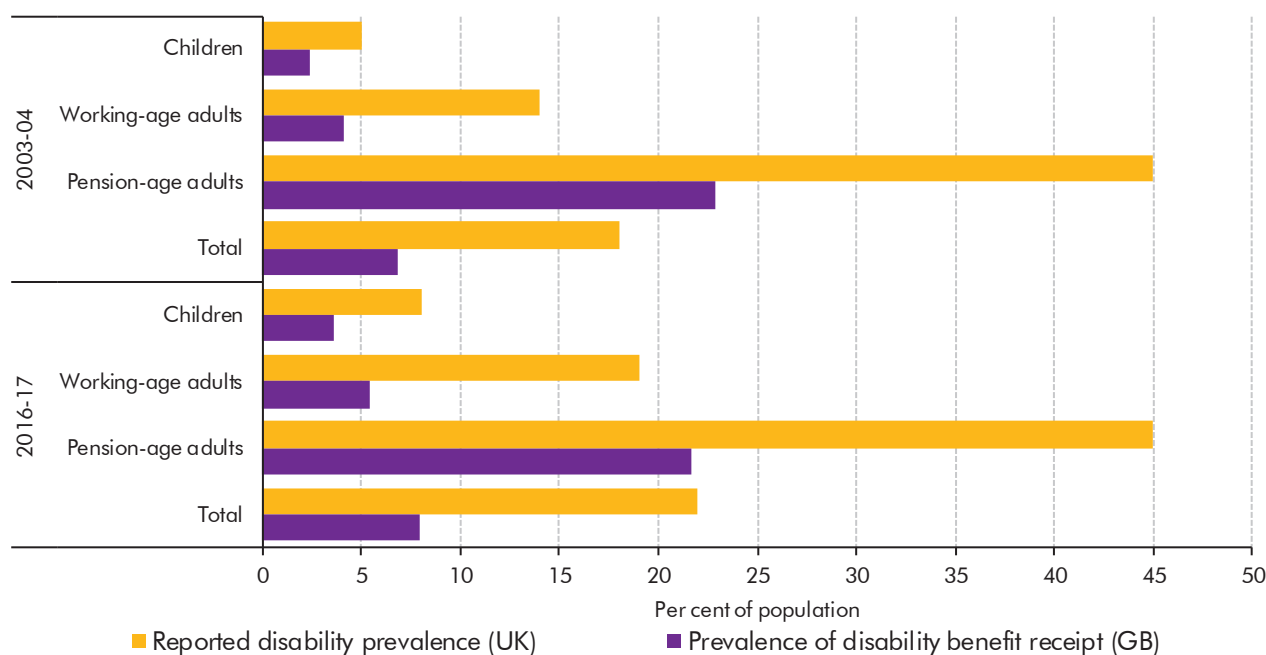
2.15 Chart 2.5 compares reported disability prevalence and the prevalence of disability benefits receipt between 2003-04 and 2016-17 – the period covered by the FRS. It shows that:

- Fewer people receive a disability benefit than report a disability in the FRS.** One would expect this to be the case, because benefit recipients must meet specific eligibility requirements and wish to take up their entitlement. This depends on the details of disability benefits policy and wider social and cultural perceptions. If one assumes that all disability benefit recipients are among those reporting a disability that limits day-to-day activities, as derived from the FRS, the difference between reported disability prevalence and the prevalence of disability benefits receipt is an indication of the combined effect of policy design and take-up behaviour among potential recipients.
- The implied proportion of disabled children and working-age adults who receive disability benefits has fallen slightly between 2003-04 and 2016-17.** Reported prevalence has risen slightly faster than the proportion of these age groups in receipt of disability benefits, but the differences are small relative to the uncertainty around the survey-based measure of prevalence. Among children, reported prevalence increased from 5 to 8 per cent (a 60 per cent rise in prevalence) while the proportion of children in receipt of a disability benefit increased from 2 to 4 per cent (a 50 per cent rise). Among working-age adults, these figures are 14 to 19 per cent (up 36 per cent) and 4 to 5 per cent (up 31 per cent). To the extent that these discrepancies are a true reflection of real-world developments, they indicate how the scope of disability benefits and take-up have changed relative to reported disability prevalence. But the differences could also reflect changes in perceptions of disability, differences in the definitions across surveys as well as sampling variability and rounding in the FRS.

Trends in disability

- The prevalence of pensioner disability benefits receipt changes more over time than pensioner disability prevalence.** Comparing 2003-04 with 2016-17 shows little change on either measure among pensioners, but reported disability prevalence among pensioners has fluctuated between 42 and 47 per cent over that period, while the prevalence of disability benefit receipt increased until 2009-10, but has been falling since then. This may be related to changes in disability and other benefits for pensioners, as discussed in Chapter 3.

Chart 2.5: Reported disability prevalence versus disability benefit receipt



Source: DWP, ONS

- 2.16** Why might the prevalence of disability benefit receipt be so much lower than reported disability prevalence? This could reflect eligibility criteria being more narrowly defined than the survey questions underpinning reported prevalence or less-than-complete take-up among those eligible for disability benefits. Against that, some recipients of disability benefits might not fall within the reported prevalence population, for example due to fraudulent or erroneous claims. But this is unlikely to be material – DWP estimates that in 2017-18, only 2.6 per cent of PIP claims were the result of error or fraud on the part of claimants, with a further 0.6 per cent due to error on the part of officials. That amounts to £260 million of the £8.2 billion total cost of PIP in 2017-18.
- 2.17** Based on the analysis in Chapter 3, the rise in the prevalence of disability benefit receipt after the introduction of disability living allowance reflects both an active broadening of eligibility criteria, relative to the definition of reported prevalence, and higher take-up thanks to the self-assessment basis for claiming the benefit. But it is very difficult to quantify the relative importance of these two elements, because determining eligibility is often not straightforward.¹⁰ This means that we never know the extent to which the difference between

¹⁰ See, for example, Berthoud (2009), *Measuring the impact of disability benefits: A feasibility study*, and Kasparova et al (2007), *The take-up rate of Disability Living Allowance and Attendance Allowance: Feasibility study*.

reported prevalence and benefit receipt is due to some people that consider themselves disabled not being eligible for disability benefits or to those eligible not taking up their entitlement. Both are likely to play a role. When comparing eligibility for benefit versus self-reported disability, the relatively large share of claims that are unsuccessful suggests that this is part of the explanation. And it is likely that some disabled people are unaware that they would be eligible for support or are deterred from claiming by the burden of doing so.

Implications for disability benefits forecasting

- 2.18 Trends in reported disability prevalence suggest that (holding all else equal) we should expect to have seen a steadily rising trend in the share of the population in receipt of a disability benefit, as has been the case. To the extent that disability prevalence continues to rise – for example due to the trends in mental health conditions outlined above – upward pressure on disability benefits spending would also be expected to continue. But the discussion in this chapter has also shown the importance for spending of changes in the extent to which support afforded by the disability benefits system covers all disabled people.
- 2.19 One implication of the above discussion for forecasting spending on disability benefits, is that trends in reported disability prevalence can only inform the judgements we make. Trying to forecast spending by starting from a forecast of trends in underlying or reported disability prevalence would be hampered by the difficulties in assessing eligibility for disability benefits and therefore take-up rates. Instead, we take the prevalence of disability benefit receipt as our starting point and forecast how that will change over time due to demographic and other factors (see Chapter 5).

3 Disability benefits spending

Introduction

3.1 This chapter:

- describes **the evolution of the disability benefits system** in the UK;
- summarises **trends in the amount spent on providing disability benefits** since 1971;
- analyses **the rising prevalence of disability benefit receipt** over that period;
- discusses drivers of **changes in average amounts paid to recipients**; and
- draws some **lessons for forecasting spending on personal independence payment**.

Evolution of the disability benefits system

3.2 State support for disabled people dates back at least to 1911, with the introduction of the National Insurance Act. Support was expanded under the National Assistance Act of 1948 to include compensation for industrial injuries and basic income replacement for those who had to leave employment due to sickness or disability and were deemed sufficiently in need. But cash benefits to help meet the extra costs associated with disability only began in earnest in the 1970s with the introduction of attendance allowance (AA) and mobility allowance (MobA). The scope and generosity of these benefits expanded with the introduction of disability living allowance (DLA) for children and working-age adults in the early 1990s. The system was reformed again for working-age adults with the introduction of personal independence payment (PIP) in 2013, the rollout of which is still in progress.

1971-72 to 1991-92: attendance allowance and mobility allowance

3.3 The main disability benefits during the first phase of extra-cost benefits were:

- **Attendance allowance:** introduced in 1971, AA was designed to assist with care costs where care was required during *both* the day *and* the night. This was initially a flat-rate benefit targeted at severely disabled adults and children aged 2 or over, but a lower rate was introduced in 1973 for those that required care during *either* the day *or* the night. AA is only payable where a claimant has required help for six months.
- **Mobility allowance:** introduced in 1976, MobA provided financial support for individuals who faced extra costs getting around. Initially targeted at working-age adults, this was a taxable flat-rate benefit. The upper age limit was extended for pre-existing claimants from 65 to 75 in 1979 and from 75 to 80 in 1989. In 1977 it was

supplemented by the 'motability' scheme, which enabled claimants to use their MobA to lease specialist vehicles directly rather than having to arrange leasing separately.

3.4 As outlined above, the scope of these benefits increased over time thanks to a succession of policy changes. Further expansions in eligibility took place a decade later, with AA extended to 2-year olds and MobA to all aged up to 80.

3.5 The introduction of these benefits, and the subsequent widening in their scope, partly reflected increased awareness of the prevalence and impact of disability. The Department of Health and Social Security and other government departments commissioned the Office of Population Censuses and Surveys (OPCS) to carry out a comprehensive survey, reporting in 1971. This sought to estimate the prevalence of disability in the population and the poverty caused by the associated extra costs of daily living and getting around, so as to inform the design of AA.¹ While the precision of the definitions behind these estimates is much-debated, subsequent OPCS surveys continued to influence policy-making. The surveys in the late 1980s suggested that the needs of certain groups of disabled people were not being met by the system as it stood at the time. In particular, they found that less severely disabled people were often ineligible for help with the costs they faced and that *"there was a much greater disparity between the incomes of disabled and non-disabled people under pension age"* compared to those above pension age.² This prompted the Government to issue the 'The Way Ahead' White Paper in 1990, which sought to address these issues and laid the foundation for the introduction of DLA.³

1992-93 to 2012-13: attendance allowance and disability living allowance

Introduction of DLA

3.6 In 1992 the Government introduced DLA, combining support for mobility and care costs into a single benefit for children and working-age adults up to the age of 64. For those aged 65 and above, new claims for disability benefits continued to be made to AA.⁴ Introducing the Disability Living Allowance and Disability Working Allowance Bill, the Secretary of State for Social Security set out three aims:

- to improve *"the balance of benefits available to people who are unable to work... in particular to do more for those who are disabled from birth or early life"*;
- to improve *"the coverage of help with the extra costs associated with disability"* for children and working-age adults; and
- to help *"those disabled people who can and wish to work by making it easier for them to take up and keep jobs"*.⁵

¹ *Handicapped and impaired in Great Britain. Part 1*, Harris (1971), London: Her Majesty's Stationary Office.

² See House of Lords debate, Disability Living Allowance and Disability Working Allowance Bill, 7 March 1991 (Hansard volume 526, columns 1534-1536).

³ *The Way Ahead – Benefits for Disabled People*, Department of Social Security (1990), Her Majesty's Stationary Office.

⁴ However, prior to reforms in 1997, an individual could claim DLA in their 66th year where their disabling condition was experienced before turning 65.

⁵ See Disability Living Allowance and Disability Working Allowance Bill HC Deb, 21 November 1990 (Hansard, volume 181, column 311).

3.7 These aims were reflected in two key features of the initial design of DLA:

- **The creation of lower rates for care costs and mobility costs.** This sought to address the concern that the two-rate structure in AA and the flat-rate MobA did not match the spectrum of disabled people's needs.⁶
- **The introduction of 'self-assessment'.** Entitlement to AA and MobA was established through functional assessments conducted by medical practitioners, but initial entitlement for DLA was assessed by claimants themselves. On receipt of a claimant's self-assessment, the Department of Social Security (DSS) decision-makers determined the appropriate award based on the information provided by the claimant, drawing on DSS medical guidance regarding the characteristics of different conditions and the consequent needs.⁷

3.8 DLA is not means-tested and – unlike its MobA predecessor – is not taxable. Eligibility for the care component is largely determined by the extent to which claimants' conditions affect their ability to care for themselves without support or supervision. Eligibility for the mobility component is determined by their ability to move 'when using their normal aid' and whether they need supervision from another person when they are in an unfamiliar environment out of doors. Although new claims were restricted to under-65s, existing claimants can continue to claim DLA beyond age 64 where the conditions for which they are claiming were present prior to them turning 65 and they continue to meet the entitlement conditions. Both components of DLA are only payable where a claimant has already required help for at least three months and can expect to need help for at least a further six months.⁸ A precise diagnosis is not required to establish eligibility, so long as claimants can demonstrate difficulties in care and mobility on the grounds of mental or physical health.

The care and mobility components

3.9 The care component of DLA consists of three different rates:

- **The lowest rate** – for working-age adults, this was awarded where claimants needed attention with bodily functions for a significant portion of the day or were unable to prepare a cooked main meal. For claims on behalf of a child (which can still be made), this is awarded where the child needs attention for some of the day or night and their needs are significantly greater than their non-disabled peers.
- **The middle rate** – for working-age adults, this was awarded where claimants needed frequent help or supervision during the day, supervision at night or assistance with dialysis at home or in a self-care unit. The same criteria still apply for children.
- **The highest rate** – for working-age adults, this was awarded where the conditions of the middle rate were met both during the day and the night or the claimant was terminally ill. These conditions also currently apply to child claims.

⁶ See Disability Living Allowance and Disability Working Allowance Bill HC Deb, 21 November 1990 (Hansard, volume 181, columns 312-313).

⁷ The DSS became the Department for Work and Pensions in June 2001.

⁸ Exceptions exist for those with terminal illnesses, whereby individuals whose death is likely to occur within six months are still eligible.

3.10 The mobility component consists of two rates:

- **The lower rate** – for working-age adults, this was awarded where claimants “can walk but are so severely disabled mentally or physically that they need guidance or supervision from another person for most of the time when walking out of doors”.⁹ This rate is still awarded for child claims where the child is aged 5 years or more and meets the same conditions as applied for working-age adults.
- **The higher rate** – for working-age adults, this rate was awarded to those with more severe physical disabilities that left them unable or virtually unable to walk or, subject to certain conditions, those that were severely visually or mentally impaired.¹⁰ Child claims are awarded this rate where they meet those working-age requirements. For this rate, children are eligible if they are aged 3 and over (with eligibility having been extended from those aged 5 and over in 2001).

Subsequent changes to DLA

3.11 The initial design of DLA reflected an active intention to expand the coverage of disability benefits. Subsequently the scope of DLA was further widened by two important legal cases: Mallinson (1994) and Halliday (1994). These expanded interpretation of the term ‘bodily functions’ in the requirement that individuals needed “attention in connection with bodily functions” to qualify for the care component, so that it included a wider range of activity.

3.12 Trends in the wider welfare system also affected the administration of disability benefits. Growing numbers of incapacity and disability benefits claims in the first half of the 1990s prompted several changes to the administration of DLA. These typically required more evidence from claimants and introduced more regular reassessments. Changes included:

- **Safeguarding:** introduced in 1996, this required more evidence when assessing eligibility for the higher rate mobility component. This change contributed to a significant fall in the share of all new awards that included this component from an average of around 60 per cent in the three years up to 1996-97 to an average of around 50 per cent in the subsequent three years.
- **Benefit integrity project (BIP):** a 1996 Government review of DLA suggested that around a quarter of claimants’ awards were incorrectly calculated due to fraud or error with around £500 million overpaid and £230 million underpaid. The review concluded that the rate of fraud in DLA was 12.2 per cent, of which 1.5 percentage points was deemed to be ‘confirmed fraud’.¹¹ In order to tackle incorrect payments, the BIP was introduced in April 1997 and ran until March 1999, collecting up-to-date information from DLA claimants. Activity targeted those receiving the higher mobility component together with either the highest or middle care component, with some exemptions. The NAO reported that the policy reviewed around 183,000 DLA cases

⁹ *Decision Maker’s Guide, Volume 10, Chapter 61: Attendance Allowance and Disability Living Allowance*, DWP (2018).

¹⁰ *Decision Maker’s Guide, Volume 10, Chapter 61: Attendance Allowance and Disability Living Allowance*, DWP (2018).

¹¹ *Synopsis of the DLA Benefit review, Memorandum submitted by the Department of Social Security (DLA 11, Annex D)*, House of Commons Social Security Committee – minutes of evidence, 1 April 1998.

and saved a modest £40 million over the two years that it operated. Of the cases reviewed, 22 per cent of awards were disallowed or reduced, 76 per cent were not changed and 2 per cent were increased. The NAO also reported that around 28,000 claimants requested a review of the decision taken on their award under the scheme with around a third of those having their awards increased.¹²

- **Periodic enquiry:** introduced in June 1999 in response to criticism of the BIP, periodic enquiry (also known as periodic review) was designed to be a more even-handed approach to the reassessment of disability claimants' circumstances, applying across all rates of benefit with greater scope for awards to be revised up. The number of reviews was intended to be much lower than under the BIP. Between June 1999 and September 2000 24,000 cases were reviewed, of which 19 per cent were increased, 7 per cent were decreased, and 75 per cent were left unchanged.¹³
- **Right Payment Programme:** this was introduced in 2007 to replace periodic enquiry. The initiative selected 12,000 cases a year from the DLA caseload for further investigation and had fewer exemptions than periodic enquiry.

3.13 Policy changes over this period had relatively small spending implications. They included:¹⁴

- **Limiting back-dated payments on review to one month:** introduced in April 1997, this reduced the duration of back-dated payments a claimant could receive where an award review had determined that they had been underpaid.
- **Restricting the upper age at which DLA claims could be made to 65:** introduced in October 1997 to ensure timely claims. Previously, disabled people could claim DLA in their 66th year where they had experienced a disabling condition prior to turning 65. This policy meant that claims could only be made before an individual's 65th birthday.
- **Lowering the minimum age at which children could claim the higher rate mobility component of DLA:** introduced in April 2001, this extended the higher rate mobility component to cover children aged 3 and 4 (from only those aged 5 and above).
- **Extending the higher rate mobility component to severely visually impaired people:** introduced in April 2011, around 22,000 were thought to gain initially with subsequent increases of 1,000 people a year.

Early delivery challenges

3.14 The early years of DLA highlight the challenges associated with delivering large-scale benefit reforms – something we have seen again 20 years later with PIP (as discussed in Chapter 4). An unexpectedly high volume of claims proved to be an early issue in the

¹² See Figure 6 in Chapter 2 of *Appropriation Accounts 1998-99, Volume 12: Class XII, Department of Social Security*, National Audit Office, January 2000.

¹³ See Secretary of State for Social Security, House of Commons written answer on 'Disability Living Allowance', 30 October 2000 (Hansard volume 355, columns 262-263).

¹⁴ Unpublished information provided by the Department for Work and Pensions.

operational delivery of DLA. One month after launch, in February 1992, new claims were more than double the Government's pre-implementation forecast. By April, the number of 'top-up' claims (those made by individuals already in receipt of AA and MobA) had already exceeded the Government's full-year forecast and they were 35 per cent higher by the end of September. Perhaps due to the increased publicity around disability benefits associated with the introduction of DLA, AA claims also rose to 42 per cent higher than expected between February and April. This placed substantial pressure on processing times, with the backlog for both benefits reaching around 400,000 in June before declining to close to 240,000 in September. The Benefits Agency hired 800 more staff to help clear the backlog of claims.¹⁵ High claim volumes and new staff would no doubt have meant that the claims handling process was less accurate than would otherwise have been the case.

- 3.15 The backlog of new claims eased over the course of the year, only to be replaced by large numbers of requests for award reviews. By the beginning of 1993-94, around 520,000 DLA claims had been received in total across Great Britain, of which close to 95 per cent had received a decision (57 per cent of which received an award and 43 per cent of which were refused). But around 100,000 award reviews had been requested, with less than half having been conducted by April 1993. Of the reviews where final decisions had been reached, the majority maintained awards for those that had initially received one.¹⁶ Spending on DLA in 1992-93 and 1993-94 reached £2.0 billion and £2.8 billion respectively, compared with initial Government forecasts of £1.8 and £2.2 billion.¹⁷

Overall trends in disability benefits spending

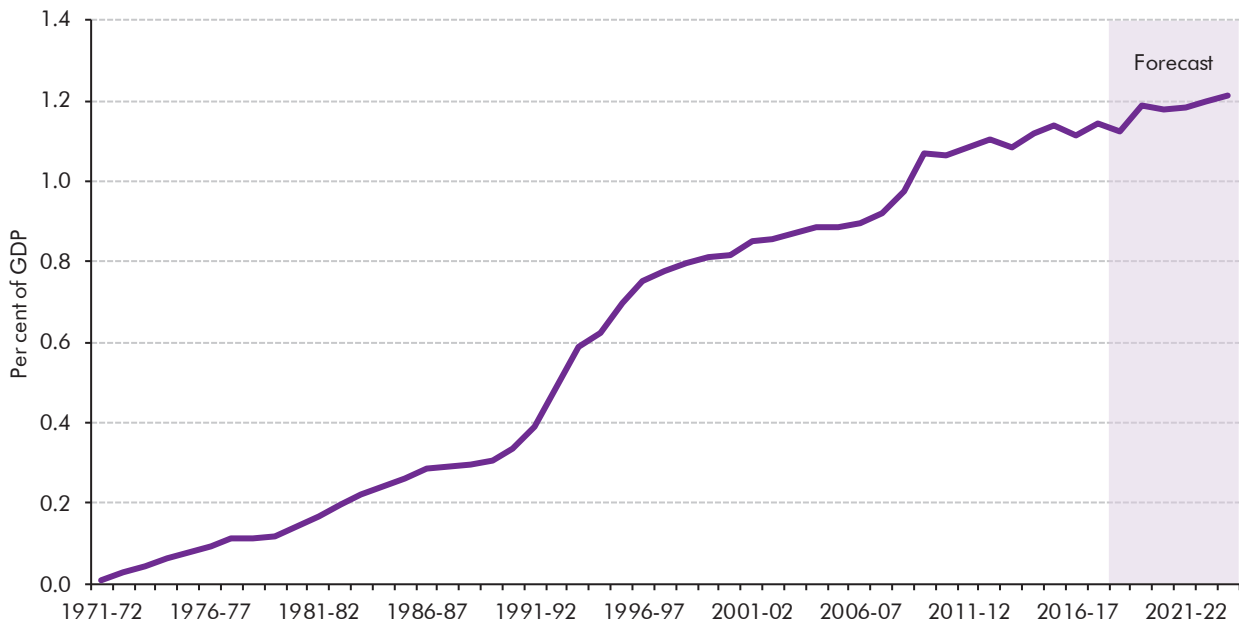
- 3.16 Spending on the disability benefits covered in this *Welfare trends report (WTR)* has risen from less than 0.1 per cent of GDP in 1971-72 to 1.1 per cent in 2017-18 and we expect it to reach 1.2 per cent of GDP by 2023-24 (Chart 3.1). In large part this reflects both intended and unintended increases in the scope of disability benefits and therefore the prevalence of their receipt across the population, rather than increased generosity.

¹⁵ See Secretary of State for Social Security, House of Commons written answer on 'Benefits Agency', 27 October 1992 (Hansard volume 212, columns 628-629).

¹⁶ See Secretary of State for Social Security, House of Commons written answer on 'Disability Living Allowance', 30 April 1993 (Hansard volume 223, columns 572-573).

¹⁷ See Secretary of State for Social Security, House of Commons written answer on 'Disability', 28 February 1991 (Hansard volume 186, column 605).

Chart 3.1: Disability benefits spending relative to GDP



Note: Attendance allowance caseloads interpolated for 1971-72 and 1972-73.
Source: DWP, OBR

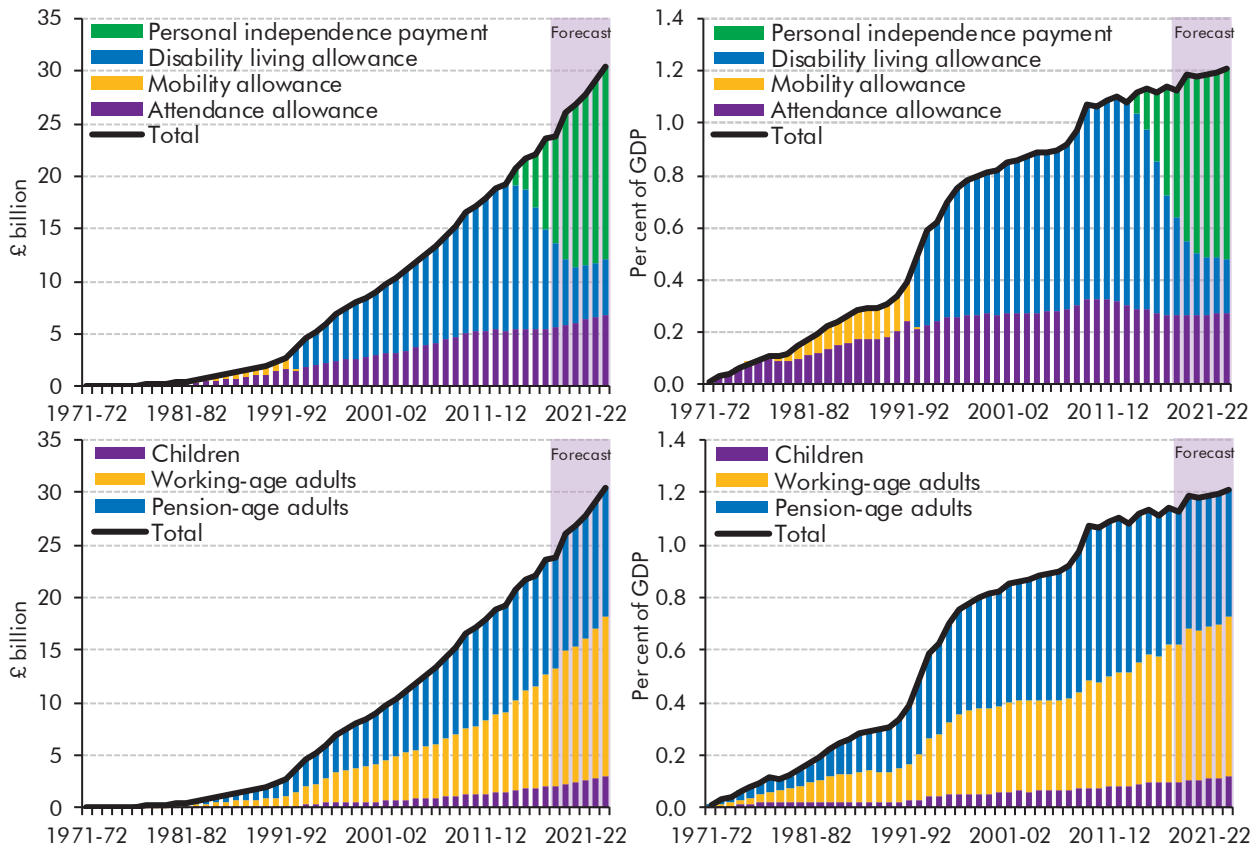
3.17 Chart 3.2 illustrates the build-up in spending on disability benefits, both in cash terms and relative to GDP, split by the different benefits (in the top panels) and the age of recipients (in the bottom panels). The former illustrates the different paces of increase under the three phases of the extra-costs disability benefits system, with growth most rapid in the early years of DLA. The latter show that all ages have contributed to the long-term rise in the cost of disability benefits. Taking each phase of the system in turn:

- **From 1971-72 to 1991-92** spending on AA and MobA increased steadily to reach £2.8 billion (0.4 per cent of GDP) in 1991-92, the year before DLA was introduced. For most of the period, the proportion of spending accounted for by pension-age adults increased, rising from 51 to 57 per cent over the period. By 1991-92, 36 per cent of spending was on working-age adults and just 7 per cent on children.
- **From 1992-93 to 2012-13** – following the introduction of DLA as the main disability benefit for children and working-age adults – spending increased rapidly. Relative to 1991-92, spending more than doubled in cash terms by 1995-96 and doubled relative to GDP by 1996-97. Thereafter, spending continued to rise, but less rapidly, in cash terms and relative to GDP. Spending then spiked relative to GDP during the late-2000s recession as GDP fell. That rise did not unwind with the subdued recovery in GDP that followed. The composition of spending by age group was relatively stable over this period, with pension-age adults accounting for a little over half the total, working-age adults for around two-fifths and children for less than a tenth.
- **From 2013-14 to date** – as PIP has been phased in to replace DLA for working-age claimants – cash spending continued to rise steadily up to 2017-18. Spending remained around 1.1 per cent of GDP and we expect it to reach 1.2 per cent by

Disability benefits spending

2023-24. The past four years have seen a shift from pension-age to working-age adults, with the latter accounting for the largest share of spending in 2017-18 – for the first time since 1980-81. We expect this trend to continue as working-age prevalence continues to rise while pensioner-age prevalence declines. We discuss the DLA to PIP transition and the forecast in greater detail in Chapters 4 and 5 respectively.

Chart 3.2: Disability benefits spending by benefit and by age group



Note: Attendance allowance caseloads interpolated for 1971-72 and 1972-73.
Source: DWP, OBR

3.18 This section has focused on the four current and previous 'extra-costs' disability benefits, but there are other ways that the welfare system and broader public spending support disabled people, some of which are described in Box 3.1.

Box 3.1: Other welfare spending in support of disabled people

Public financial support for disabled people extends beyond the extra-costs disability benefits considered in this report, and includes several other welfare payments. In many cases, these payments are directly related as eligibility for one affects eligibility for another. This box gives an overview of some of the most important interactions between disability and other benefits. Our 2014 *Welfare trends report* provided a fuller overview of sickness and disability benefits.

Disability premia in DWP-administered benefits

Disability premia are extra amounts of money included in assessment for income support, income-based jobseeker's allowance, income-related employment and support allowance (ESA), housing benefit and pension credit. Premia vary according to the severity of conditions, with enhanced and severe disability premia awarded for those with greater needs. Eligibility is linked to the receipt of qualifying benefits such as AA, DLA and PIP. Changes in AA, DLA and PIP caseloads therefore affect the cost of disability premia awarded with other benefits.

Just over a million working- and pension-age adults receive a severe disability premium in ESA, pension credit, income support or jobseeker's allowance, worth £64.30 a week for each recipient, and around £3.5 billion a year in total.^a 225,000 claimants receive an enhanced disability premium in ESA or income support that arises solely from their receipt of a relevant disability benefit.^b This is worth £16.40 a week per single recipient (£23.55 for couples) and costs around £0.2 billion a year. A small number of income support claimants also receive a disability premium solely by virtue of receiving DLA or PIP.^c

Looked at another way, 24 per cent of working-age DLA or PIP claimants receive a severe disability premium, and 20 per cent of pension-age disability benefit claimants do so.

ESA, income support, jobseeker's allowance and housing benefit are being replaced by universal credit, which does not include disability premia. Pension credit will continue to have disability benefit-contingent amounts under current policy.

Disability elements in tax credits

Working tax credit (WTC) and child tax credit (CTC) both pay additional amounts in respect of disability. The 'disabled worker element' in WTC is worth £3,090 a year and is paid to families containing a disabled person who works at least 16 hours a week and meets both a disability test and a qualifying benefit test. 121,000 disabled worker elements were in payment in 2016-17, the latest year of finalised award statistics. The 'severely disabled worker element' in WTC is worth £1,330 a year and is paid to families containing at least one person in receipt of a higher rate disability benefit, regardless of whether that person is working: 42,000 were in payment in 2016-17. The 'disabled child element' in CTC includes two rates: the disabled child rate is worth £3,275 a year and the severely disabled child rate is worth an additional £1,325 a year. Payment is determined by receipt of a qualifying benefit, with the rate paid determined by the rate at which the qualifying benefit is paid. 199,000 disabled child elements and 77,000 severely disabled child elements were in payment to in-work families in 2016-17.^d

In 2017-18, the total cost of disability elements in tax credits was £1.9 billion.

Carer's allowance

Carer's allowance (CA) provides support for carers of sick and disabled people who require regular care. Eligibility is subject to caring for someone in receipt of a qualifying rate within a qualifying benefit. This includes AA, the highest and middle rates of the DLA care component, and the PIP daily living component. CA cannot be received where the person being cared for receives a severe disability premium. Around 53 per cent of child DLA qualifying claims have an associated CA payment for a carer, while 19 per cent of qualifying working-age disability benefit claims and 8 per cent of pension-age qualifying claims do. Spending on CA reached £2.8 billion in 2017-18, with around 0.8 million people receiving on average £3,400 over the year. CA in Scotland has been devolved to the Scottish Government.

Overlaps and interactions with other benefits and wider public spending

Disability benefit recipients often receive one or more other benefits, whether related to their disability or not. ESA is the main incapacity benefit that supports working-age people who are unable to work due to sickness or disability. Spending on ESA in 2017-18 was estimated at £15.4 billion, with around 2.2 million people receiving on average £6,600 over the year. Around 1.4 million ESA recipients (60 per cent) were also in receipt of DLA or PIP. There is no direct link between ESA and DLA or PIP – other than for premia – and the claims processes are entirely separate. But receipt of them is highly correlated due to overlapping eligibility criteria and the fact that claiming one can prompt an individual to claim the other as they realise they are entitled to both. This effect is seen most prominently around state pension age where there is no income-replacement benefit tied to health for pensioners.

Beyond the benefits system, there are other important interactions, most significantly with the social care system, where changes in provision can affect claims to disability benefits through the take-up behaviour of claimants.

^a *People on income-related ESA and Enhanced or Severe Disability Premium, or both*, DWP, June 2018. The estimated spending is based on the weekly amount of severe disability premium and the caseload. It should therefore be taken as a broad indication only. In practice, some claimants will receive less than this amount due to income being partially offset against it.

^b *People on income-related ESA and Enhanced or Severe Disability Premium, or both*, DWP, June 2018. This figure does not include 1.3 million claimants of the ESA support group, who automatically receive an enhanced disability premium regardless of whether they receive a qualifying rate of a disability benefit.

^c Receipt of DLA or PIP is not the sole criterion for payment of a disability premium. While such premiums are also available in housing benefit, information on these is not readily available and their impact on claimants' entitlements depends on the other means-tested benefits received.

^d Information on tax credit disability elements is not available for out-of-work families.

Drivers of changes in disability benefits spending

- 3.19 We can decompose changes in spending into the proportions due to changes in the caseload and in the average amount paid to each claimant. We can then decompose changes in the caseload into the amounts reflecting population growth and changes in the prevalence of disability benefit receipt in the population. Ideally, we would also like to decompose changes in prevalence into the amounts due to changes in new benefit receipt versus changes in the average length of time spent in receipt of them – or to compare them with changes in underlying or reported disability prevalence, eligibility for benefits and the rate at which they are taken up. But this is rarely possible, especially over longer periods.
- 3.20 Table 3.1 decomposes changes in spending as a share of GDP into contributions from changes in the caseload relative to the total population and those from changes in average awards relative to GDP per person. Because spending rises from a very low starting point, and due to the relative long periods involved during which interactions between changes in the age structure of the population and the different levels of prevalence and average awards can be material for spending, this decomposition is illustrative rather than precise.
- 3.21 In the absence of data on the degree to which the AA and MobA caseloads overlapped, we have used the earliest available DLA data to inform assumptions on the degree of the overlap. We assume that the proportion of DLA claimants in each age group that received a DLA mobility component but not a care component can be applied to MobA caseloads to estimate the caseload that would not also have received AA. This assumption relies on the DLA caseload offering a reasonable approximation of the characteristics of the caseload under the preceding disability benefits system and is therefore subject to some uncertainty.
- 3.22 On this basis, the decomposition shows that:
- **Between 1971-72 and 1991-92**, the 0.4 per cent of GDP increase in spending was dominated by the caseload rising as a share of the population (and in this breakdown has simply been allocated entirely to this source). By 1991-92, 1.8 per cent of the population was in receipt of AA and 1.2 per cent in receipt of MobA. On the assumptions we have used about overlapping claims, that implies 2.5 per cent of the population was in receipt of a disability benefit. Around 55 per cent of the growth in spending was related to pension-age caseload prevalence and 35 per cent to prevalence among working-age adults. Caseload prevalence among children increased.
 - **Between 1991-92 and 2012-13**, the 0.7 per cent of GDP increase in spending was again dominated by the caseload rising as a share of the population. The largest contribution came from greater prevalence of DLA receipt among working-age adults in 2012-13 than had been the case under AA in 1991-92 (up from 1.1 to 4.7 per cent over that period). But rising prevalence of benefit receipt among pension-age adults also contributed significantly to the overall increase in spending, with 24.8 per cent of pensioners in receipt of DLA or AA in 2012-13 compared with 10.3 per cent in receipt

of AA or MobA in 1991-92. Average awards in 2012-13 were little changed from their 1991-92 level relative to GDP per person, although that reflected a steady decline between 1996-97 and 2007-08 that was largely reversed in the two years to 2009-10 as GDP per person fell sharply during the recession.

- **Between 2012-13 and 2017-18**, spending was flat as a share of GDP, as the rise in benefit receipt prevalence and average awards among working-age adults associated with the PIP rollout was offset by the decline in prevalence among pension-age adults. We discuss the transition from working-age DLA to PIP in detail in Chapter 4.
- **Between 2017-18 and 2023-24**, we expect spending to rise by 0.1 per cent of GDP, largely due to prevalence of benefit receipt continuing to rise among children and working-age adults, plus the boost to working-age average awards from the completion of the PIP rollout. The drivers of these changes are described in Chapter 5.

Table 3.1: Sources of change in disability benefits spending as a share of GDP

	Per cent of GDP			
	1971-72 to 1991-92	1991-92 to 2012-13	2012-13 to 2017-18	2017-18 to 2023-24
Spending at start of period	0.0	0.4	1.1	1.1
Spending at end of period	0.4	1.1	1.1	1.2
Change	0.4	0.7	0.0	0.1
<i>of which changes due to:</i>				
Caseload as a share of the population	0.4	0.8	0.0	0.1
<i>of which:</i>				
Children	0.0	0.1	0.0	0.0
Working-age adults	0.1	0.3	0.0	0.0
Pension-age adults	0.2	0.4	0.0	0.0
Average award relative to GDP per capita	-	0.0	0.0	0.0
<i>of which:</i>				
Children	-	0.0	0.0	0.0
Working-age adults	-	0.0	0.1	0.0
Pension-age adults	-	0.0	0.0	0.0

Note: Components may not sum to totals due to interactions with changes in the age structure of the population.

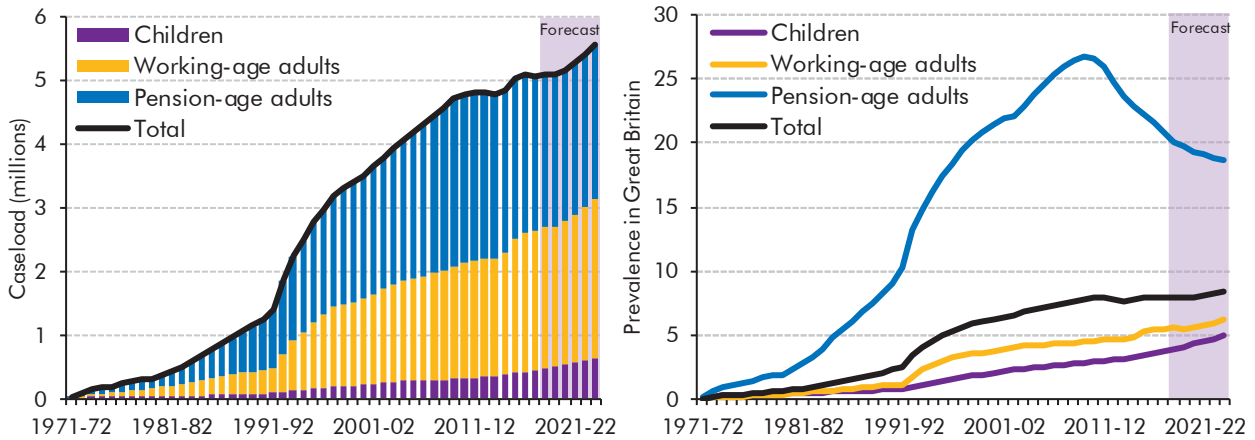
Note: Attendance allowance caseloads interpolated for 1971-72 and 1972-73.

Trends in the prevalence of disability benefit receipt

3.23 The main driver of the growth in disability benefits spending has been the large rise in the proportion of the population in receipt of such payments (Chart 3.3). From zero in 1970-71, before the introduction of AA, the caseload increased to 5.1 million (7.9 per cent of the population) in 2017-18.¹⁸ We expect it to increase by a further 0.5 million by 2023-24 to reach 5.6 million (8.4 per cent of the population) as we discuss later in the Chapter 5. Rising prevalence has been a feature across different age groups and, with the exception of recent years among pension-age adults, across the 50 years covered in this report.

¹⁸ In the period from 1971-72 to 1991-92, the overall disability benefits caseload has been estimated using the assumptions about overlaps between AA and MobA cases set out in paragraph 3.21.

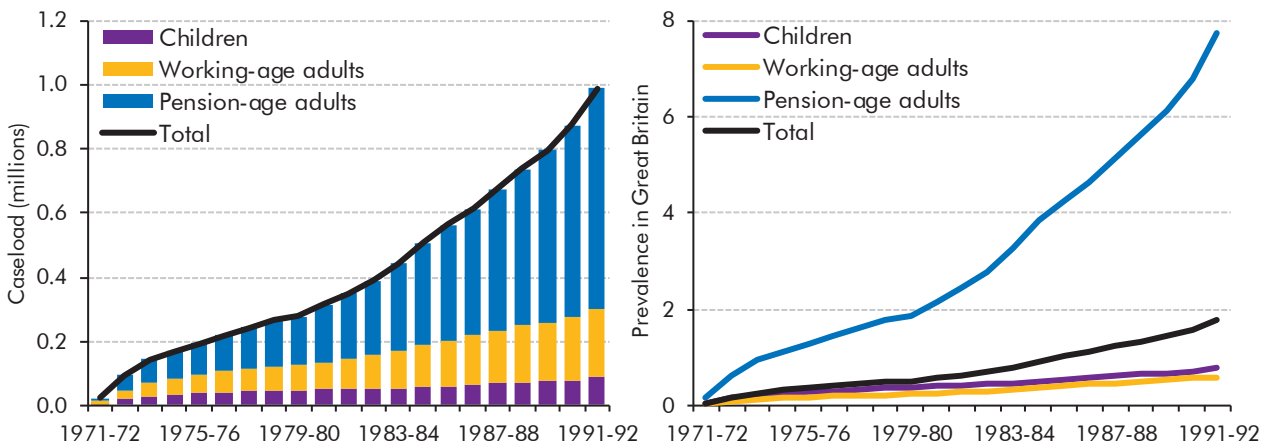
Chart 3.3: Disability benefits caseloads and prevalence by age



Source: DWP, ONS, OBR

3.24 In the first phase up to 1991-92, the AA caseload reached 1.8 per cent of the population and the MobA caseload reached 1.2 per cent. These rises reflected varying changes in prevalence by age, with pension-age prevalence of AA receipt rising most rapidly. A larger proportion of the MobA caseload was made up of working-age adults, but prevalence of benefit receipt in this group remained low in comparison to pensioners. The modest rise in prevalence relative to subsequent periods reflects the relatively narrow scope of these benefits, as evidenced by the debates about coverage that preceded the introduction of DLA. For example, the adequacy of their coverage of children was often questioned over this period, with political pressure leading to the extension of AA to children under 2 in 1990 and an unsuccessful drive to extend MobA to children aged under 5.¹⁹

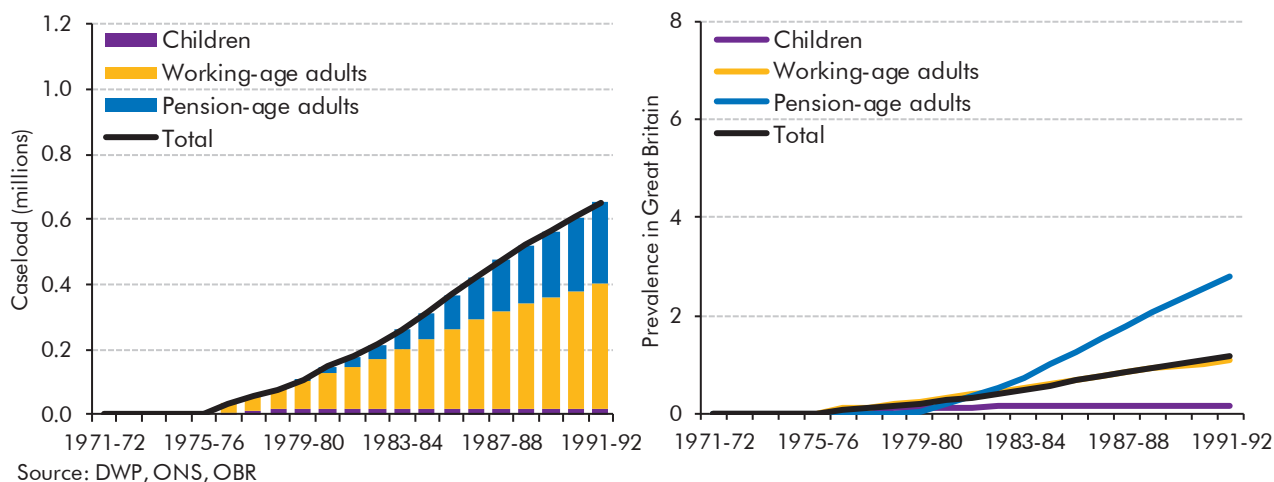
Chart 3.4: Attendance allowance caseloads: 1971-72 to 1991-92



Source: DWP, ONS, OBR

¹⁹ See Disabled Children (Mobility Allowance) HC Questions, 16 October 1990 (Hansard, volume 177, columns 1186-1192).

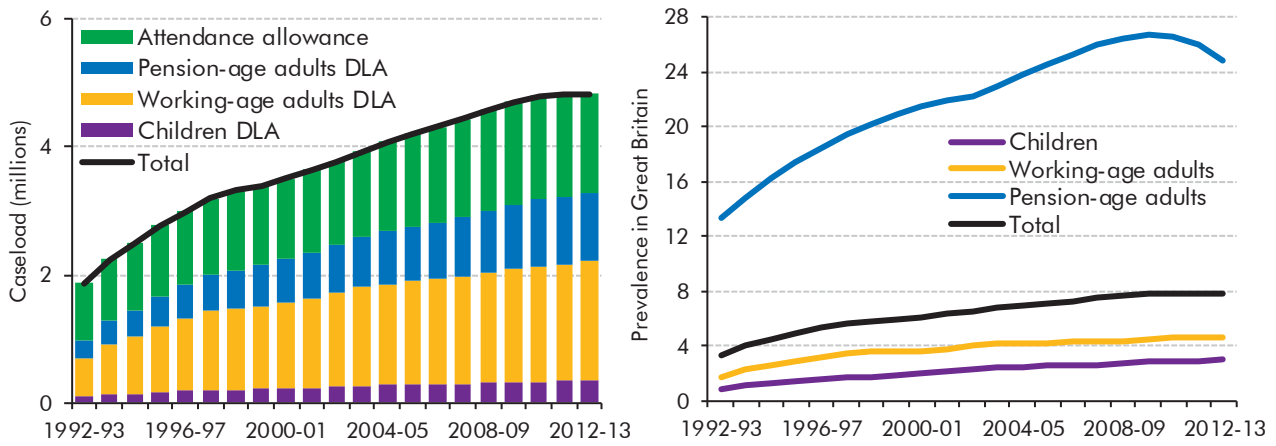
Chart 3.5: Mobility allowance caseloads: 1971-72 to 1991-92



3.25 In the second phase between 1992-93 and 2012-13, the numbers claiming either AA or DLA increased from around 2 million to close to 5 million. The vast majority of this change reflected rising prevalence of disability benefit receipt among the population. It increased most rapidly among children and working-age adults but from a relatively low base given the narrower coverage in the preceding period. Prevalence increased from 0.8 to 2.9 per cent among children, from 1.7 to 4.6 per cent among working-age adults and from 13.3 to 24.8 per cent among pension-age adults.

3.26 It is not possible to disentangle the drivers of these rises precisely, but it is clear that the introduction of DLA and subsequent changes to the system considerably widened the scope of disability benefits both for less severely disabled people and for those below pension age. Subsequent legal rulings and administrative changes then served to widen the scope of DLA even further. The more rapid growth in caseloads from 1992 was not solely the result of the new lower rates being introduced, as the existing rates carried forward from AA and MobA also showed significant increases, suggesting changes in the assessment system was also a major influence. Reform and policy focus also served to raise awareness of disability and disability benefits, which may have increased take-up among the eligible population. More generally, social attitudes towards disability appear to have changed during the period covered by DLA, which may have also affected take-up rates (see Chapter 2).

Chart 3.6: Attendance allowance and DLA caseloads: 1992-93 to 2012-13

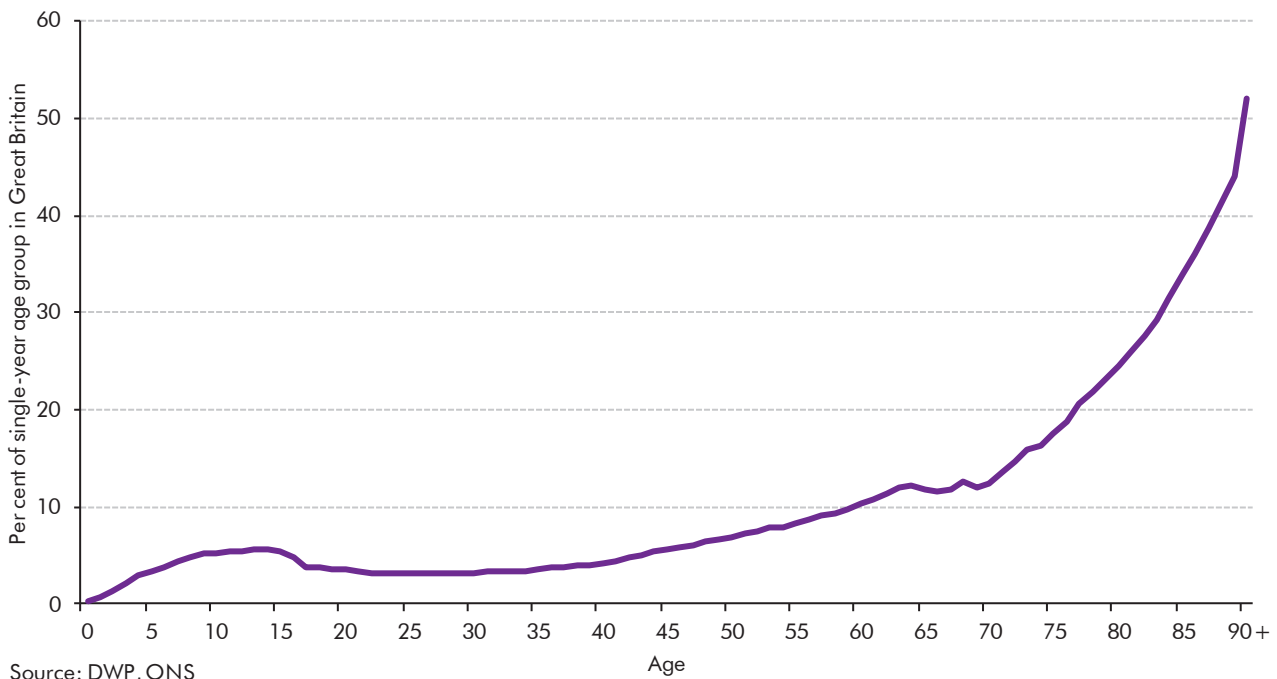


Source: DWP, ONS, OBR

Disability benefit receipt by age

3.27 In Chapter 2 we saw that reported disability prevalence tends to be higher among older age groups. This is also true of the prevalence of disability benefit receipt. Chart 3.7 shows the age profile as it stood in May 2018. Most strikingly it shows the extent to which prevalence rises at older ages, from 11 ½ per cent at age 65, to 17 ½ per cent at 75, 34 per cent at 85 and more than 50 per cent among those over 90 years of age. It also shows how prevalence generally rises with age among children (topping 5 per cent from ages 9 to 15), drops slightly among younger working-age adults, then rises steadily again among older working-age adults (doubling from around 3 per cent in the mid-to-late 20s to around 6 per cent in the mid-40s and again to around 12 per cent by the mid-60s).

Chart 3.7: Disability benefit receipt by age (May 2018)



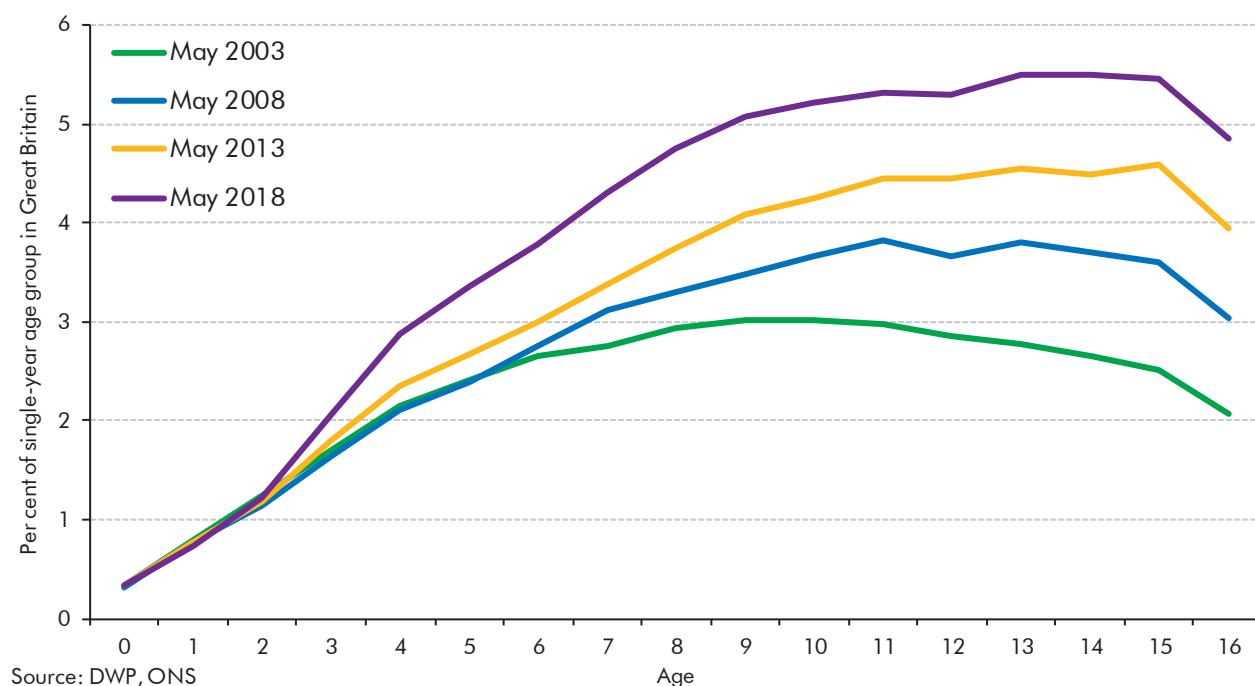
Source: DWP, ONS

Trends in prevalence among children

3.28 The disability benefit caseload among children increased steadily from around 30,000 in 1973-74 to 90,000 in 1991-92 (up from 0.2 to 0.8 per cent of all children). After the introduction of DLA, the child caseload increased at a faster rate, reaching 450,000 (3.7 per cent of all children) in 2017-18. We expect the caseload and prevalence to continue to rise in future years, reaching 630,000 (5.0 per cent of all children) by 2023-24.

3.29 Chart 3.8 shows how age-specific prevalence among children has changed over the past 15 years. Over each five-year period, prevalence has increased at almost all ages, consistent with the aggregate trend described above. In the earliest year, 2003, prevalence increased with age up to age 9 before tailing off from age 11 and dropping more sharply at age 16. In 2008 the pattern was similar, this time tailing off at age 13. In 2013 and 2018, prevalence increased with age up to age 13 and held broadly flat until age 15 before falling back at age 16. As PIP can only be newly claimed by working-age adults, children on DLA begin to be reassessed for transition to PIP as they approach age 16. These reassessments can result in some children ceasing to be eligible. Since 2008 there have been more substantial rises among pre-school-age children, which was not the case between 2003 and 2008.

Chart 3.8: Child disability benefit prevalence by age

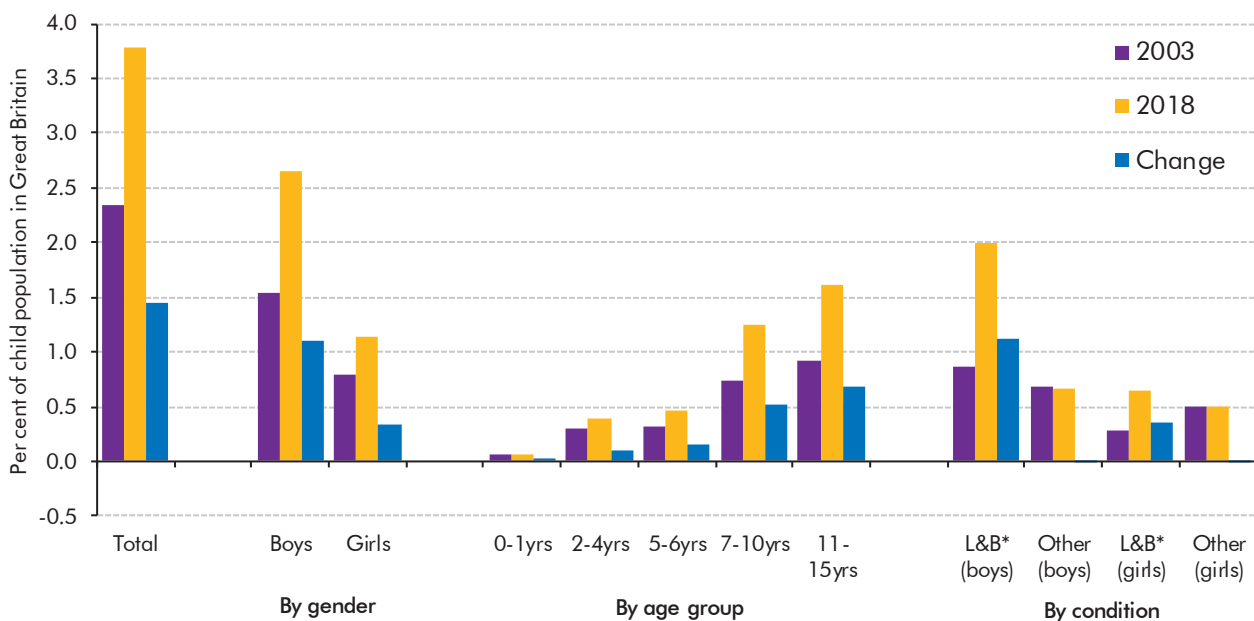


3.30 Chart 3.9 compares disability benefit prevalence among children in May 2003 and May 2018 using different breakdowns of the caseload. Of the 1.4 percentage point rise in prevalence over that period, it shows that:

- **By gender**, prevalence among boys was higher in both periods and increased more rapidly over the 15 years (with the caseload rising by 85 per cent among boys versus 54 per cent among girls). As a result, boys accounted for around three quarters of the rise in disability benefits prevalence among children over the period.

- **By age group**, caseload growth was more rapid among older school-age children (as was clear from the age profiles in Chart 3.8 above). Around half the change in prevalence among children was accounted for by the 11-to-15-year old age group and another third by 7-to-10-year olds.
- **By condition**, three conditions – learning difficulties, behavioural disorders and hyperkinetic syndrome (otherwise known as attention deficit hyperactivity disorder or ADHD) – account for all the rise in benefit receipt prevalence among children, with the split between boys and girls roughly three-quarters boys to one-quarter girls. Among both boys and girls, the caseload in respect of these three conditions combined increased by almost 150 per cent over the period.

Chart 3.9: Child disability benefit prevalence by gender, age and condition



Note: 'L&B' refers to learning difficulties, behavioural disorders and hyperkinetic syndrome.
Source: DWP, ONS, OBR

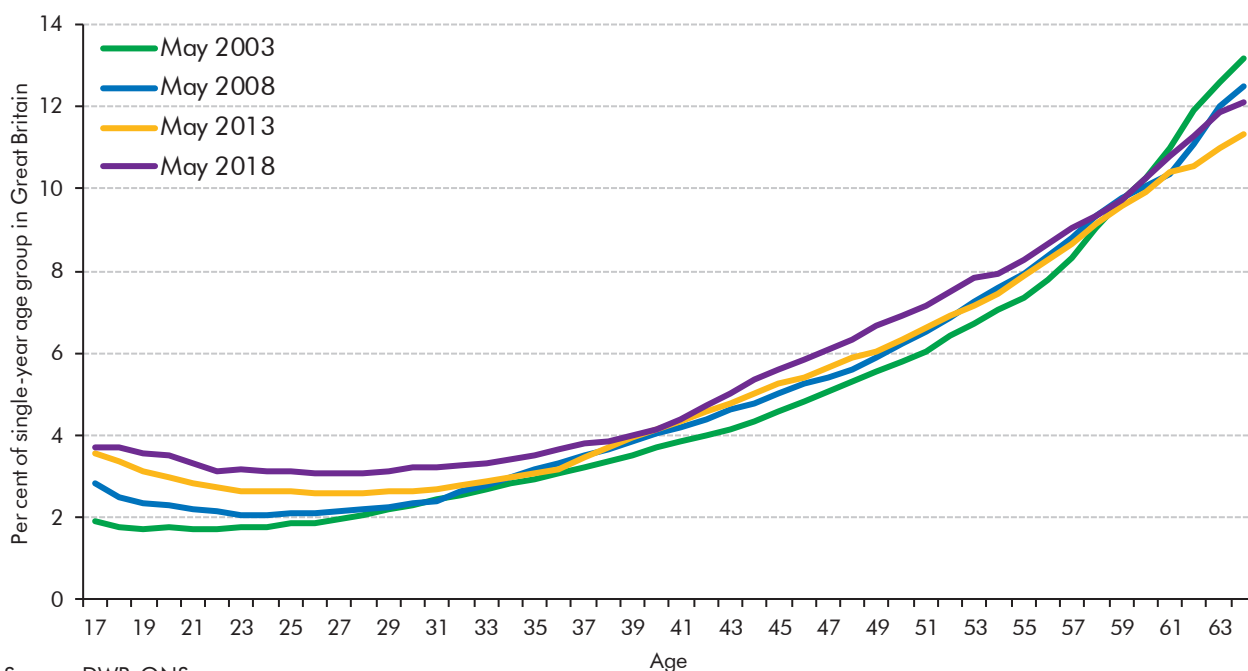
Trends in prevalence among working-age adults

3.31 The disability benefit caseload among working-age adults increased steadily from around 40,000 in 1973-74 to around 400,000 in 1991-92 (from 0.1 to 1.1 per cent of all working-age adults). Working-age adults are defined here as those aged 16 to 64, consistent with the eligibility criteria for DLA. As with children, the working-age caseload increased at a faster rate after the introduction of DLA, reaching 1.9 million (4.7 per cent prevalence) in 2012-13. It stepped up again after the introduction of PIP, reaching 2.2 million (5.4 per cent prevalence) in 2017-18. We expect the caseload and prevalence to continue rising in the coming years, reaching 2.5 million (6.2 per cent of all working-age adults) by 2023-24, as described in Chapter 5.

3.32 Chart 3.10 shows how prevalence by age has evolved over the past 15 years within the working-age population. Notable changes include:

- **Prevalence has increased for those under 60.** This is especially the case for younger people – for example, it has almost doubled for 17-year olds and more than doubled for those aged 18 to 19. This could reflect the increase in reported disability prevalence among younger people, particularly as regards mental health, behavioural and learning conditions (described in Chapter 2).
- **Prevalence has generally fallen for those aged over 60.** In particular, prevalence of disability benefits receipt for those aged 64 – just under the cut-off for new working-age claims – is 1 percentage point lower in 2018 than it was in 2003. But this has not been a consistent trend. Prevalence for those aged over 60 fell between 2003 and 2008 and again between 2008 and 2013, but has increased over the past five years.

Chart 3.10: Working-age disability benefit prevalence by age



Source: DWP, ONS

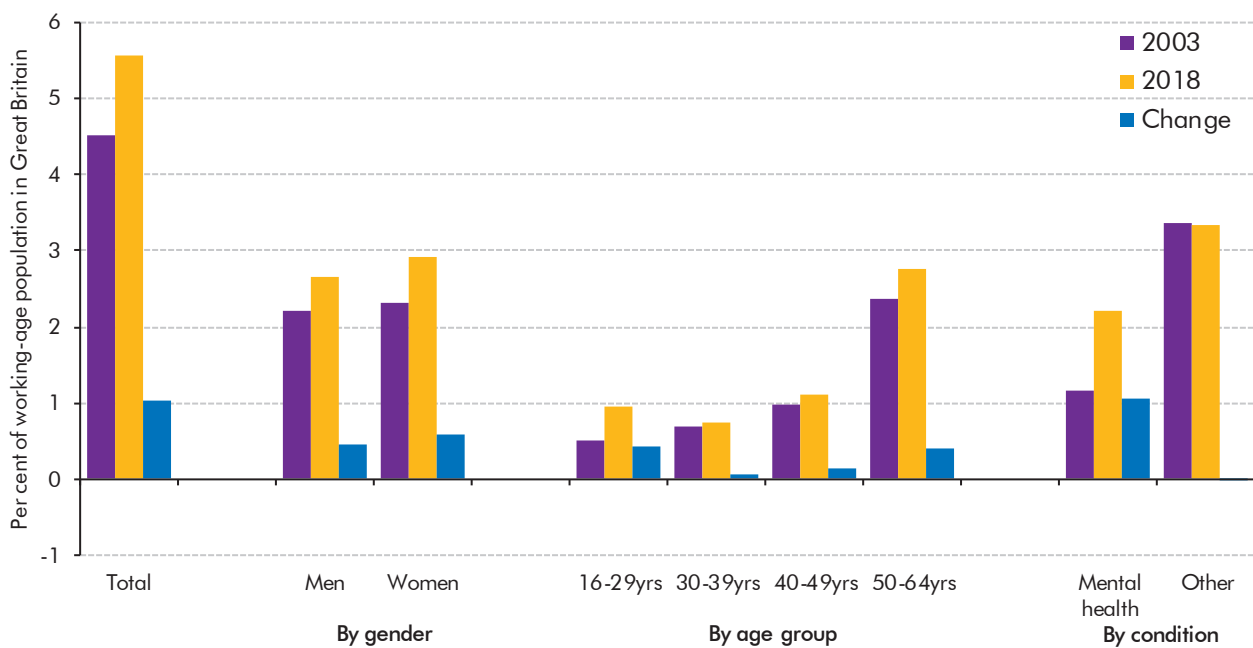
3.33 Chart 3.11 compares disability benefit prevalence among working-age adults in May 2003 and May 2018 using different breakdowns of the caseload. Working-age prevalence increased by 1.0 percentage points from 4.5 to 5.6 per cent over the past 15 years:

- **By gender**, prevalence among working-age adults is slightly higher for women, and has risen slightly faster over the past 15 years, compared to men (with the caseload increasing by 36 per cent for women versus 31 per cent for men). As a result, women accounted for 57 per cent of the rise in working-age prevalence over the period.
- **By age group**, while prevalence rises significantly with age (as shown in Chart 3.10 above), the rise in prevalence over the past 15 years has been dominated by the

increases among younger adults aged 16 to 29. The caseload among this group doubled over the period and accounted for 42 per cent of the overall rise in working-age prevalence, despite representing just 11 per cent of the caseload in 2003 (rising to 17 per cent in 2018). 38 per cent of the rise in prevalence was accounted for by older working-age adults aged 50 to 64.

- **By condition**, the prevalence of receipt in respect of mental health conditions has almost doubled over the last 15 years. Prevalence in respect of other conditions was little changed. As a result, the proportion of the working-age caseload reporting a mental health condition increased from around 25 per cent in 2003 to 40 per cent in 2018.²⁰

Chart 3.11: Working-age disability benefit prevalence by gender, age and condition



Source: DWP, ONS, OBR

3.34 Chart 3.12 shows the proportion of working-age adults receiving each rate of DLA or PIP over the past 15 years. Where an individual receives both the care/daily living and mobility components, they are counted under both, so the total caseload is less than the sum of the components shown in the chart. The proportion of cases receiving a care/daily living component has risen steadily from 79 per cent in 2003 to 94 per cent by 2018. The proportion receiving a mobility component was stable at 88 per cent until the introduction of PIP, but has since fallen to 75 per cent in 2018.

3.35 The composition of the DLA caseload by care component was reasonably stable between 2003 and 2012, with around a quarter of cases receiving the highest rate and the remainder split evenly between the middle and lowest rates. PIP does not include an equivalent of the DLA lowest care rate, hence the sharp fall in prevalence of the lowest care

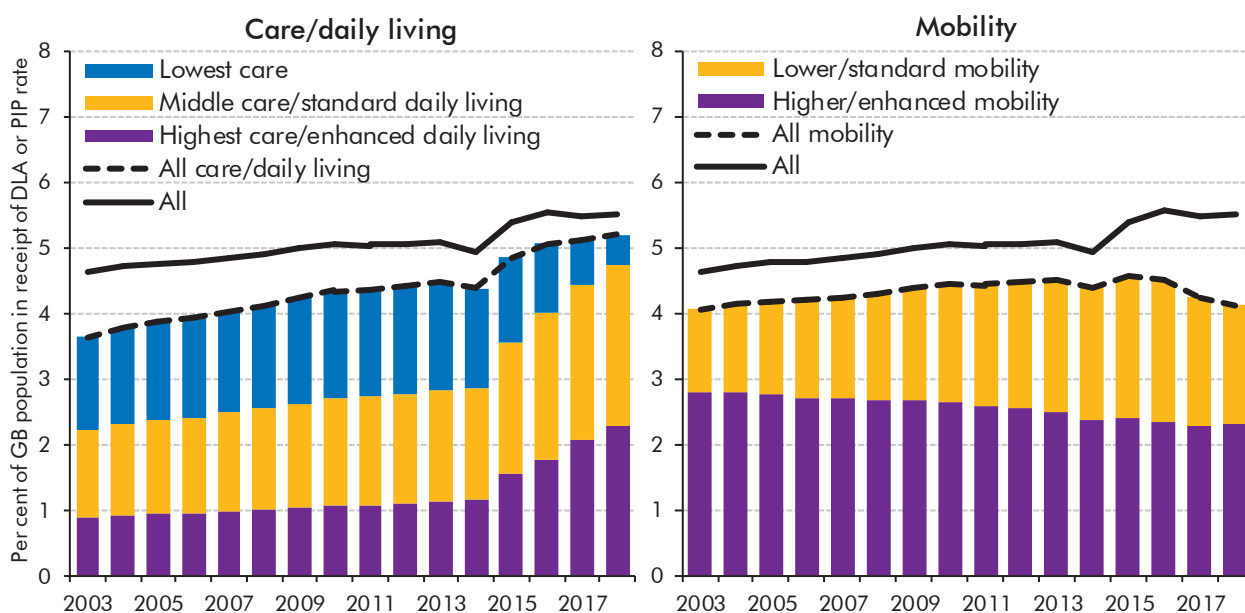
²⁰ Obtaining a breakdown by condition over this period for working-age adults is complicated by the switch from DLA to PIP, which has been accompanied by differences in the recording of claimants' conditions under each benefit.

Disability benefits spending

component receipt since 2013. But instead of this reducing overall prevalence of receipt of daily living support (as had been expected), prevalence of the standard and enhanced daily living components (equivalent to middle and highest care rates paid under DLA) has risen sharply. Indeed, the rise in these two components has more than offset the decline in the DLA lowest care rate prevalence. This pattern is explored further in Chapters 4 and 6.

- 3.36 Before PIP was introduced there had been a long-term decline in the prevalence of higher mobility claimants, more than offset by rising prevalence of the lower rate. Initially these trends appeared to continue as PIP was introduced, but since around 2016 the prevalence of lower/standard mobility receipt has fallen somewhat, while the decline in the higher/enhanced mobility rate has flattened off. Taken together, this still results in a substantial fall in prevalence of mobility components overall.

Chart 3.12: Working-age disability benefit prevalence by rate (age-standardised)



Note: Each series is standardised to remove the effect demographic change has on the overall rate of benefit receipt per capita. This is done by weighting the individual single-year-of-age figures, for males and females separately, by the population age distribution in 2010 (the year in which DLA reform was announced and the mid-point of the data analysed).

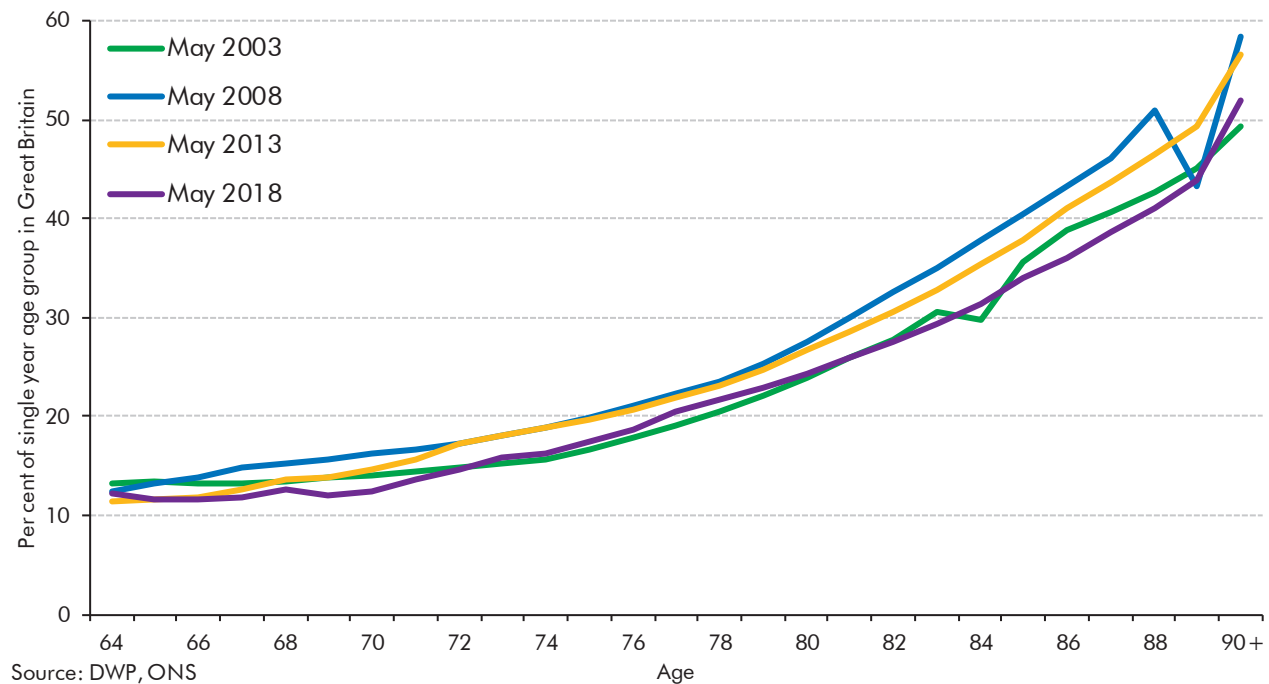
Source: DWP, ONS, OBR

Trends in prevalence among pension-age adults

- 3.37 The disability benefit caseload among pension-age adults increased relatively quickly from around 70,000 in 1973-74 to around 0.9 million in 1991-92 (from 1.0 to 10.3 per cent of all adults aged 65 and over). The pace at which the caseload increased picked up after the introduction of DLA in 1992-93, doubling to 1.8 million in 1997-98. Prevalence peaked at 26.8 per cent of pension-age adults in 2009-10, by which point the caseload stood at 2.6 million. Prevalence has declined more recently – and by enough to offset the effect of a rising pension-age population on the caseload – so that by 2017-18 there were 2.4 million disability benefits cases among adults aged 65 and over.

3.38 As Chart 3.13 shows, pension-age prevalence varies very significantly by age.²¹ Over the past 15 years, prevalence has risen then fallen back at almost all ages from 65 up. Pin-pointing the drivers of these movements is difficult, but one possible explanation is that the official efforts made to increase pension credit take-up around its introduction in 2003 could have prompted people to claim disability benefits to which they were entitled but of which they were previously unaware. Such activity has been absent in more recent years.

Chart 3.13: Pension-age disability benefit prevalence by age



3.39 Chart 3.14 compares disability benefit prevalence among pension-age adults in May 2003 and May 2018 using different breakdowns of the caseload.²² Pension-age prevalence fell by 0.2 percentage points from 20.6 to 20.4 per cent over the past 15 years:

- **By gender**, prevalence among pension-age adults is higher for women than for men, but has risen considerably faster among men over the past 15 years. The male caseload increased by 35 per cent over that period, whereas the larger female caseload rose by only 17 per cent. As a result, the male caseload raised pension-age prevalence, but that was more than offset by the female caseload reducing it.
- **By age group**, growth in the caseload was faster among older pensioners, rising by 45 per cent over the period for those aged 85 and over (thanks to both growth in the number of very old people and to higher prevalence of receipt among them). Among those aged 84 or less, the caseload grew more slowly than the overall pensioner population, more than explaining the overall drop in pension-age prevalence.

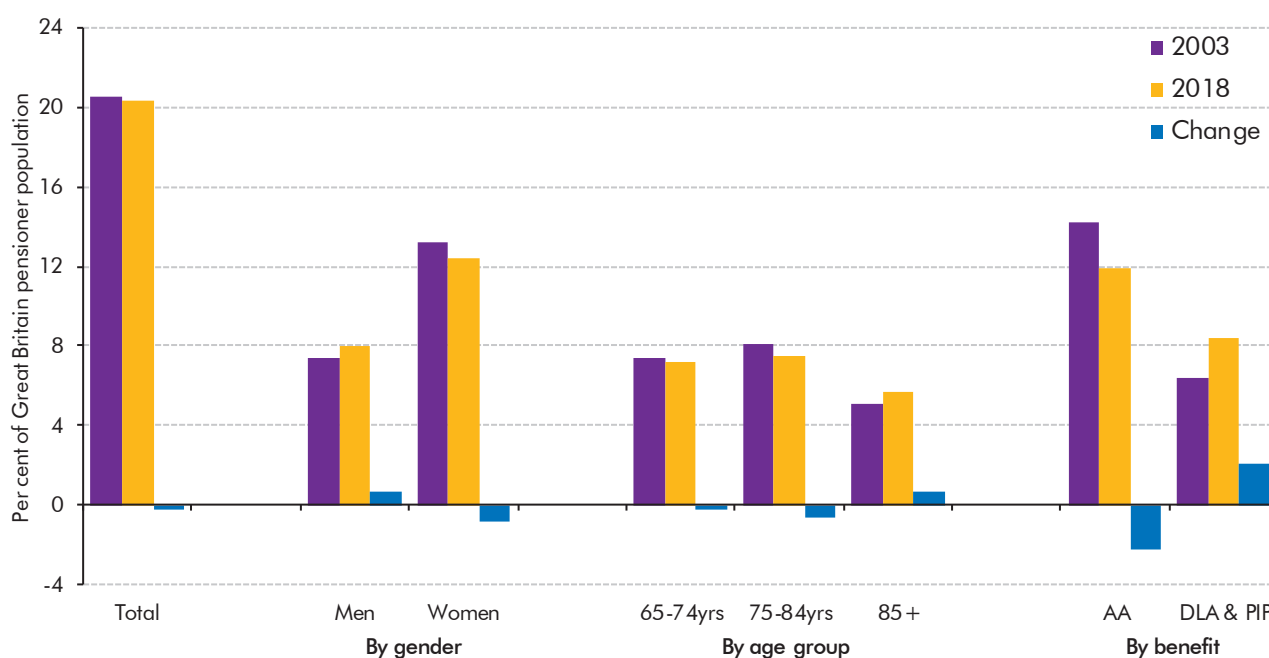
²¹ Note that the 89 year olds in the May 2008 analysis and the 84 year olds in May 2003 reflect the cohort of post-WWI births that survived the Spanish flu epidemic. This cohort's characteristics were notably different from those around it, as we noted in our 2014 *Welfare trends report*, in which Chart 3.3 depicted cohort life expectancy, which is higher for this cohort than for those born in adjacent years.

²² Detailed data on AA claims by condition are not available for May 2003, so a breakdown by condition is not included.

Disability benefits spending

- By benefit**, the composition of the caseload shifted over the period, with prevalence of AA claims falling from 14.2 to 12.0 per cent of pensioners but prevalence of DLA or PIP claims rising from 6.4 to 8.4 per cent. The latter reflects the slow process of working-age DLA and PIP claims that are retained as an individual passes pension age, which build up slowly. As of May 2003, this process had converged to near a steady state for DLA claims among younger pensioners, such that between then and May 2013 the number of 70-year olds claiming DLA increased by 33 per cent (only slightly more than the overall pension-age disability benefits caseload). By contrast, the number of 80-year olds claiming DLA increased by 254 per cent. This reflects the long duration of claims, with close to three quarters lasting five years or more by 2013.

Chart 3.14: Pension-age disability benefit prevalence by gender, age and benefit



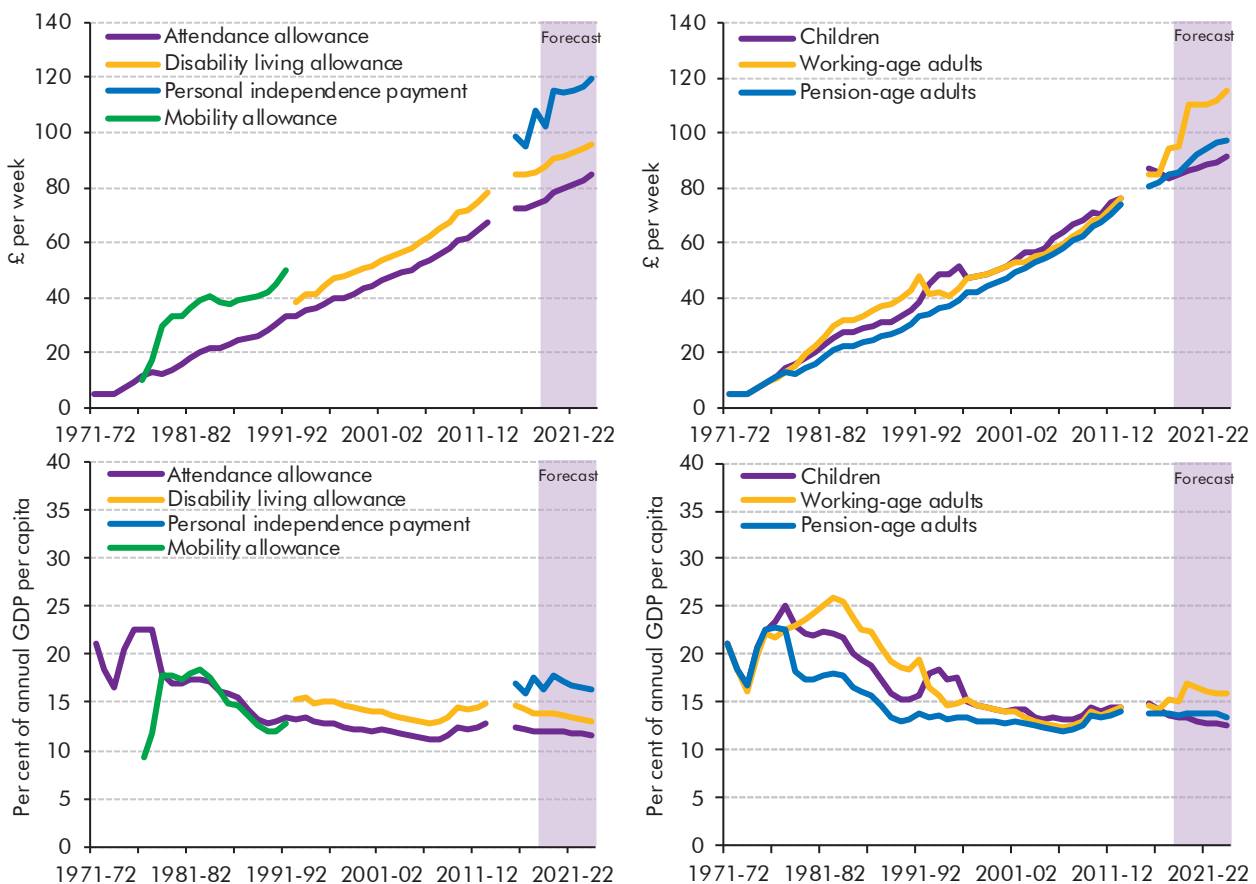
Source: DWP, ONS, OBR

Trends in the average amounts paid to recipients

3.40 Average disability benefit awards have risen in cash terms, in large part reflecting the default policy of uprating statutory rates in line with inflation (Chart 3.15, top panels). Relative to GDP per person, average awards have tended to follow a declining trend – thanks to real incomes rising faster than real average awards (bottom panels). Average awards fell relative to GDP per person for children and working-age adults after DLA was introduced in 1992-93. Spending as a share of GDP continued to rise over this period as the fall in average awards relative to GDP was more than offset by higher caseloads. Average awards jumped relative to GDP per person during the late 2000s recession, as GDP fell. They have been rising again in recent years as the working-age caseload has moved from DLA to PIP, where average awards have been higher than on the predecessor benefit (see Chapter 4).

3.41 Chart 3.15 excludes average PIP awards in 2013-14 and 2014-15, its first two years of operation, when the caseload was small and contained a disproportionately high share of ‘special rules’ claims for terminally ill people receiving higher awards. PIP average awards fell by more than half in cash terms by 2015-16 as other ‘normal rules’ claims were processed and the composition of the caseload approached steady-state. The chart also applies a simplified methodology to account for overlapping claims between AA and MoBA prior to 1991-92, in the absence of actual data (see paragraph 3.21).

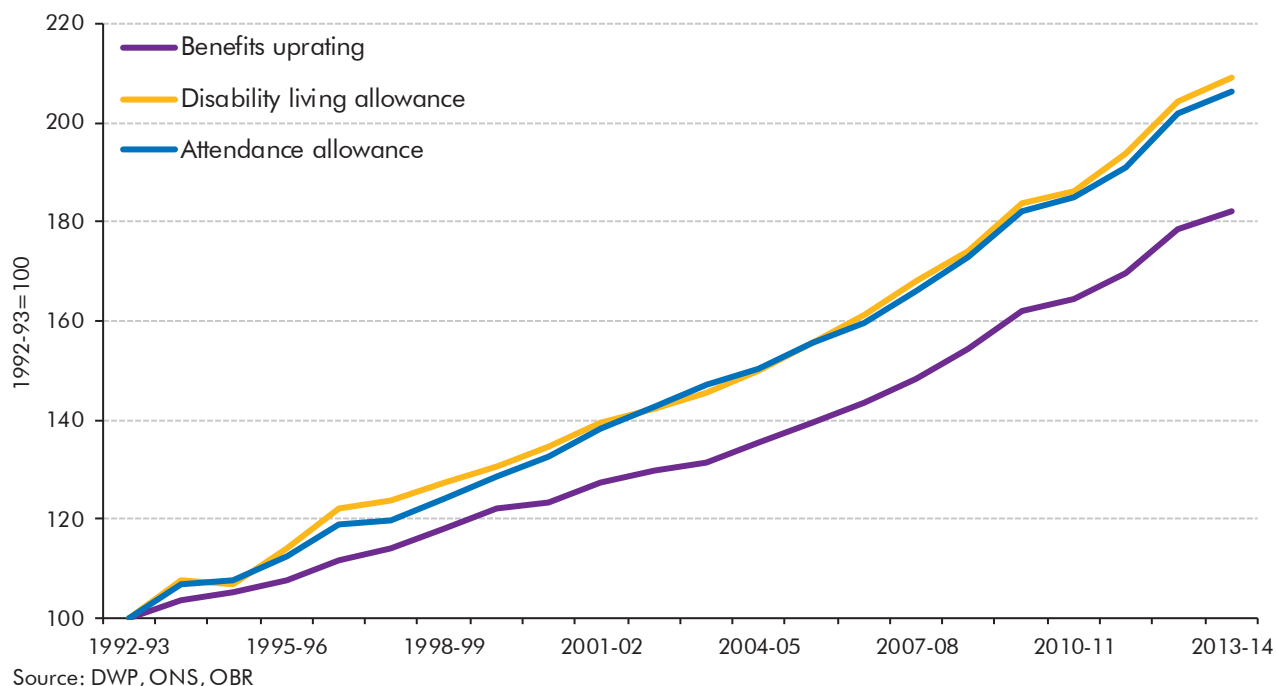
Chart 3.15: Average disability benefit awards



Note: Attendance allowance caseloads interpolated for 1971-72 and 1972-73.
Source: DWP, ONS, OBR

3.42 Chart 3.16 shows how DLA and AA average awards increased faster than would have been the case if they had followed the path of inflation uprating alone (in line with RPI inflation up to 2010-11 and with CPI inflation thereafter) between 1992-93 and 2012-13. Given the graduated rate structure of each benefit, the faster pace of average award growth reflects changes in the composition of the caseload. For example, in 1991-92 around 41 per cent of AA cases received the highest award rate but this share had risen to around 58 per cent by 2012-13. Meanwhile the proportion of the DLA caseload receiving higher rates for both care and mobility components rose from around 12 per cent in 1992-93 to around 16 per cent in 2012-13.

Chart 3.16: DLA and AA average awards versus uprating (1992-93 to 2012-13)



Lessons for forecasting PIP spending

3.43 Trends in spending over the 40 years prior to the introduction of PIP – and particularly the period after the introduction of DLA – point to several factors that we should consider when forecasting the cost of PIP over the medium term (as described in Chapter 5):

- Prevalence of disability benefit receipt varies considerably by age, so **changes in the size and age profile of the population are key drivers** of disability benefits spending.
- When a new disability benefit is introduced, **it takes many years for the average duration of claims to reach a steady state**. This means that there is uncertainty over trends in the prevalence of benefit receipt for an extended period.
- **Changes in the caseload composition have typically pushed average awards higher** than would be explained simply by uprating policy. This could reflect claimants and their advisors learning how to navigate the system to greater benefit – a factor that is likely to be more important now than in the past due to the internet and social media.
- Echoing conclusions that we have reached in each of our previous *Welfare trends reports*, **the effects of major reforms on spending are hard to predict and subject to the risk of optimism bias**. This was true of the early years of DLA and has been true again of the transition from DLA to PIP for working-age claims described in Chapter 4.

4 The DLA to PIP transition

Introduction

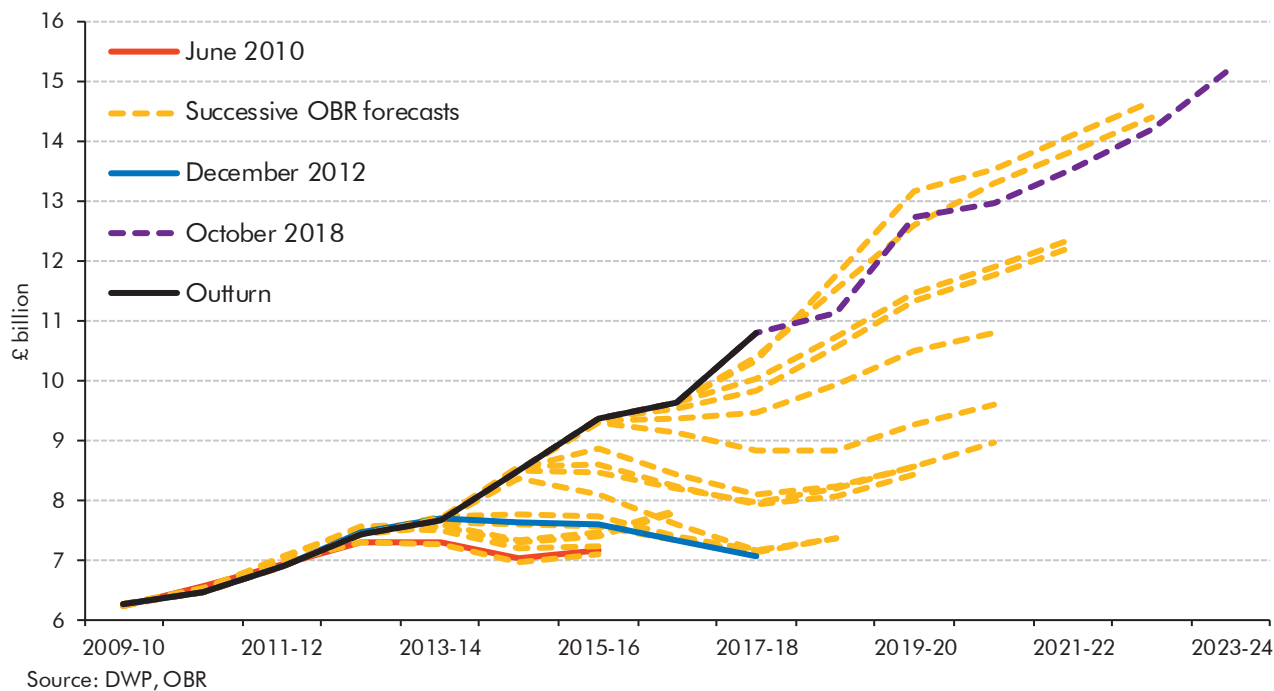
- 4.1 Reform of disability living allowance (DLA) for people of working age was announced in June 2010. The reformed benefit was subsequently named personal independence payment (PIP) and was introduced in April 2013. This chapter:
- briefly reviews **our PIP forecasts** and how they have differed from outturns;
 - discusses **the development of PIP** since DLA reform was announced in June 2010; and
 - details **the performance of PIP in practice** and how that differed from the assumptions underpinning our various forecasts.
- 4.2 Reflecting our remit, we focus on the impact of PIP on welfare spending rather than its effectiveness in meeting the aims the Government has for it. We do not make judgements about how PIP has affected claimants' well-being, beyond considering potential behavioural responses that might affect the amounts of benefit received. Neither do we consider efficiency, effectiveness or the value for money of the delivery models or the performance of particular contractors, except where they have consequences for benefit spending.

PIP and our disability benefits forecasts

- 4.3 Spending on PIP and DLA for working-age adults has been one of the largest sources of difference between our welfare spending forecasts and outturns. Chart 4.1 shows successive forecasts of spending on these benefits.
- 4.4 Prior to the introduction of PIP, our working-age DLA forecasts were relatively accurate, with a slight tendency to over-predict spending. Since then, most outturns have exceeded the corresponding forecast, often by substantial amounts. The savings anticipated in June 2010 – which were increased substantially in December 2012, but pushed back as the migration of existing DLA claimants was delayed – have not been realised. If anything, the chart suggests that PIP costs more than a continuation of DLA would have done. The analysis presented in Chapter 6 suggests that that has indeed been the case.
- 4.5 In the two to three years following the introduction of PIP, spending was significantly higher than we had expected. We assumed at the time that this reflected teething troubles and that the expected savings would be realised, just at a later date. When we published our third *Welfare trends report (WTR)* in October 2016 we still assumed that PIP would deliver savings relative to DLA, albeit much reduced. Our optimism on that score finally dissipated

completely in November 2017. Our latest forecast actually lies a little below the two that preceded it, as the weight we placed on the experience in the early years of DLA led us to over-estimate 2017-18 spending in our November 2017 and March 2018 forecasts (on a like-for-like basis, removing the effect of a legal provision from the DWP outturn figures).¹

Chart 4.1: Successive OBR working-age disability benefits forecasts since 2010

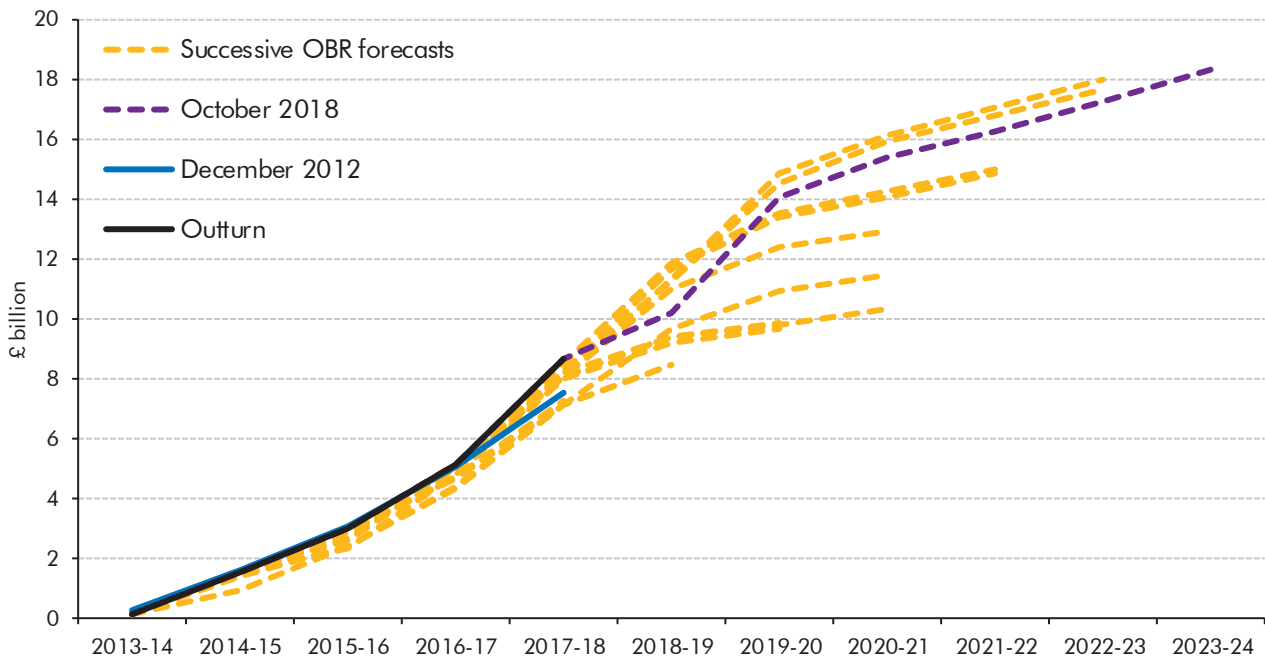


4.6 Chart 4.2 shows successive forecasts of spending on PIP alone since December 2012, when it was first separated from the DLA forecast. This chart includes spending on pensioners with continuing claims, which accounts for a growing proportion of spending over the forecast (reaching 17 per cent of the total by 2023-24). The cost associated with claimants remaining on PIP after reaching pension age contributes significantly to expenditure growth, so is an important forecast issue.

4.7 Despite the rollout of PIP being pushed back repeatedly, most of our forecasts have been below the eventual outturn. The effects of the rollout delays (which reduce spending on PIP, but increase it on DLA) have been more than offset by the higher cost per claim for PIP claimants within the new system. Spending growth is expected to slow from 2020-21 as ‘full PIP rollout’ – the reassessment of existing working-age DLA claimants – is completed.

¹ The 2017-18 outturn appears above the last two forecasts in the chart due to DWP published data including a provision in respect of backdated payments that were expected to be made in light of the MH v Secretary of State for Work and Pensions legal ruling. Our forecasts do not include such provisions, but allocate the payments to when they are made, consistent with how they are treated in the National Accounts. Without this provision of around £425 million, the outturn would have been below those forecasts.

Chart 4.2: Successive OBR personal independence payment forecasts since 2012



Source: DWP, OBR

Development of personal independence payment

June 2010 estimates

- 4.8 The reform announced in the Coalition Government's first Budget in June 2010 was the first substantive reform to disability living allowance since its inception in 1992. The Budget 2010 document stated: "The Government will reform the Disability Living Allowance (DLA) to ensure support is targeted on those with the highest medical need. The Government will introduce the use of objective medical assessments for all DLA claimants from 2013-14 to ensure payments are only made for as long as a claimant needs them."²
- 4.9 The Treasury's policy costings document described the Government's costing of the reform as follows: "Drawing on the evidence of the impact of the WCA [work capability assessment], the central assumption for this policy is that it will result in a 20 per cent reduction in caseload and expenditure once fully rolled out. It is assumed that existing claimants would be reassessed over three years, with 25 per cent of the caseload reassessed in the first year, 75 per cent by the end of the second year and 100 per cent by the end of the third year."³ Savings from the measure were put at £360 million in 2013-14 and £1,075 million in 2014-15 (including in Northern Ireland).
- 4.10 The costing in effect assumed that the average amount payable under any reform would remain unchanged. It also implicitly assumed a two-year reassessment profile, rather than the stated three years. The steady-state saving of around £1.4 billion would be achieved in full in 2015-16 (year 3), while the savings in 2013-14 and 2014-15 were around 25 per

² Budget 2010, HM Treasury, June 2010.

³ Budget 2010 policy costings, HM Treasury, June 2010.

cent and 75 per cent of that total respectively. Assuming a constant monthly profile (and ignoring natural turnover of claims), this would have required all reassessments to have been completed by the *start* of the third year, not the end of it. This was the first of several errors made in costing the impact of PIP, as this chapter explains.

- 4.11 The costing was updated for the March 2011 and March 2012 Budgets, but the revisions were small with similar cash savings being assumed. Extending the forecast horizon by a year resulted in projected savings of around £1.5 billion in 2016-17. Between June 2010 and December 2012 we revised up our forecast of working-age DLA and PIP spending combined a little, by an average of £100 million a year.
- 4.12 The embryonic OBR certified the initial costing of the PIP reform in the June 2010 Budget, but, as we noted in our March 2016 *Economic and fiscal outlook (EFO)*: “there was little evidence on which to base this costing, which in essence reflected the Government’s desire to reduce spending on disability benefits by 20 per cent ... We would no longer certify costings where detail on policy design and delivery is so sparse.”⁴
- 4.13 The one piece of evidence cited in the Treasury’s costing document related to the work capability assessment (WCA) in employment and support allowance (ESA), introduced in October 2008. At the time that the DLA reform was being costed, little more than a year’s worth of WCA outturns were available, and – given the time it took for appeals to be heard – virtually no post-appeal information. Although ESA and DLA are not strictly comparable, in particular because initial WCAs for ESA were undertaken several months into the benefit claim rather than prior to an award, the changes in WCA outcomes are still informative:⁵
- For initial assessments, the **‘fit-for-work’ outcome rate** was 64 per cent in the first year of ESA. After appeal, this fell to 53 per cent. For repeat assessments, which would be more analogous to reassessed DLA cases, the initial ‘fit-for-work’ rate was 25 per cent.
 - **Proportions allocated to the ‘support group’**, an indicator of greater medical needs, were correspondingly low initially: 10 per cent of initial assessments in the first year of ESA (12 per cent after appeal), and 33 per cent for repeat assessments.⁶
 - Towards the end of 2010 the picture on ESA started to change substantially. An external review by Professor Malcolm Harrington and an internal DWP review both recommended various **changes to the process and descriptors**.⁷ A full analysis of these changes is beyond the scope of this report, but they resulted in significant changes to the operation and outcomes of WCAs that could have informed the PIP costing.
 - Thanks to these reviews and other factors, including some operational pressures, in 2013 the **proportion of initial assessments resulting in a fit-for-work outcome, post**

⁴ *Economic and fiscal outlook*, OBR, March 2016.

⁵ *Employment and Support Allowance: WCA outcomes of Work Capability Assessments, Great Britain*, DWP, March 2017.

⁶ Data on post-appeal outcomes for repeat assessments are not available.

⁷ *An Independent Review of the Work Capability Assessment*, Professor Malcolm Harrington, November 2010; and *Work Capability Assessment Internal Review*, DWP, October 2009.

appeal, had fallen to 33 per cent, while support group recommendations had reached 48 per cent. Repeat assessments had shown a decline in fit-for-work recommendations to 19 per cent, and a sharp rise in support group recommendations to 67 per cent.

- 4.14 Consequently, the WCA evidence cited in support of the caseload and spending effects of DLA reform turned out to be significantly out of line with subsequent experience.

Post-June 2010 development of PIP

- 4.15 Policy development progressed over the following two years, culminating in the Welfare Reform Act that received Royal Assent in March 2012. Consultations on the reform of DLA had fleshed out the objectives of the new system. For example, the Government's early 2011 response to the consultation issued in late 2010 stated:

*"Personal Independence Payment will be a more dynamic benefit that acknowledges that people's conditions change over time and that our understanding of how disability affects people changes too, so rather than having 70 per cent of people on indefinite awards, as is currently the case with DLA, we will introduce a new fairer, more transparent and objective assessment, and, in most cases, introduce fixed term awards. In doing so, we need to take account of the full range of disabilities and treat people as individuals, not labelling them by impairment type, creating a truly personalised benefit that evolves over time."*⁸

- 4.16 A Government summary of the differences between PIP and DLA from 2016 stated that:⁹

- *"PIP is for people aged 16 to 64. You can only make a new claim for DLA if you're under 16."*¹⁰
- *"PIP isn't about diagnosing your disability or health condition. PIP is based on how your condition affects you, not on the condition you have."*
- *"If you make a claim for PIP, you'll need to be assessed by a health professional. This will usually happen face-to-face."*
- *"PIP is assessed on different criteria to DLA – it has a score-based system that relates to the help you need, with a list of daily living and mobility activities."*
- *"PIP treats all conditions equally and takes into account mental, intellectual, cognitive and sensory impairments."*

⁸ Government's response to the consultation on Disability Living Allowance reform, DWP, April 2011.

⁹ Disability Living Allowance and Personal Independence Payment: main differences, DWP, April 2016.

¹⁰ The upper age limit will rise in line with state pension age to 66 between November 2018 and October 2020. People claiming PIP can continue to receive it over the upper age limit provided they continue to meet the other qualifying criteria, and people who were under age 65 on 8 April 2013 and receiving DLA will be reassessed for PIP, even if they are now above the PIP upper age limit.

The DLA to PIP transition

- *“The care component of DLA has three rates of payment and the daily living activity in PIP has two.”*
- *“Most PIP awards will be fixed term with a review point built in. That review mechanism will apply even if your condition is permanent, but will not apply if you’re terminally ill.”*

- 4.17 Although the desired effect on spending was noted in the consultations (keeping PIP “affordable and sustainable”), the headline goals were for it to be “fairer, more straightforward to administer, and for it to be easier and clearer to understand.”¹¹ The savings were expected to arise from (in most cases face-to-face) assessment by a health professional (rather than by DWP ‘decision-makers’ on the basis of the claimant’s application form) and more frequent reviews (thanks to much greater use of fixed-term awards and hence reviews at the end of them). But the experience of periodic reviews a decade earlier showed that reviewed awards could go up as well as down.
- 4.18 Some features of PIP were likely to increase spending. Greater recognition of fluctuating conditions through regular award reviews would have been more likely to increase, rather than decrease, spending. Greater transparency might also have been expected to enable claimants and their advisors to navigate the system more easily, and to determine the right responses for a successful claim.
- 4.19 PIP might also have been expected to reduce spending by placing greater emphasis on notions of personal responsibility. PIP handbook guidance suggests that claimants are higher functioning if they can take pre-emptive or ameliorating action, such as use of painkillers. Recognising claimants’ ‘personal responsibility’ in this way could act as a tool to reduce spending, particularly in cases that might have received the lowest care rate of DLA.
- 4.20 Structurally PIP is very similar to DLA, the difference being that there is no equivalent of DLA’s lowest care rate in PIP. Otherwise the care (renamed ‘daily living’) and mobility components were carried over from DLA to PIP, paid at the same rates, and gave rise to the same additional entitlements in means-tested benefits and carer’s allowance.

December 2012 estimates

Testing PIP on a sample of volunteers

- 4.21 Between May and September 2011 DWP tested its draft assessment criteria with around 900 volunteers, which fed into further consultation and modifications to those criteria. The volunteers were identified from across Great Britain and reflected the range of different DLA rates, allowing DWP to work with people who had a wide range of health conditions and impairments. Most volunteers were randomly identified using administrative data, and included people who were currently receiving or had previously claimed DLA. They were then contacted to gain consent. In addition, DWP also identified several small samples of volunteers with specific conditions through the relevant disability organisations in order to look at specific issues that had been raised during policy development, such as the impact

¹¹ Government’s response to the consultation on Disability Living Allowance reform, DWP, April 2011.

on individuals with fluctuating conditions. In total, around 1,600 volunteers were identified with the intention of achieving a final sample of around 1,000 (taking into account volunteer availability and their right to withdraw). In the event, around 900 individuals took part. The results were weighted to be representative of the DLA caseload at that time.

- 4.22 The assessments were carried out by trained health professionals and involved a face-to-face appointment with each volunteer. During these appointments, information on the individual's circumstances was gathered and considered against the criteria.

Using the results to estimate the effect of PIP on spending

- 4.23 Although not designed with analytical use in mind, the results from this policy development exercise were subsequently used in the impact assessment published by the Government in May 2012 and then in updated adjustments to our disability benefits forecast in December 2012. At this point, the assumed rollout of PIP was delayed, but the expected steady-state savings were increased to nearer 30 per cent of working-age spending. So while the expected savings in 2015-16 had fallen by around £200 million to £1.2 billion, because of a slower rollout, the expected savings in 2017-18 were put at almost £2.9 billion, with savings of £0.1 billion in ESA premia on top.¹² We also revised down tax credits spending by around £0.1 billion in 2017-18 to reflect fewer disability elements in working tax credit.
- 4.24 The main change between the May 2012 impact assessment and the estimates used in our December 2012 forecast was to reflect the final assessment criteria. Other changes to forecast assumptions and methodology altered the mix of cases in the DLA counterfactual.¹³
- 4.25 Table 4.1 reproduces the modelled effects of PIP relative to a continuation of DLA in May 2018 (the comparison point used in the December 2012 costing), taken from the December 2012 technical note¹⁴. It uses the prevailing forecast benefit rates to estimate annual expenditure, although actual benefit rates have been lower due to lower inflation. The modelling included an allowance for mandatory reconsiderations and appeals. The total is less than the sum of the individual lines in the lower part of the table because some claimants receive both a care/daily living component and a mobility component.
- 4.26 The table shows that:
- The **overall effect of PIP relative to DLA** was assumed to be a reduction in the working-age caseload of around 28 per cent (600,000 claimants) and a cut in disability benefits spending of around £2.8 billion (27 per cent).

¹² The impact assessment analysis suggested there would be little effect on premia in means-tested benefits, but this was revised for the December 2012 costing and was first included in our March 2013 forecast for ESA. Neither costing identified a material effect on carer's allowance claims, although this was because the effects for gainers and losers were assumed to be broadly offsetting.

¹³ The results of the sample exercise were summarised in: *Personal Independence Payment: assessment thresholds and consultation*, January 2012 and *Personal Independence Payment - Reassessment and Impacts*, December 2012.

¹⁴ These estimates are grossed up from the May 2018 forecasts, so do not take account of trends in PIP or the DLA counterfactual within 2018-19, which was beyond the forecast horizon in December 2012. These savings are marginally lower than those estimated for 2017-18 (£2.9 billion), despite benefit rates being higher. This is because managed migration was only forecast to finish in September 2017, and with reconsiderations and appeals (that reduce initial savings) taking some time to complete, cash savings in 2017-18 would be higher than would apply in a steady state.

The DLA to PIP transition

- **By benefit rate**, the only one where the number of recipients was expected to rise was the highest care (now 'enhanced daily living') rate. The lowest care rate was not replicated in PIP, though some of those claimants would still have received a mobility component. The number of recipients of the middle care ('standard daily living') and both mobility rates were expected to fall significantly. Around 725,000 fewer mobility components and around 815,000 fewer care components were expected to be paid.

4.27 The aggregate comparisons mask a great degree of 'churn'. For the 1.75 million expected reassessments the costing also estimated that 510,000 claimants would receive more benefit, 510,000 would receive less but still something, and 450,000 would receive no award. Only 270,000 were expected to have no change in their award as a result of the reassessment. The modelling took account of this 'churn', as well as the 'hypothetical change' for new claimants (i.e. those who would have received a different amount in the DLA counterfactual against which PIP was being compared). This was important, since those losing benefit would have a high probability of seeking a reconsideration and appealing if necessary. The costing assumed that 38 per cent of those who lost some or all of their benefit as a result of a reassessment would subsequently have their award increased at reconsideration or appeal. For new claims, who were not already receiving a disability benefit and therefore would not be cash losers, 15 per cent of claimants were assumed to have their initial award increased. A purely static model focused on net changes would not have been able to take such considerations into account.

Table 4.1: December 2012 estimates of the impact of PIP in May 2018

PIP rate combination		DLA equivalent		Estimates for May 2018		
				Caseload (thousand)		
				PIP	DLA counter-factual	Difference
Enhanced mobility, enhanced daily living	Higher mobility, higher care	357	354	3		
Enhanced mobility, standard daily living	Higher mobility, middle care	117	293	-176		
	Higher mobility, lower care	-	270	-270		
Enhanced mobility, no daily living	Higher mobility, no care	128	113	15		
Standard mobility, enhanced daily living	Lower mobility, higher care	198	175	23		
Standard mobility, standard daily living	Lower mobility, middle care	198	476	-278		
	Lower mobility, lower care	-	235	-235		
Standard mobility, no daily living	Lower mobility, no care	238	43	195		
No mobility, enhanced daily living	No mobility, higher care	119	10	109		
No mobility, standard daily living	No mobility, middle care	221	34	187		
	No mobility, lower care	-	179	-179		
Total		1576	2182	-606		
By rate¹						
Enhanced mobility	Higher mobility	602	1030	-428		
Standard mobility	Lower mobility	634	929	-295		
Enhanced daily living	Higher care	674	539	135		
Standard daily living	Middle care	536	803	-267		
	Lower care	-	684	-684		
Estimated expenditure (£ billion)		7.5	10.2	-2.8		

¹ Figures do not sum to the total as claimants can receive one or both components.

- 4.28 The modelling suggested an initial success rate for new claims to PIP of 23 per cent, compared with around 40 per cent under DLA, with 42 per cent of claimants no longer being eligible at initial assessment. Once reconsiderations and appeals were factored in, the success rate for new claims increased to 35 per cent (compared with around 44 per cent under DLA), and the success rate for reassessments increased to 74 per cent.
- 4.29 Compared to the estimates used in our prior forecasts, extended to 2017-18, the new assumptions reduced spending by a further £1.4 billion. But a slower rollout increased spending by £250 million a year on average between 2013-14 and 2015-16.

Problems with the evidence base and its use

- 4.30 At the time of its use in our December 2012 forecast, there was insufficient information on the results from the 900 test cases. We were aware of some limitations, but took the view that it was the only evidence directly related to PIP and therefore the best available. So we used it as the sole guide to the effect of the assessment process on spending. In hindsight it would clearly have been better to aim off the results, although it would have been hard to judge by how much. We would not now rely so heavily on such information without much more scrutiny of how it was collected and what it represented.¹⁵
- 4.31 The main concerns that deeper scrutiny of the results has revealed include:
- **Participation was voluntary**, rather than being randomly drawn – and therefore potentially subject to self-selection bias.
 - The results pertain to a **hypothetical situation** in which there was no potential effect on claimants' benefit entitlement. Claimants' and assessors' behaviours could therefore have been different to what would be seen in live running of the benefit – in particular, claimants would not have had any knowledge of what was required to 'pass'.
 - **The results were partial**, covering the assessment only, which excluded background paper-based medical evidence, and did not take account of how decision-makers would respond to the assessment report and any additional information subsequently provided by the claimant. An allowance was made in the costing for decision-makers making different judgements to the assessors, but this was not based on evidence.
 - **The assessment criteria were subsequently changed before being finalised**. The face-to-face assessments occurred early on and tested the first draft of the assessment criteria. The possible impact of subsequent changes was estimated using these initial results, but without re-interviewing the claimants.
 - **We did not know about the environment surrounding these assessments**. Were they limited to a similar length of appointment to that which would have applied in live running? Were they done by people with similar background experience and culture as

¹⁵ Our staff team was significantly smaller in December 2012 than it is now, so our capacity to undertake such scrutiny is greater too.

would apply in live running, bearing in mind that personal experience could influence how an assessor would view more marginal decisions?

- It **did not cover the reconsideration and appeals processes**, which can have a substantial impact on awards.

4.32 Even absent concerns about the applicability of the results themselves, their direct use in the PIP costing was not appropriate:

- It **reflected a stock with a particular composition**. Although some re-weighting of the results was undertaken, the relatively small sample means that this could not be done reliably along many dimensions, and some characteristics were not measurable. Our discussions with DWP analysts at the time noted two possible sources of bias: that those claimants whose impairments significantly limited their participation in activities outside their home were less likely to take part; and that claimants who were aware that their circumstances had changed would be unlikely to turn up to report the change because they might suffer a real-world reduction in benefit. But, in the absence of information to calibrate suitable adjustments to the results, none were made.
- The **results were applied to all potential DLA claimants**, including new ones. Arguably the exercise was more applicable to the reassessment of existing DLA cases.
- Even then, the **composition of the eligible stock of DLA claims to be reassessed would be expected to change over time**, and by the time rollout commenced would be materially different as there would be no shorter-duration cases needing assessment.
- The **results were largely drawn from existing DLA claimants**, so there was limited coverage of those who had been refused DLA under the existing criteria, but who would qualify for PIP, and no coverage at all of those who would not have claimed DLA but would claim PIP.
- Although the substantial **changes in the outcomes for ESA work capability assessments** were known by the time of our December 2012 forecast, resulting in large increases in our ESA forecasts, knowledge of this was not used to aim off the PIP sample results.

4.33 These results drove our PIP forecasts until well beyond implementation, and even when they had been superseded for new claims, continued to underpin the reassessment assumptions.

4.34 Some sensitivity analysis was undertaken for DWP's PIP business case, but this was limited in scope, focusing on different timetables for PIP roll out, and the likelihood of unsuccessful claimants appealing. No sensitivity analysis was undertaken on the key variables of claim volumes, success rates and amounts of benefit awarded, even to determine confidence limits given the relatively small sample. Consequently, even the 'worst case' scenario, with a 95 per cent appeal rate for claimants who were unsuccessful at reconsideration (compared to 90 per cent in the central forecast), showed savings of £2.35 billion in 2017-18. That

said, given the substantial savings indicated by the sample results, it is unlikely that extending the sensitivity analysis would have led to anticipation of no savings at all.

Contracted disability assessments

4.35 In July 2012 DWP signed three regional contracts to provide PIP assessments in Great Britain: two with Atos Healthcare (now Independent Assessment Services) and one with Capita Business Services Limited. This reflected the continuation of a strategy to outsource provision of medical services that had been in place since 1998. Prior to PIP being introduced, DWP's main contracted medical services related to work capability assessments in ESA, themselves representing a significant increase in the use of contracted providers starting in late 2008.

4.36 In any welfare delivery system, the fiscal consequences will be influenced by several factors:

- **Entitlement:** The number of people who meet the qualifying criteria for the benefit. As discussed in Chapter 2, this is particularly difficult to determine for disability benefits.
- **Take-up:** Not everyone who meets the qualifying criteria will claim, perhaps due to a lack of awareness, to the hassle (perceived or real) of making a claim or to the possible stigma associated with claiming. Estimates of 'take-up' (the proportion of entitled people who receive a benefit) are published routinely for some benefits, but estimating disability benefits take-up is difficult due to the problem of measuring entitlement. That said, disability benefits take-up is generally thought to be quite low.
- **Certainty of success:** One important consideration influencing take-up is how certain the claimant can be that, given their circumstances and the information they provide, they will be successful in their claim. This can be influenced by the availability of information on the claim process and assessment criteria, and the ability of claimants and their representatives to tailor their claim to the criteria. The growing use of social media and the internet are likely to have a material impact here.
- **Objectivity:** The ability to assess entitlement objectively is a critical element in determining spending. Most benefits have verifiable entitlement criteria, such as income, presence of children or employment status. While some conditions for which people might be entitled to disability benefits can be assessed objectively, in many cases there is a degree of judgement as to the severity or impact of the condition, such that different assessors could reach different conclusions given the same set of information. Furthermore, there is scope for new information to affect the outcome.
- **Compliance:** How easy it is for the system to determine whether someone is entitled to a benefit or not, for example through cross-referencing across different administrative systems to identify mutually incompatible statuses (such as claiming housing benefit in two different locations simultaneously) or obtaining other information (such as universal credit's use of 'real-time information' from the PAYE income tax system). For disability benefits, apart from the mutually exclusive nature of the benefits themselves,

there are no other benefits or recorded statuses (such as being in work) that prevent receipt. While information held on health recording systems could be of use, this is not currently carried out systematically. Consequently, the scope for identifying fraudulent claims is likely to be quite limited.

- **Organisational incentives:** The incentives placed on those delivering the system can materially affect the amount of benefit paid out. Where those incentives are formalised in a contract there may be a different effect to similar incentives acting within informal arrangements. This is discussed further in the next section.
- **System capacity:** The ability of the system to handle demand, and its response to fluctuations in that demand, is critical for both the overall amount of payments made and their timing. This is also discussed further in the next section.

Organisational incentives

- 4.37 For good reason, it is difficult, if not impossible, to formalise an objective to reduce spending directly within an assessment delivery contract. Since disability benefits are demand-led, benefit must be awarded to anyone who is deemed to meet the qualifying criteria. So, for example, a performance measure that imposed a limit on the proportion of claims that could be awarded benefit would be unworkable, if not unlawful.
- 4.38 Consequently, the performance criteria and metrics included within the PIP contracts are focused on speed of processing, measures of quality, and customer service. In the contracts in place up to 2016 the required performance levels were:¹⁶
- **Turnaround:** 97 per cent success in getting from referral to the provider to return of the completed report in 30 working days for normal rules claims; 99 per cent in two days and 100 per cent in five days for terminally ill claimants.
 - **Quality:** The proportion of *assessment reports* not meeting standards must be less than 4 per cent in year one, less than 3 per cent from year two; re-work (where DWP returns the report to the provider if it is deemed not fit for purpose) to be no more than 1 per cent in year one, 0.75 per cent in year two and 0.5 per cent from year three.
 - **Customer service:** 90 per cent of customers to be seen within 30 minutes of scheduled timing (one hour if a home assessment); no more than 1 per cent of customers sent home unseen; 90 per cent of calls answered (80 per cent within 30 seconds); and a 90 per cent customer satisfaction score.
- 4.39 Particularly noteworthy are the requirements regarding the 'quality' of the reports written by the assessors. This is not necessarily the same as the quality of the assessments undertaken or the judgements made, which creates the potential to trade off actual assessment time against report writing time within the overall time allocated to any assessment.

¹⁶ *Contracted-out health and disability assessments* (Figure 8), National Audit Office, January 2016.

- 4.40 Reputational concerns are also likely to be important in delivering assessments. And they are likely to be different for outsourced providers than for government departments, particularly since such providers will often have wider businesses to consider, and their participation in health services contracts is a choice that they can reverse. Assessments for PIP (and ESA) have been unpopular, with high profile cases of apparently unjust decisions. As those implementing unpopular policies, providers have been the target of the same criticism as the minister or department deciding on those policies. The contractor for ESA WCAs, Atos, notified DWP that it wished to exit the contract following “concerns about the negative impact of the contract on claimants, and Atos’s reputation, staff and profitability”.¹⁷
- 4.41 Reputational incentives, and the lack of fully objective assessment criteria, mean that the assessor is more likely to recommend that a descriptor applies (implying greater chance of, or more generous, entitlement) where there is room for judgement to do so, as this is less likely to result in an appeal or public criticism. Needless to say, the customer is unlikely to appeal against, or complain about, their treatment if they get the outcome they want.

System capacity

- 4.42 Processes that are both labour-intensive and relatively specialised are vulnerable in the face of fluctuations in demand, given the limited ability to adjust resources quickly. This can result either in the process changing (whether intentionally or not) or in a backlog of unprocessed claims building up. A typical response to having insufficient capacity to meet demand is to reduce the resource devoted to each claim – with potential consequences for the benefit awarded. For disability benefits, switching from face-to-face assessments to paper-based reviews is one way in which capacity pressures can be alleviated.
- 4.43 The geographical distribution of capacity is also important. Disability benefit claims are largely handled centrally in a few benefit centres, but if assessments need to be undertaken face-to-face then they will need to take place close to claimants. Capacity may be sufficient at a national level, but there may still be operational pressures in certain areas if there are localised resource constraints and insufficient ability to move work around the country. Again, switching from face-to-face assessments to paper-based reviews, which do not have to be location-specific, is one way of handling these pressures.
- 4.44 Key factors affecting capacity for disability assessments include:
- **Labour supply:** It is widely acknowledged that there is a shortage of health professionals in the UK. Providers told the National Audit Office (NAO) that they identified the supply as high risk.¹⁸ DWP contracts are a small part of the market, but the job characteristics may make them more vulnerable to wider supply shortages – effects that would be amplified at a local level. Setting up the required capacity at the outset is likely to be harder when the market is supply-constrained. Contracting-out,

¹⁷ *Contracted-out health and disability assessments*, National Audit Office, January 2016.

¹⁸ *Contracted-out health and disability assessments*, National Audit Office, January 2016.

rather than providing services in-house, will not relax this constraint unless the provider can shift under-utilised resources from other parts of its business.

- **Job attributes:** The attractiveness of the job, and the salary offered, will affect providers' ability to recruit and retain the necessary staff. Perceptions of the role in an industry traditionally focused on doing the best for the patient may be a barrier for some potential applicants. Conversely, greater control over working hours may be an attraction for some. The provider's reputation may also matter – the availability of alternative jobs in a supply-constrained market makes capacity more vulnerable to reputational shocks. Such factors can also affect staff productivity.
- **Speed of change:** A slow and steady increase in capacity is more likely to be deliverable than a sharp rise, as it takes time to recruit and train staff and there is higher staff attrition during training and in the first few months of work. Similarly, the prospect of a sharp drop in required capacity could lead to a premature loss of staff.
- **Contract renewal** can pose problems as uncertainty can prompt staff to look for alternative jobs, even when the service is continuing and there is a high likelihood of transfer to any successor supplier. Better staff are more likely to have suitable alternative options, or be moved to other areas of the business by the provider. Even where the contract is retained by the incumbent supplier, uncertainty before the contract is renewed is likely to affect staff retention.
- **Customer behaviour**, such as the attendance at appointments and the quality of information initially provided, will affect how much capacity is actually utilised.
- **Support systems and processes**, such as IT, estates, the interfaces between contracted providers and DWP's benefit administrators, and how they deal with any special requirements among claimants (whether disability-related or not, such as the need for an interpreter) will all affect the system's capacity.

4.45 PIP increased required medical assessment capacity in DWP significantly, at a time when problems were already apparent in the ESA work capability assessment contract. That contract covered new ESA claims from October 2008, and then the reassessment of incapacity benefit (IB) claimants from mid-2011. Both at the introduction of ESA and the commencement of IB reassessments, performance was below target as the provider struggled to keep up with the volume of assessments required, resulting in greater backlogs. Although this had largely been rectified by the time PIP commenced in 2013, PIP added a further 60,000 assessments a month for new claims and natural reassessments on top of the 110,000 assessments being undertaken for ESA, with only a small amount of phased introduction. At the height of managed reassessments, then planned to occur during 2016 and 2017, 95,000 assessments a month would need to be undertaken for PIP.

Reform of the benefit appeals system

- 4.46 At the same time that PIP was being introduced, the benefit appeals system was being reformed to resolve disputes more swiftly and reduce the volume of appeals being handled by HM Courts and Tribunals Service (HMCTS). A new stage of the process – ‘mandatory reconsideration’ – was introduced before a claimant could appeal to HMCTS, as well as changes to the subsequent process so that appeals would be lodged directly with HMCTS, removing DWP’s involvement in this element of the process. The mandatory reconsideration phase would encourage claimants to identify and provide any additional evidence that could affect the decision, so that they received a correct decision at the earliest opportunity.
- 4.47 In a process with an element of subjectivity in some cases, the introduction of a further decision stage could only increase the success rate, since a claimant that receives a satisfactory outcome would not move to the next stage. The December 2012 costing allowed for mandatory reconsiderations and appeals. It differentiated between new claims and reassessments since the latter would be losing money that they already had, whereas new claimants would not be. We can now compare the outturn effects of reconsiderations and appeals with the original assumptions, but we cannot draw any conclusions from a comparison with the pre-reform picture given the coincident reform of disability benefits.

DLA between 2010 and 2013

- 4.48 Spending on working-age DLA proved to be relatively stable between the June 2010 reform announcement and the introduction of PIP, with spending marginally lower than forecast once the effect of unexpectedly high inflation is taken into account.
- 4.49 In the 2010 Spending Review a further policy change was announced, namely to remove mobility components from claimants living in residential care homes. This would have affected some people of working age but mostly affected those over 65. This was included in our November 2010 forecast and was expected to save around £160 million a year by 2014-15. At the following Budget in March 2011 it was announced that this policy would not apply to DLA, and would be reviewed for the reformed DLA. In December 2011 it was withdrawn altogether, but this was not reflected in our forecasts until March 2012.

Personal independence payment in practice

Initial experience

- 4.50 PIP was introduced for new claims in a small number of postcode areas in April 2013, and then nationally for new claims from June 2013. The rollout has yet to be completed for existing DLA claimants. In 2013-14 PIP spending was £161 million, £22 million (12 per cent) lower than the forecast we made in March 2013, but not because of higher DLA spending. Working-age DLA and PIP spending together in that year was £73 million lower than forecast in March 2013.

4.51 This early information painted a misleading picture of the underlying effect of PIP on spending, as in August 2013 DWP identified that claims were taking longer to process than expected. Chart 4.3 shows the volume of outstanding claims since PIP’s introduction. The average time taken for providers to return assessment reports rose almost continuously from June 2013 to October 2014, as they struggled to cope with the demand. The number of outstanding PIP claims, with providers or with DWP offices, peaked at 240,000 in July 2014, compared with around 60,000 once the backlog had been cleared in mid-2015.¹⁹ This backlog meant that the measured caseload fell, spending was virtually flat, and claims for associated benefits like carer’s allowance also fell for a period.

Chart 4.3: Outstanding claims for PIP



Source: DWP

4.52 This build-up in the number of outstanding claims had two main causes:

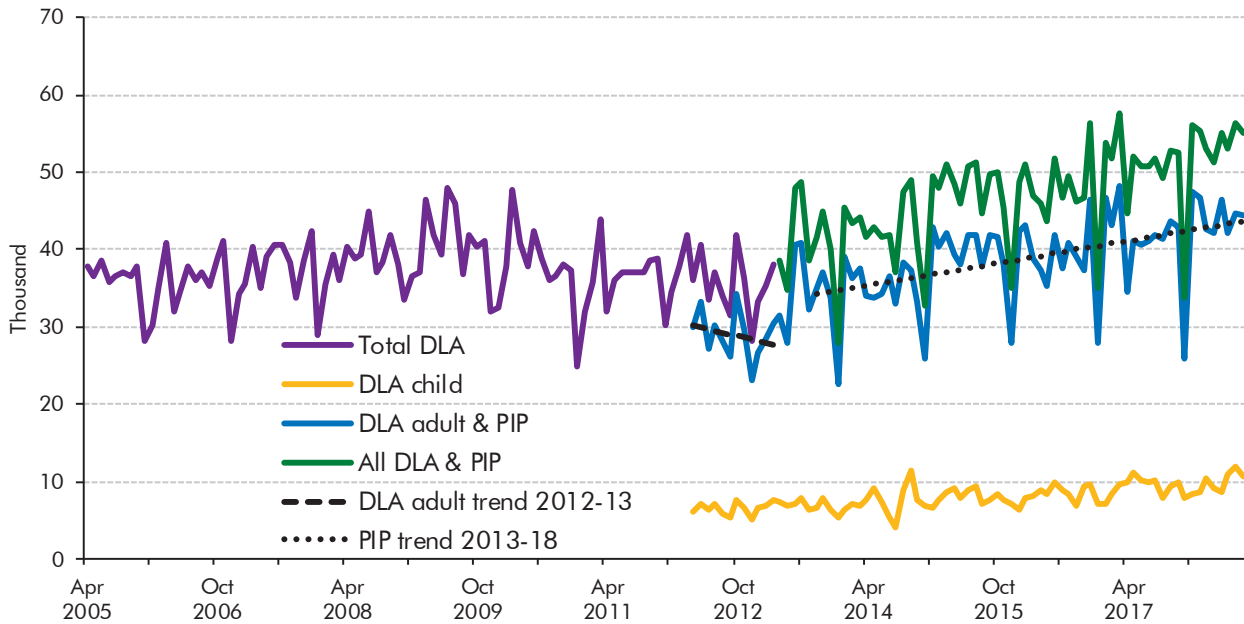
- The **number of claims for PIP was higher** than the number of claims for working-age DLA seen in the preceding few years, shown in Chart 4.4, and the contracted providers had inadequate capacity to deal with the higher volume.²⁰ The chart shows that this was not a temporary increase in claims, as might be expected if there were some pent-up demand from those newly eligible for PIP (but who would not qualify for DLA). Instead, it has been sustained ever since. Consequently, unless there was an offsetting movement in success rates, which, as we shall see, was not the case, the higher claim rate would result in a permanent increase in spending.

¹⁹ There will always be a certain number of claims outstanding at any point in time as a result of processing time and time for claimants to submit information.

²⁰ Data on DLA are not available by age group for the entire period, but with the vast majority of DLA claims being for working-age adults, the trend should be similar to DLA as a whole. Ongoing DLA for children is included alongside PIP to ensure consistency.

- The **processing time per claim was longer than expected**, spread across the time claimants took to return evidence, the providers took to assess claimants, and DWP took to make a decision.²¹ For the last two of these, it is not possible to determine how much this was influenced by the unexpectedly high volumes.

Chart 4.4: Volumes of new claims, DLA and PIP

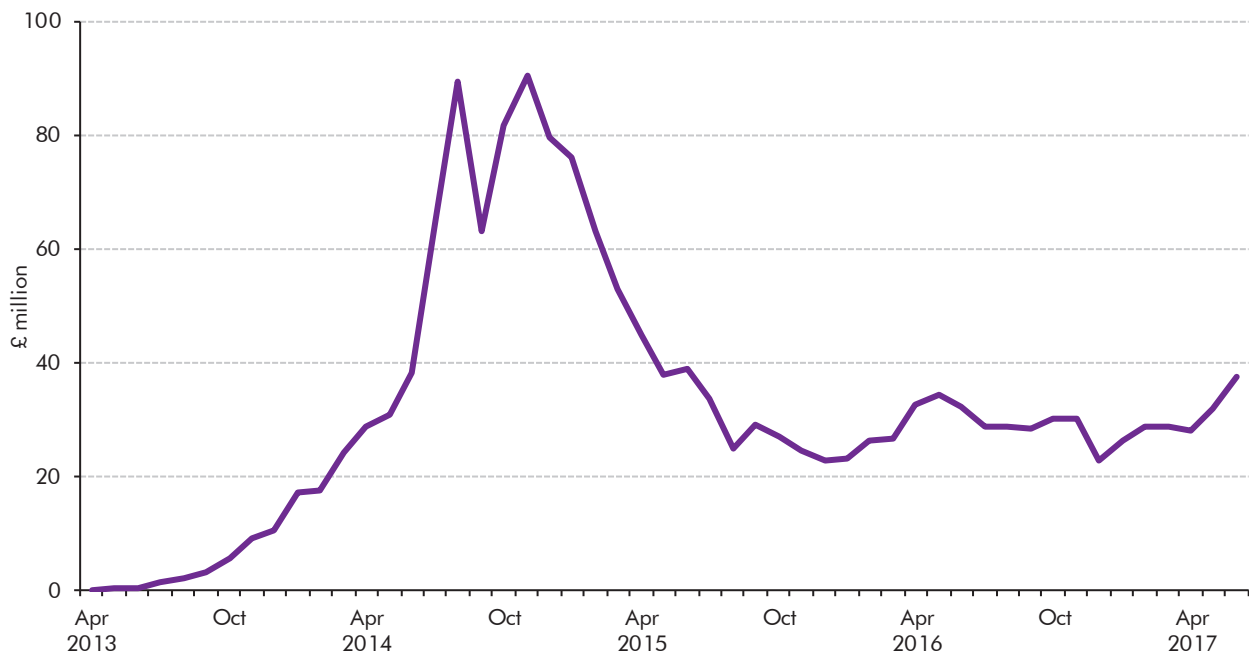


Source: DWP

4.53 These initial delivery problems kept recorded spending and caseload volumes below the amounts that eventually would apply to a given period. Then, as the backlogs were cleared from late 2014 onwards, spending was inflated through the payment of arrears, as discussed in Box 4.1. Chart 4.5 shows the value of arrears payments since PIP was introduced. In mid-to-late 2014 arrears payments reached £90 million in some months (over half of monthly spending on PIP at the time), although this may include some payments arising from mandatory reconsiderations or appeals.

²¹ *Personal independence payment: early progress*, National Audit Office, February 2014. Based on a sample of early cases, around two-thirds of the increased processing time was attributed to contracted providers.

Chart 4.5: PIP payments of arrears



Source: DWP

4.54 The consequence of these early difficulties was that initial PIP data provided very little indication of how spending was performing relative to forecast. Chart 4.3 also showed substantial fluctuations in outstanding claims subsequently, as the number of reassessment referrals fluctuated with the PIP rollout. While these later fluctuations also affected the statistical data and the value of arrears, with a greater amount of actual PIP data to work with they caused fewer problems for us in monitoring trends and forecasting spending.

Box 4.1: Benefit administration and data quality

Although administrative data from benefit systems are usually of higher quality than survey-based sources, they are susceptible to changes in how benefits are administered. If such changes create real-world effects (such as changes in award rates) then this should not be problematic. But if those changes simply affect how the real world is measured, this causes difficulties in understanding trends, and can result in incorrect conclusions being drawn. Most benefits have a degree of error in their measurement – as shown by comparison of spending data and statistical data – but this is only a problem for forecasting if this error is inconsistent over time.

A particular issue arises when backlogs build up in the administrative system, whether caused by lack of capacity within DWP, its contractors, or claimants taking longer to respond with information than they should. If the claim is successful, then benefit will be paid from the date of claim onwards (unless the qualifying period has not been met), but it will not be recorded in the statistics as being a claim in payment for the period before the claim decision is made. Similarly, if a claimant appeals successfully – which can take even longer than the initial claim process – the benefit will be awarded back to the date of initial claim, but will not appear in the statistics for the backdated period.

If the undercount is inconsistent over time, this could give a misleading impression of underlying trends. This was a particular issue in the early days of PIP. Clearance times – between the point of registration for a claim and the decision on the claim being made – peaked in July 2014 at 42 weeks, compared to an average of 12 weeks for the period since mid-2015.⁹ Consequently, the number of claims in payment in mid-2014 would have been substantially understated in the statistics relative to the actual number of claims that eventually received a payment for that period. Based on registrations and clearances data, we estimate that the data for May 2014 undercounted the caseload by around 110,000 (on a measured caseload of 68,000).

Administrative backlogs also affect spending, potentially resulting in it being recorded in a later period than that to which the spending relates. Benefit spending data record payments only when legal entitlement has been established, which is when a decision-maker has awarded the benefit. Any backdated benefit, for however long it covers, is accrued at that decision point. Spending figures can consequently include substantial arrears and, if these vary between years, may also give a misleading impression of trends in spending. For PIP, backlogs built up during 2013-14, pushing spending into 2014-15, but far less would have been moved from 2014-15 into 2015-16 as the backlog of outstanding claims was more than halved between March 2014 and March 2015. Spending in 2014-15 would therefore be higher due to arrears relating to 2013-14, with 2013-14 appearing lower as a result. Arrears can also result from mandatory reconsiderations and appeals, and vary according to how long these parts of the process take.

Data on arrears payments are not routinely available from DWP systems, other than for ESA, so they have to be inferred from statistical sources. Arrears are typically more volatile than overall spending, being related to a flow of decisions and awards, together with a variable number of weeks' backdating, rather than a stock of claimants receiving regular payments.

These potential distortions are greater for carer's allowance, which is dependent on a successful claim for a disability benefit. A claim might not even be lodged until the disability benefit has been awarded, but entitlement can still be backdated to the start of the qualifying claim. The caseload will thus be understated by more, and even measures of outstanding claims will be inaccurate as many will not be made until well after effective entitlement commences. During the early days of PIP, claims for carer's allowance fell (having been on a continuous upward trend previously), but bounced back once the PIP claims backlog had been reduced.

⁹ *Personal Independence Payment: Official Statistics*, DWP, September 2018.

Rollout plan changes

- 4.55 The result of these early problems was a delay, announced at very short notice, in the plans to start 'natural migration' from DLA to PIP – i.e. reassessments for claimants reporting a change in their care or mobility needs, those with an expiring fixed-term award of DLA and child DLA claimants reaching age 16. These had been planned to start nationwide in October 2013, but this was delayed for most areas. Our December 2013 forecast assumed that national rollout would be complete by April 2014, but subsequent changes resulted in rollout not being completed until August 2015. Table 4.2 shows successive rollout assumptions across our forecasts from June 2010 onwards, covering new claims, natural migration and managed migration. Changes to the managed element have been used to

The DLA to PIP transition

reduce the number of outstanding claims (shown in Chart 4.3), with the volume of referrals being reduced or ‘switched off’ for a period. This has moved the completion date back.

4.56 Although most of our changes to assumptions replicated changes to DWP plans, more recently we have assumed a later completion date for managed migration than DWP assumed as we felt that the risks around the completion date were not balanced. On 20 December 2018, the Minister for Disabled People, Health and Work told Parliament that some reassessments planned for 2019-20 would move to 2020-21, so it already appears that the contingency we added to the completion of the PIP rollout was insufficient.²²

Table 4.2: Successive PIP rollout assumptions

	Commencement for:			Completion of managed migration
	New claims	Natural migration	Managed migration	
June 2010				
November 2010				March 2016
March 2011	April 2013	April 2013	April 2013	(costed as March 2015)
November 2011				
March 2012				
December 2012		October 2013		
March 2013				
December 2013		Rolled out geographically from October 2013 to April 2014		
March 2014		Rolled out geographically from October 2013 to October 2014	October 2015	September 2017
December 2014	April 2013 in a limited geographical area; nationwide from June 2013	Rolled out geographically from October 2013 to March 2015		
March 2015				
July 2015				
November 2015				
March 2016			Controlled start from July 2015 to test processes, full rollout commencing October 2015	September 2018 ¹
November 2016		Rolled out geographically from October 2013 to August 2015		
March 2017				
November 2017				June 2019
March 2018				October 2019
October 2018				January 2020 ¹

¹ OBR assumption later than that contained in DWP’s own plans at the time.

Note: Natural migration effectively ends when managed migration ends.

4.57 The effect of the first change to natural migration on spending was limited, delaying for a few months the pace at which claims would be reassessed. At this stage, with PIP expected to cost significantly less than DLA, bigger delays to the rollout would delay realisation of the substantial savings anticipated in the December 2012 costing. Despite these initial

²² Personal Independence Payment: Written statement – HCWS1224, 20 December 2018.

problems, the timetable for managed migration remained unchanged, running from October 2015 to September 2017, right up to and including the July 2015 forecast.

The evolution of our PIP forecasts

4.58 As Chart 4.2 at the start of this chapter showed, our PIP spending forecasts have increased almost continuously since its introduction five years ago, and have considerably underestimated outturn spending. This section looks at what has driven that performance.

New claim volumes

4.59 Volumes of new claims to PIP were higher than for DLA, as was shown in Chart 4.4. If anything, DLA claims had been falling prior to PIP being introduced. Forecasts produced prior to the introduction of PIP did not allow for increases in claims, despite the changes in eligibility for people with certain types of conditions.

4.60 Some of this increase is likely to have reflected the broadening of eligibility for PIP, while the publicity surrounding the new benefit may have prompted others to claim, including those who may have previously been unsuccessful in claiming DLA. As the chart showed, this higher level of claim volumes has been sustained ever since and if anything has increased further – some of this reflecting previously disallowed claims making a further claim. This upward trend in new claims accounts for a substantial proportion of the subsequent upward revisions to our PIP forecasts, most notably in November 2015.

Success rates for new claims

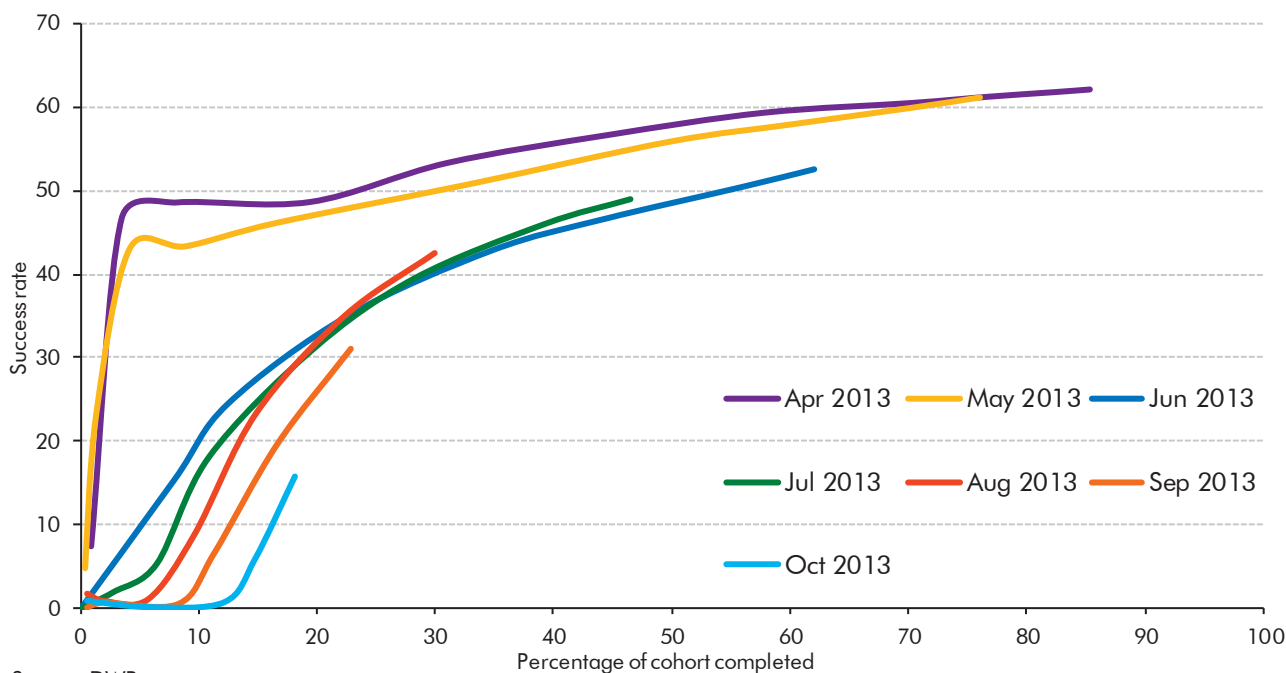
4.61 Success rate assumptions – the proportion of claims resulting in a successful award – were determined separately for the terminally ill (a small proportion of cases, processed quickly according to ‘special rules’, almost all of which receive an award) and the remainder (‘normal rules’ claims). The analysis underpinning our December 2012 forecast assumed a success rate after reconsiderations and appeals of 35 per cent for ‘normal rules’ claims.

4.62 Initial data on success rates were significantly distorted by the backlog of outstanding claims, since some types of cases tended to be cleared more quickly than others. For example, by August 2013, 36 per cent of normal rules claims cleared had been awarded PIP, similar to the costing assumption, but only 2.8 per cent of claims registered by that point had actually been cleared. Over time the observed success rate increased, such that by March 2014 it had reached 50 per cent, but still with only a fifth of claims cleared.

4.63 In order to refine our judgements we used information on successive ‘cohorts’ of claims – those made in a particular month – tracking the evolution of the success rate as the proportion of claims cleared increased. This allowed us to observe the likely success rate for a completed cohort of claims. Although our March 2014 forecasts were still based on a very limited set of information, with no cohort of claims fully cleared, this suggested the success rate for a completed cohort would be nearer 60 per cent, which was subsequently borne out. Chart 4.6 shows how claim success rates evolved in the early days of PIP as more of a cohort of claims was cleared. Where fewer than 20 per cent of claims have been cleared,

the pattern of success rates is uneven. The longer-term cohort success rates in Chart 4.6 are based on few cohorts, but as Chart 4.7 shows (which includes data not available at the time of our March 2014 forecast) once the cleared proportion exceeds 50 per cent, the success rate evolution becomes more stable, although still increasing as more claims are cleared.

Chart 4.6: PIP normal rules success rates by cohort of claims – as at March 2014



Source: DWP

4.64 Our March 2014 forecast incorporated these early outcomes, but assumed a downward trend in success rates as the process stabilised, returning to the original 35 per cent for claims made from April 2015 onwards. This added around £300 million a year to the forecast in 2014-15 and 2015-16, but the effect was expected to dissipate rapidly as claims awarded under the higher success rate came up for renewal and review after around two years. Apart from the consequences of ‘stabilisation’ of the process bringing down the success rate this adjustment involved two implicit, but untested, assumptions: first, that awards would be for a sufficiently short period to involve a review within two years; and second, that there would be sufficient capacity to undertake those reviews in the future.

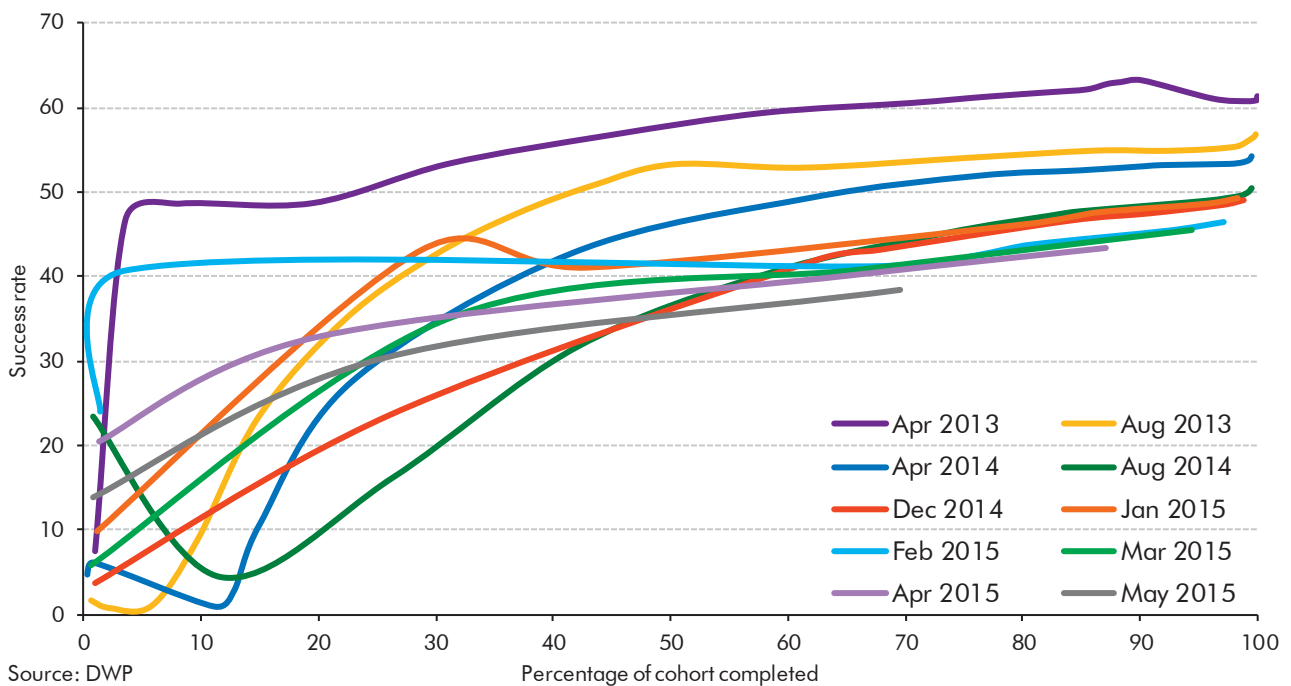
4.65 ‘Stabilisation’ of the process involved two aspects:

- **Clearance of the backlog of claims** would enable operational procedures to work as intended. To reduce waiting times providers undertook a greater proportion of paper-based reviews than had originally been intended. As paper-based reviews are likely to have a higher success rate than face-to-face assessments, the move back to the intended mix of assessments was assumed to reduce success rates.
- **Work to ensure the policy intent was delivered**, through quality improvement plans for the contracted providers, ensuring more consistency in the application of the criteria and additional training and guidance to DWP decision-makers. Analysis of some

‘high-quality’ reports provided supporting evidence of the potential impact of such initiatives, although only to justify a success rate of around 40 to 45 per cent.

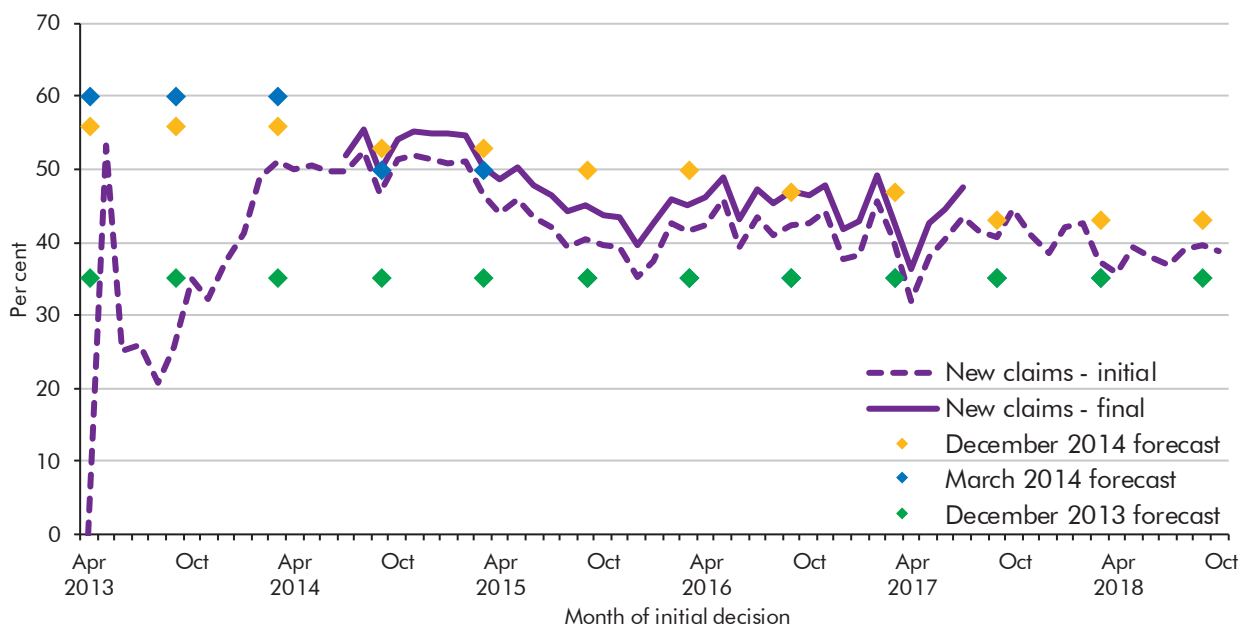
4.66 As more claims were processed, success rates did fall, as suggested by the ‘stabilisation’ hypothesis. Chart 4.7 shows the same cohort success rates as Chart 4.6, but in this case based on the data available for our November 2015 forecast. As well as a general reduction in success rates over time, it also shows that the falls were declining from the second half of 2014 and that success rates (while less volatile) tended to increase further as the proportion of claims cleared reached 100 per cent.

Chart 4.7: PIP normal rules success rates by cohort of claims – as at November 2015



4.67 As more complete data became available the ‘period’ success rates – based on decisions made in a particular month, regardless of when the claim was registered – became more representative and thus relevant for our forecasts. Chart 4.8 shows how observed ‘period’ success rates have changed over time – including the distortions caused in the first two years of PIP as a result of the claims backlogs. More recent data are less distorted as claims cleared have become more representative of all claims registered. The chart shows both initial success rates and those applying after reconsiderations and appeals – with the latter shown against the month of the initial decision. Because reconsiderations and appeals can take a long time, the data for more recent months are incomplete and so are not shown.

Chart 4.8: PIP normal rules success rates for new claims by period of claim



Note: Adjusted to smooth out known distortions arising from IT problems January-June 2014.
Source: DWP, OBR

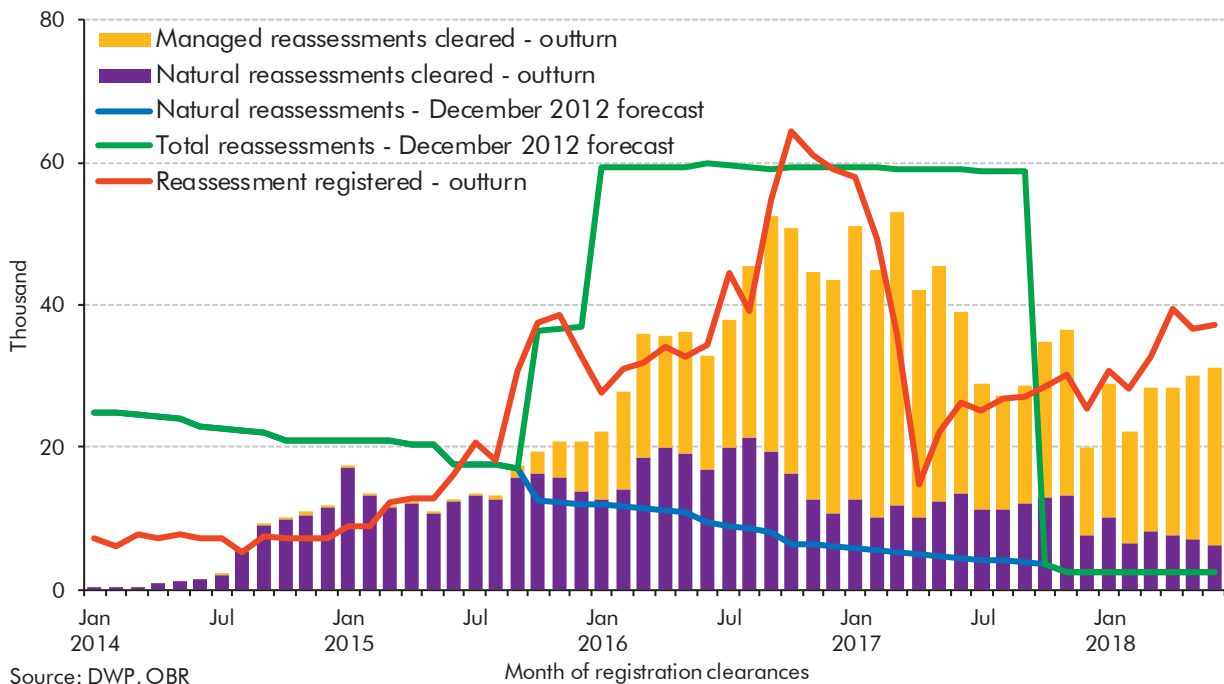
- 4.68 Initial success rates fell from their early 2014 levels as the backlog of claims was cleared, stabilising at around 41 per cent for initial decisions from mid-2015 onwards. Reconsiderations and appeals added a further 4 percentage points to the success rate. The final success rate of 45 per cent was slightly above the judgement made in December 2014 that post-appeal success rates would eventually settle at around 43 per cent, although that forecast assumed it would take longer to converge to that level. Moving away from the longer-term 35 per cent success rate assumption in that forecast added an average of £460 million a year to the forecast and £750 million in the fifth year (2019-20 at that point).
- 4.69 Further work undertaken by DWP with its contracted providers to improve the quality and consistency of assessments – highlighting, for example, those health professionals that appeared to be outliers – was also considered in more recent forecasts. However, such activities could result in awards moving up as well as down, and we did not make any explicit changes to our forecasts as a result. Success rates have been broadly flat since the end of 2015 (as shown in Chart 4.8). Although there is a slight downward trend since the start of 2018 in the current vintage of data, it would be premature to draw any conclusion regarding its significance before the outcomes of appeals are known.

Reassessment volumes

- 4.70 Chart 4.9 shows volumes of reassessments, as forecast in December 2012, and outturns. The volume of natural reassessments initially fell short of expectations, in contrast to new claims, with registrations being around a third of their expected value. Early delivery problems meant that few of these were processed until clearances picked up in the second half of 2014. Registrations subsequently increased to reach their predicted values in mid-2015, but without making up lost ground.

4.71 When included in our March and November 2015 forecasts, the slower rate of reassessment increased spending, since PIP was still expected to reduce spending relative to DLA. This also meant that, all else equal, more cases would need to be managed migrated.

Chart 4.9: Volume of reassessments



Source: DWP, OBR

4.72 As shown in Table 4.2, managed migration was assumed to start in October 2015, but in the event a ‘controlled start’ occurred from July 2015 to test processes. Although this was a rare example of a timetable being brought forward, the full rollout timescale remained challenging. During the first half of 2015, before the full rollout commenced, around 67,000 new claims and reassessments for PIP were cleared each month, most of which would have involved a provider assessment. The planned rollout would have doubled this figure, adding a further 66,500 a month – a higher number than assumed in December 2012 thanks to there being fewer natural reassessments. Concurrently, the contract for ESA WCAs had moved to a new provider in March 2015, with a requirement to clear the large backlog of assessments that had built up under the previous provider. The ESA provider was struggling to recruit the required number of health professionals to meet its demands. Soon after, the NAO noted (across all DWP’s health assessment contracts) that:

“Overall, as at August 2015, the Department expected to increase the monthly number of assessments from around 160,000 in September 2015 to 270,000 by March 2017 ... A simultaneous increase in the number of assessments presents challenges for both providers and the Department. These include recruiting, training and retraining healthcare professionals and providing enough centres for training and assessments. In April 2015, the Department estimated providers would need to increase the number of healthcare professionals by 84 per cent from 2,200 in May 2015 to 4,050 in November 2016 based on its current plans. This will be particularly

*challenging given market pressures ... Along with the Department, all providers told us they identified healthcare professional capacity as high risk.*²³

- 4.73 Because of these pressures on assessment providers, we extended the timescale for completing the PIP rollout assumed in our forecast by one year, to September 2018. This reduced the peak volume of assessments required to around 45,000 a month. DWP subsequently followed suit with its formal plans. With PIP still expected at this time to cost less than DLA, this increased our spending forecast by £0.4 billion a year on average between 2016-17 and 2018-19.
- 4.74 Even this proved to be too optimistic. The maximum number of claims and reassessments cleared, excluding those where the claimant withdrew the claim, since the start of managed migration was 90,000 a month, far short of the volume needed to clear all new claims and reassessments. Providers struggled to meet demand, and there remained issues with inconsistent outcomes. The volume of outstanding claims rose sharply between August and December 2015 and has fluctuated significantly since then. By October 2018 it stood at 134,000. While outstanding claims should, for a given processing time, move in line with claims and reassessment volumes, end-to-end clearance times have also fluctuated significantly. They stood at 14 weeks by October 2018, compared to just 10 weeks in March 2018. This increase in clearance times has been spread across providers and DWP, with the former taking seven weeks to turn around a normal rules claim.²⁴
- 4.75 Consequently, the rollout profile was extended to June 2019 in our November 2017 forecast, with further extensions in the two following forecasts – such that the end point for full PIP rollout has moved by 16 months over the space of 19 months. Our October 2018 forecasts assumed completion by January 2020, three months later than DWP’s planning assumptions, but earlier than DWP’s latest statement to Parliament on the rollout.²⁵
- 4.76 Our October forecast assumption had already looked demanding. At May 2018 there remained around 775,000 claimants aged between 16 and 69 on DLA who would be eligible to be reassessed. If they all required a reassessment, clearing them over the 20 months to January 2020 would have required an average of 39,000 assessments a month (on top of those for new claims, for children on DLA reaching age 16 and for any changes of circumstances or repeat assessments for existing PIP claimants). In practice, slightly fewer assessments would be required, as some of these claimants would leave the benefit without an assessment. Reassessment clearances in the first ten months of 2018 averaged 29,000 a month (including 16-year olds, changes of circumstances, and award reviews), suggesting that a substantial increase would have been needed from current levels. The latest data already suggest that pressures are building again, with new claim clearances (including claim withdrawals) 46,000 below registrations in the first seven months of 2018.
- 4.77 We have not yet considered DWP’s latest announcement to see how far into 2020-21 the planned completion date has been shifted and what that implies for monthly assessment

²³ *Contracted-out health and disability assessments*, National Audit Office, January 2016.

²⁴ *Personal Independence Payment: Official Statistics to October 2018*, DWP, December 2018.

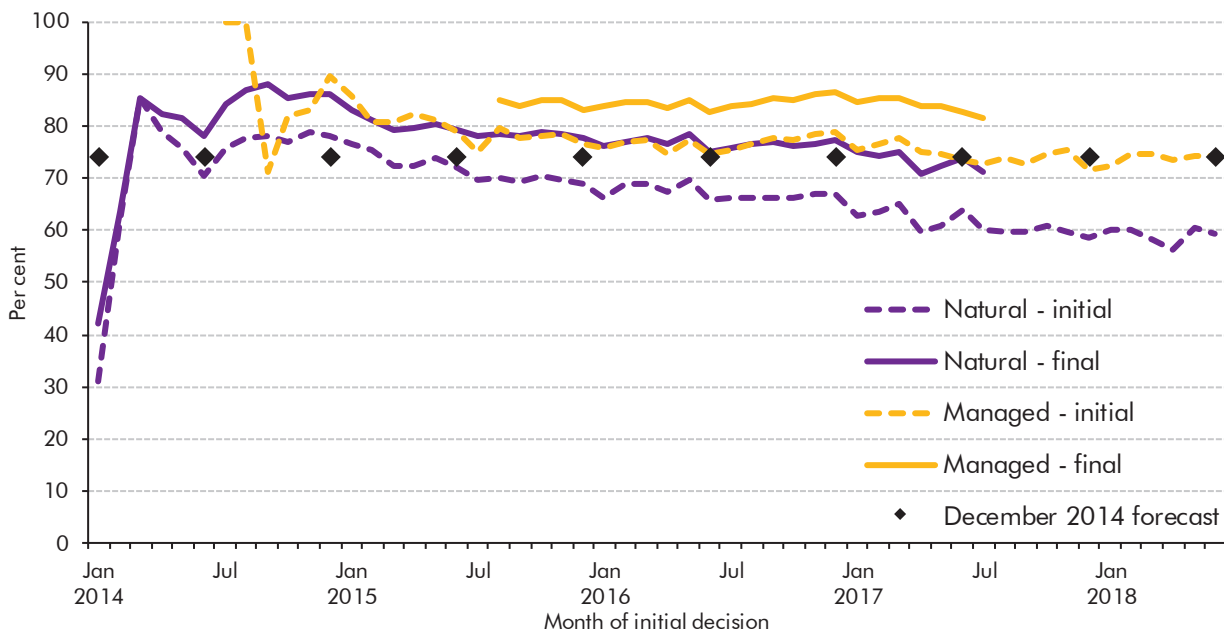
²⁵ *Personal Independence Payment: Written statement - HCWS1224*, 20 December 2018.

volumes. We will do so ahead of our next forecast, but the effect of this further extension on spending is likely to be small, since it is close to cost-neutral. The additional three months' delay in completion included in our October 2018 forecast added an average of just £14 million a year to DLA spending and reduced PIP spending by £12 million a year on average, resulting in an average net increase of only £2 million a year.

Success rates for reassessments

4.78 The December 2012 costing assumed that the success rate for reassessments would be 74 per cent, after reconsiderations and appeals. This assumption proved to be more accurate, with initial success rates for natural reassessments of around 70 per cent once the initial backlogs had been cleared by mid-2015, and success rates after reconsiderations and appeals averaging 78 per cent in 2015-16. Chart 4.10 shows success rates for reassessments, distinguishing between natural and managed ones. For natural reassessments there has been a steady decline in success rates, with initial outcomes appearing to level off over the year to June 2018 at around 60 per cent, while the final success rate had moved below the December 2012 assumption for those claims whose initial clearance was between April and July 2017.²⁶

Chart 4.10: PIP reassessment success rates



Note: Adjusted to smooth out known distortions arising from IT problems January-June 2014.
Source: DWP

4.79 The first data on managed reassessments became available for our March 2016 forecast, based on the 'controlled start' from July 2015.²⁷ This showed substantially higher success rates, of 76.5 per cent before reconsiderations and appeals. At that time there was very little data on reconsiderations and appeals, so the additions to success rates from these sources was still modelled, adding a further 7 percentage points to result in a final success rate of

²⁶ As with new claims, because of the time taken for reconsiderations and appeals, more recent information is likely to be incomplete.

²⁷ Around 7,300 case outcomes were available at this point, and they were broadly representative of the relevant DLA caseload.

The DLA to PIP transition

83.5 per cent. We assumed this would apply across the forecast, adding an average of £590 million a year to spending.

- 4.80 Chart 4.10 shows that initial success rates on managed reassessments have gradually fallen, to average 74 per cent over the year to July 2018. Reconsiderations and appeals increased success rates by an average of 8 percentage points in the year to July 2017, suggesting that the final success rate has settled at around 82 per cent, only a little below our March 2016 forecast assumption.

Reconsiderations and appeals

- 4.81 Overall, the December 2012 assumptions overstated the effect of reconsiderations and appeals, increasing the initial success rate for new claims by 12 percentage points to 35 per cent. The same assumptions applied to initial success rates of around 41 per cent (the average from July 2015 to July 2017) would have added 9 percentage points to give a final success rate of 50 per cent. The actual impact of reconsiderations and appeals in 2016-17 was to increase success rates by only 4 percentage points. The overestimate in this element of the costing partly offset the significant underestimate of initial success rates.
- 4.82 As with the initial success rates, reconsideration and appeal assumptions for reassessments were closer to outturn than they were for new claims. The December 2012 assumptions, which did not distinguish between natural and managed reassessments, added 10.5 percentage points to success rates. The outturn effect for the year to July 2017 was 10.7 percentage points for natural reassessments and 8.4 percentage points for managed ones. As Chart 4.10 showed, the final success rates for natural reassessments appear to have settled at a level close to the assumption made in December 2012.

Outflows

- 4.83 Most of our forecasts used DLA data to determine the likelihood of people moving off PIP once their claim had started, without any adjustments for the differences in how PIP was administered. This reflected there being two potential opposing effects on outflows from the introduction of PIP, at least at the time that our earlier forecasts were produced:
- **The tightening of access to PIP relative to DLA** would be expected to result in those receiving PIP being more severely disabled on average, and hence less likely to move off benefit subsequently due to their condition improving, reducing outflows.
 - **The increase in the number of fixed-term awards**, and hence award reviews, would be expected to increase outflows, all else equal.

Whether these factors broadly offset each other, or one outweighed the other, could not be assessed due to lack of evidence. Although information on the duration of awards would become available fairly soon after implementation, at least for new claims, this would not say anything about the likelihood of a claimant leaving the benefit at their next review.

4.84 The first change to our outflow assumptions in December 2014 was to increase them to reflect the higher claims and success rates – as these would, all else equal, have brought more people with less severe conditions onto the benefit. In addition, as discussed in paragraph 4.65, it was assumed that ‘stabilisation’ would result in a large proportion of the unexpectedly high volume of claims not having their benefit renewed at the next assessment. This was supported by analysis of DLA undertaken in the mid-2000s, which suggested that a substantial proportion of the estimated 7.8 per cent of DLA spending that was overpaid as a result of some claimants’ conditions improving occurred because there was no systematic process to identify this and amend the benefit payment.²⁸

4.85 In practice, outflows were lower than expected. In our December 2014 forecast, around 1 per cent of the new claims caseload was expected to flow off each month, gradually reducing after around two years as the maturing of the caseload left a growing proportion of longer-duration claimants. In the short term, the outflow rate was increased by about a quarter to reflect the additional cases expected to exit as the process stabilised. In practice, after a few months the outflow rate from PIP was a little over half that expected.²⁹ At that time relatively few, if any, award reviews would have been conducted, so any impact would have been due to reduced natural outflows. Possible reasons include:

- **The filtering out of very short-term claims.** Extended processing times may have resulted in some short-term claims being withdrawn before assessment.
- **Fixed-term awards induced a behavioural response among claimants,** with them viewing fixed-term awards as just that, rather than recognising that they still had an obligation to report changes in their condition in the meantime. This would tend to result in shorter-term claimants spending longer on benefit as they waited for their award to end, which could be exacerbated if the subsequent review was delayed.
- **The changes to the criteria** brought in people who were less likely to outflow, even if they had less severe conditions. Greater recognition of fluctuating conditions could result in people staying on benefit for longer.
- **Award reviews did not happen as intended,** due to providers’ capacity constraints, so that claimants stayed on the benefit for longer. The delayed initial assessments would also mean that an award of a given length would end at a later date.
- The effect of claimants staying on PIP for longer, for whatever reason, can then compound as **recipients become more dependent on the benefit,** the loss of a stream of income being felt more acutely after a long period than if it had been received for only a short period. And a claimant who is successful once will know which responses are likely to deliver the required points when their claim is reassessed.

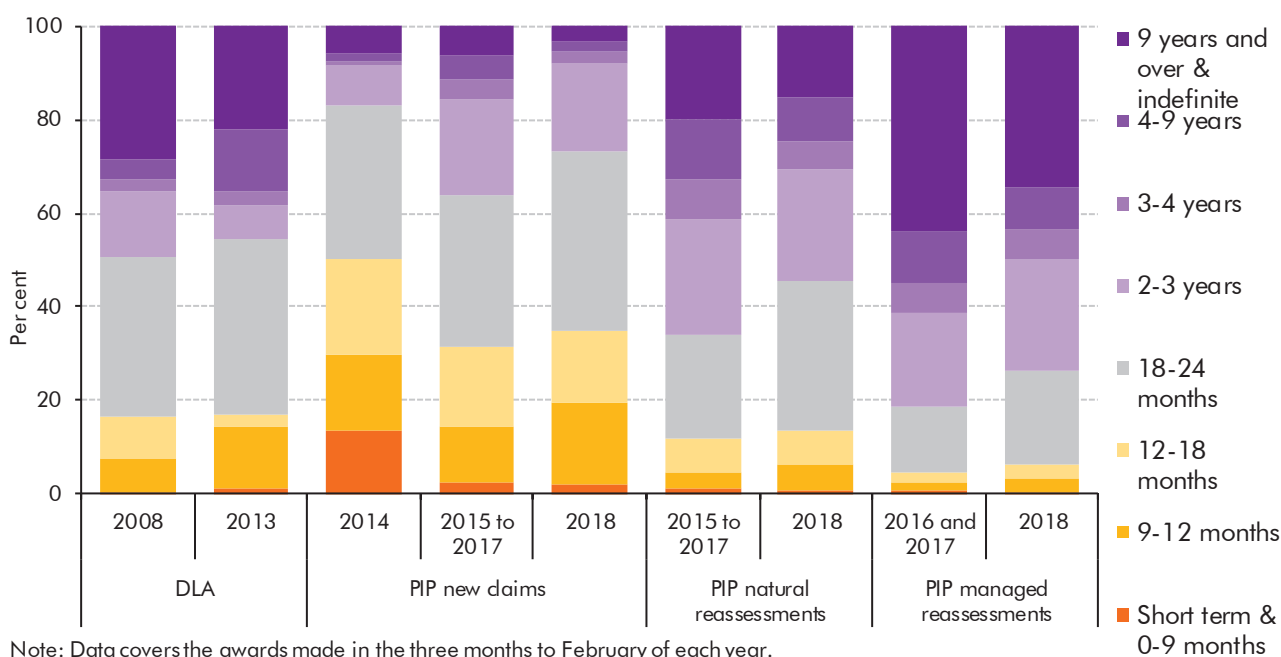
²⁸ *Fraud, Error and other Incorrectness in Disability Living Allowance*, DWP, 2005.

²⁹ Outflow rates from PIP were much higher in the first few months due to the high proportion of terminally-ill ‘special rules’ claims.

The DLA to PIP transition

- 4.86** These unexpectedly low outflow rates occurred despite PIP having a higher proportion of short-term awards than DLA, as shown in Chart 4.11. The proportion of awards of under a year's duration was stable at around 14 per cent for PIP between 2015 and 2017, and increased to 19 per cent in 2018.³⁰ These proportions are similar to DLA in its final year, but were still quite an increase on the 8 per cent seen five years previously. By contrast, PIP has a noticeably higher proportion of claims with a duration between one and two years (50 per cent for PIP from 2015 to 2017 and 54 per cent in 2018, versus 40 per cent for DLA), and between two and three years (20, 19 and 7 per cent respectively). Consequently there is a far smaller proportion of awards for more than three years – 16 per cent in PIP from 2015 to 2017, and only 8 per cent in 2018, compared with 38 per cent for DLA in its final year.
- 4.87** Chart 4.11 also shows the distribution of the lengths of reassessment awards in PIP, which are much longer, compared both to new PIP claims and to DLA. This is not surprising given the composition of the claimants, as by definition they will be more likely to have long-term conditions having already been in receipt of DLA for a considerable time.

Chart 4.11: Distribution of award lengths, initial decisions only



- 4.88** In July 2015 we revised up our forecast by an average of £115 million a year to allow for a higher-than-expected caseload (due to higher new claims and lower outflows). Then in November 2015 we factored in more detailed modelling of outflows using the relatively new PIP data, which added a further £240 million a year to the forecast.
- 4.89** As data on award review outcomes started to come through, however, these upward revisions to the forecast started to be reversed. Our March and November 2016 forecasts were on average £275 million a year lower due to the effect of the higher outflow rates

³⁰ The 2014 data covered December 2013 to February 2014, and were based on decisions made during the period which were likely to be skewed towards particular types of claim that could be processed more quickly, and were unrepresentative of the overall mix of claims.

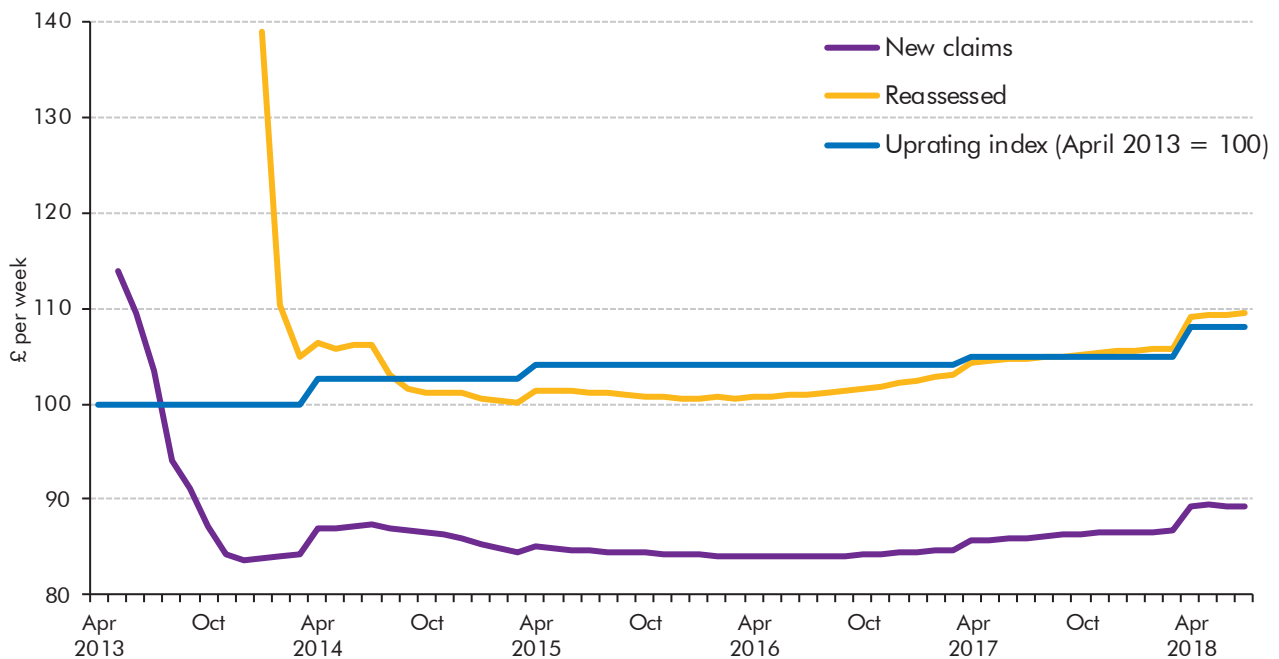
arising from award reviews. These higher rates were assumed to be temporary, with the outflow rate at subsequent reviews implicitly assumed to decline, such that in the longer term outflow rates converged on those seen under DLA.

Average awards

- 4.90 Information on average awards for PIP first became available for our March 2014 forecast. In tandem with unexpectedly high success rates, average amounts awarded during the first few months of PIP were also around £10 a week higher than assumed in previous forecasts at around £84 a week. As with success rates, we assumed that this upside surprise in average awards would ease over time as the process stabilised.
- 4.91 Average awards for natural migrations to PIP were also substantially higher than expected, at £99 a week versus an assumption of £84 a week in our July 2015 forecast. These higher rates were first included in our November 2015 forecast, but only for those claimants that had already been reassessed. The assumption for future migrations, whether natural or managed, was held at the previously assumed level.
- 4.92 The controlled start for managed reassessments also showed higher average awards than assumed – £100 a week instead of the £86 shown in data up to January 2016, on top of the higher success rates. Including these data in our March 2016 forecast added £740 million a year to the forecast and over £1 billion in the fifth year (then 2020-21).
- 4.93 Chart 4.12 shows how average awards have changed over time for normal rules cases, distinguishing between ‘new’ claims to PIP and those migrated from DLA,³¹ alongside an index of the benefit rates. At the start of both series average awards are very high, probably reflecting a disproportionate number of severely disabled claimants being processed very quickly. They then drop rapidly as the caseload becomes more representative, possibly also reflecting the ‘stabilisation’ of the process noted above. Interestingly, new claim awards declined marginally as the backlog of claims was cleared – and have since risen very slowly relative to uprating. This is most likely to reflect claimants receiving higher amounts as their conditions deteriorate, or possibly those with lower amounts being more likely to leave the benefit. Since the backlog of claims cleared, average awards have increased more rapidly for reassessed cases than for new claims (and for uprating), possibly reflecting the increasing proportion of managed migrated claims in the total, with slightly higher awards.
- 4.94 The main message from the outturn data is that, although average awards fell in the initial months, the hoped-for substantial reduction in awards, back to their previously assumed levels, did not occur, and unwinding this assumption contributed to substantial upward revisions to our November 2015 and, particularly, March 2016 forecasts. Later forecasts also assumed a gradual rise in average awards relative to uprating.

³¹ Covering both natural and managed migrations.

Chart 4.12: Average awards for 'normal rules' PIP cases



Source: DWP, ONS, OBR

Policy changes

4.95 Since PIP was introduced, there have been no substantial changes to the policy itself, other than those arising from legal challenges (covered below). This is in marked contrast to, say, the introduction of universal credit. There was, however, one major policy *announcement*. In response to the large increases in our spending forecast in November 2015 and March 2016, Budget 2016 announced a reduction in the number of assessment points awarded for needing to use an aid or appliance to carry out two of the 'daily living' activities, to take effect for new claims and reassessments from January 2017. This was expected to reduce spending by £1.3 billion in 2020-21 (the forecast horizon in March 2016). But this proposed change was withdrawn five days after its announcement in the Budget.

4.96 Also announced in Budget 2016 were:

- Changes to the arrangements for **terminally-ill claimants** migrating from DLA to PIP – where claimants who were granted a larger award under PIP would receive that higher award from the date of the decision, rather than remaining on their DLA award for the standard four-week waiting period.
- **Increases in the number of presenting officers** at tribunal hearings, "to support the tribunal in making the right decision". Introduction of the policy was delayed and then the savings arising were revised down significantly as the officers attended fewer hearings and had less effect on tribunal outcomes than expected.

4.97 One other policy that would have affected PIP and DLA, but has not been implemented, was the reform underpinned by the 2011 independent Commission on Funding of Care and Support (the ‘Dilnot Commission’) and legislated for in the Care Act 2014. Implementation was periodically delayed and we removed its assumed effects on disability benefits spending from our forecast altogether in October 2018, as a result of further consultation announced by the Government on the future of adult social care. Had they been implemented, these reforms would have reduced DLA and PIP spending marginally as more care home residents would have received local authority funding, making them ineligible to receive DLA or PIP. Most of this effect would have been among older claimants.

Legal challenges

4.98 As with DLA before it, interpretation of the PIP legislation has been subject to several legal challenges. The response to these, and hence their effect on our forecasts, has varied. The most significant example is ‘MH v Secretary of State for Work and Pensions’.³² This held that someone who cannot make a journey without assistance due to psychological distress should be scored in the same way as a person who needs assistance because they have difficulties navigating. The Government’s initial response was to lay amendments to the PIP regulations to “*restore the original aim of the benefit*”, which was factored into our March 2017 forecasts.³³ This adjustment involved a one-off cost of around £100 million to cover the period from December 2016 to March 2017, between the date of the upper tribunal judgement and the expected date of the amended regulations coming into force. As this entailed a ‘legal entitlements and administrative practices’ (LEAP) exercise, involving the review of previously made claims, it could not usually be undertaken quickly. So while costs were originally expected to be incurred in 2017-18, in our November 2017 forecast these were assumed to arise in 2018-19 instead.

4.99 Following judicial review, these new regulations were declared unlawful by the High Court on the grounds that they discriminated against people with mental health conditions, and that this discrimination could not be objectively justified. The Government decided not to appeal the High Court judgement,³⁴ and a further adjustment was included in our March 2018 forecast. This increased the forecast by around £400 million a year in steady-state, but by £170 million and £580 million in 2018-19 and 2019-20 to reflect the time taken to process claims and the additional awards of backdated benefit.

4.100 PIP might also have been affected by other legal cases where it is used as a criterion for entitlement to other benefits, in particular to provide an easement from a particular rule or condition. The main example has been the Carmichael case in housing benefit (and the housing element of universal credit) where restrictions had been applied to the number of bedrooms covered by housing benefit, depending on the size and composition of the household – commonly referred to as ‘the bedroom tax’. The case involved situations where the disabled person could not be expected to share a bedroom due to their condition. The presence of the easement could encourage additional claims for PIP, for example from

³² MH v Secretary of State for Work and Pensions (PIP) [2016] UKUT 0531 (AAC).

³³ Social Security Written statement – HCWS495, 23 February 2017.

³⁴ Welfare Written statement - HCWS414, 19 January 2018.

eligible claimants being made aware of PIP as a result of the potential to avoid the bedroom tax. Following a Supreme Court judgement in November 2016, we added around £25 million a year to our forecast from our March 2017 forecasts. Since this involves behavioural change, there is a high degree of uncertainty around these estimates.

Forecasts from November 2016 onwards

- 4.101 The consistent under-forecasting of PIP and DLA since 2013, along with the emergence of several legal cases with potentially substantial costs, led us to reappraise our approach to the forecasts and to make significant changes in November 2016. Our forecasts had been based on detailed modelling of forecast determinants, which interacted with each other in ways that were hard to observe, and while individual forecast judgements may have looked reasonable, in totality they had led us to under-forecast spending. And for a caseload where a substantial proportion would be on the benefit for many years, even decades, the early data on PIP could not give much insight into longer-term behaviour. Finally, as with DLA previously, there was likely to be a stream of future legal judgements that would affect the forecast, but at any given point only a small number would then be known about.
- 4.102 In November 2016 we made a top-down adjustment to the forecast that aimed to capture the upward trend in the prevalence of disability benefit receipt in the population. We hoped that this would finally deliver a central forecast around which the risks were balanced. The adjustment looked at growth in DLA prevalence in the late 1990s, a similar period after its introduction to PIP at the time. Initially half the difference between the PIP detailed modelling and the DLA experience was added to the forecast, but in November 2017 our forecast put its whole weight on the DLA prevalence growth. Both these changes resulted in significant upward forecast revisions, adding around £1 billion in the final year of each forecast.
- 4.103 In practice, basing the forecast on the late 1990s experience of DLA appeared to be too pessimistic given the subsequent outturn data, with a more recent reference period giving results that better matched outturns. Further work to improve the bottom-up modelling meant a reversion to that model as the primary source of our forecast in October 2018, but we retained the top-down prevalence approach as a cross-check. For a group of benefits where significant reform is still not complete, and the longer-term behaviour of claimants is not yet known, a combination of the two methodologies is likely to remain preferable to sole reliance on either one of them. Chapter 5 details our latest forecast.

Lessons learnt

- 4.104 Our experience of forecasting PIP from its inception, through its development and yet-to-be completed implementation over the past five years has provided several important lessons on estimating the fiscal effects of major reforms, not just those affecting welfare spending. Many of these have already been applied in our forecasting and costing roles:
- **The effects of a policy change should only be ‘scored’ and factored into our forecasts when there is a clear and credible plan for implementation;** mere aspirations are not

enough. We would no longer certify the scorecard cost or yield of policy proposals where the amount of detail is as sparse as was the case for PIP.

- The need to **look more deeply at the nature and interpretation of key pieces of underpinning evidence**, testing for bias, applicability and sensitivity to key assumptions, and avoiding as far as possible reliance on a single source of evidence. This is particularly important where the information was not collected with subsequent analytical use in mind.
- Ensure that we **fully consider the hard-to-estimate effects of policy changes**, especially behavioural consequences among both customers and suppliers, as well as considering the elements that are easier to quantify.
- Be sceptical of any **improbable ramping-up of operational activity** (especially where it requires putting many more trained staff in place quickly), interrogate delivery plans more thoroughly, and monitor performance more closely. This is now routine in scrutiny of policy costings and in our forecasts in respect of ESA, PIP and UC.
- **Distinguishing news from noise in early vintages of administrative data** can be a major challenge, but the PIP experience suggests we were too slow to abandon prior forecast judgements in the early years of PIP, which ultimately led to large revisions when that inertia in our judgements was overcome. This experience has influenced our approach to forecasting universal credit, where we have focused on extracting forecast-relevant information from early vintages of corresponding administrative data.
- **Draw on evidence from other relevant parts of the system** (such as ESA in this instance, which could have been brought to bear sooner), and from previous experience. Ensuring this learning is documented fully in this report will help build an evidence base for future forecasters to draw upon.

5 The disability benefits forecast

Introduction

5.1 This chapter:

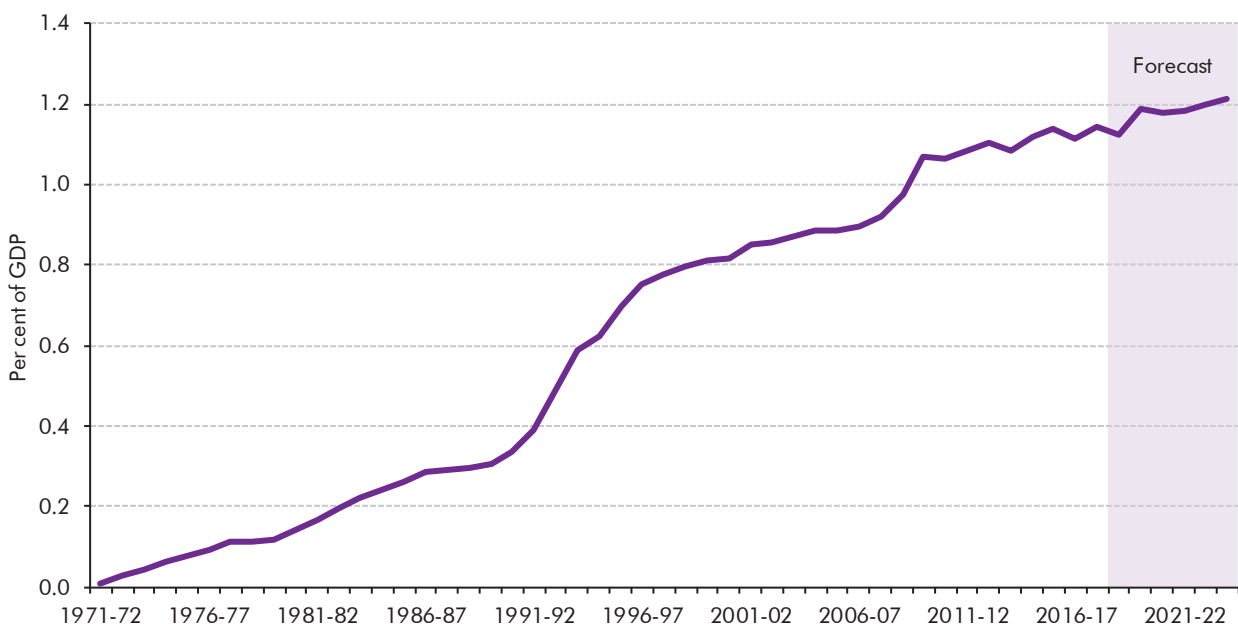
- presents our **October 2018 forecast for spending on disability benefits**;
- discusses **risks and uncertainties** around our central judgements; and
- previews issues that will be pertinent as **devolution of disability benefits spending to the Scottish Government** proceeds and provides an illustrative medium-term forecast.

Our latest medium-term forecast

Spending

5.2 Cash spending on disability living allowance (DLA), personal independence payment (PIP) and attendance allowance (AA) is expected to rise by 29 per cent to £30.5 billion between 2017-18 and 2023-24. This is slightly faster than growth in the cash size of the economy, so that spending rises by 0.1 per cent of GDP over the forecast. Other than in 2019-20, this steady rise relative to GDP would continue the trend observed in recent years.

Chart 5.1: Disability benefits forecast in historical context



Note: Attendance allowance caseloads interpolated for 1971-72 and 1972-73.

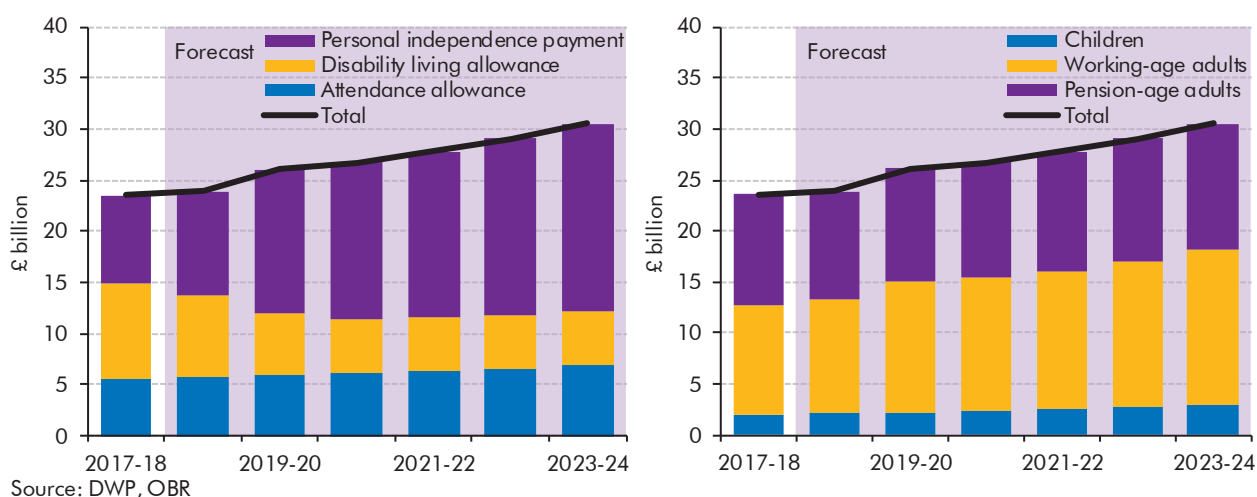
Source: DWP, OBR

The disability benefits forecast

5.3 DLA and PIP spending combined is expected to rise by 31 per cent in cash terms and by 0.1 per cent of GDP between 2017-18 and 2023-24. As the reassessment and transfer of existing working-age DLA claims to PIP is completed during this period, spending on DLA is expected to fall by 44 per cent, while spending on PIP rises by 112 per cent. Meanwhile, spending on AA is expected to rise by 24 per cent and to remain stable as a share of GDP.

5.4 As regards spending by age group, it is expected to rise fastest among children (by 53 per cent between 2017-18 and 2023-24), then working-age adults (by 41 per cent), with spending on pension-age adults rising more slowly (by 14 per cent). This takes the proportion of spending accounted for by children up from 8.3 to 9.8 per cent and by working-age adults up from 45.8 to 50.0 per cent. Pension-age spending therefore falls from 45.8 to 40.2 per cent of the total. Around 2.5 percentage points of the move from pension-age to working-age spending reflects the rise in the state pension age to 66 between 2018 and 2020, alongside which the cut-off for new claims to PIP will rise to 65. The remaining changes largely reflect our assumption that the prevalence of disability benefits receipt among children and working-age adults will continue to rise.

Chart 5.2: Disability benefits spending forecast by benefit and age group

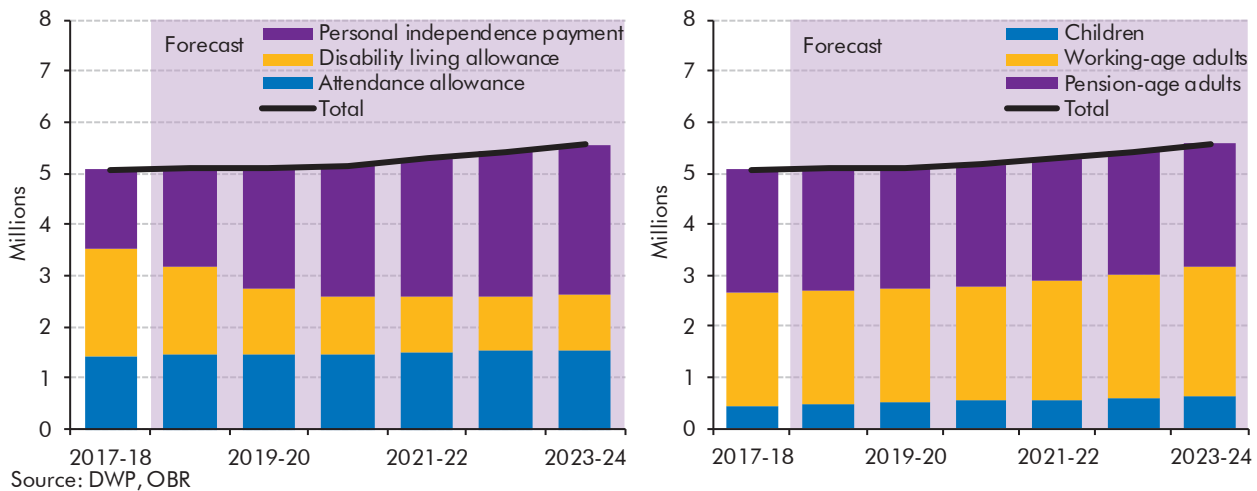


5.5 In the next two sections, we describe the caseload and average awards forecasts that underpin our spending forecasts, highlighting how the issues discussed in this report have influenced our approach to forecasting DLA and PIP spending. The various approaches we have used to forecast working-age DLA and PIP spending since the introduction of the latter are summarised in Box 5.1. As AA and DLA for children are benefits that have been in place for decades, our forecasting approach for each has remained the same. Both are based on projecting forward entry and exit rates, which determine the caseloads, together with average awards, to get to spending. All elements are informed by developments in the corresponding administrative data. Relatively few additional judgements are required beyond deciding the extent to which recent movements in administrative data should be treated as 'news' that should affect the forecast or 'noise' that should be ignored.

Caseload forecasts

5.6 The caseload across the three benefits is expected to increase by 9.7 per cent between 2017-18 and 2023-24 (Chart 5.3). This takes the prevalence of benefit receipt up from 7.9 to 8.4 per cent of the population. The combined DLA and PIP caseload is forecast to rise by 10.4 per cent (with the DLA caseload down 50 per cent and the PIP caseload up 93 per cent) and the AA caseload to rise by 8.0 per cent over this period.

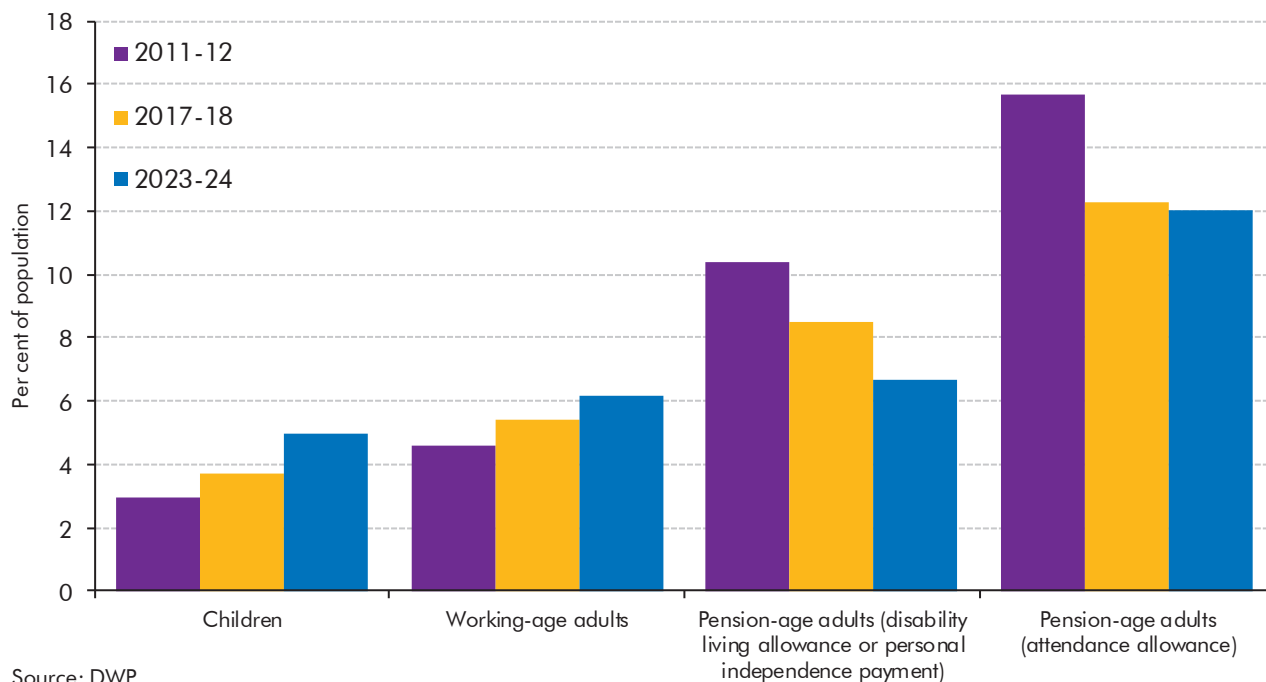
Chart 5.3: Disability benefits caseloads forecasts by benefit and age group



5.7 In terms of prevalence, Chart 5.4 shows that between 2017-18 and 2023-24 we expect:

- the proportion of **children receiving DLA** to rise from 3.7 to 5.0 per cent – i.e. as described below, we expect prevalence to rise by a third in six years, a somewhat faster rise than over the six years from 2011-12 to 2017-18;
- the proportion of **working-age adults receiving DLA or PIP** to rise from 5.4 to 6.2 per cent – continuing the pace of increase observed in the preceding six years;
- the proportion of **pension-age adults receiving DLA or PIP** to fall from 8.5 to 6.7 per cent – a faster pace of decline than observed over the preceding six years; and
- the proportion of **pension-age adults receiving AA** to fall from 12.3 to 12.0 per cent.

Chart 5.4: Prevalence of disability benefit receipt by age group



5.8 The rise in child DLA prevalence in our forecast is quite striking. It reflects recent trends in the administrative data that point to continued rises in the incidence of new claims among children – which would be consistent with continued rises in the prevalence of mental health and behavioural disorders among children – but also lower exit rates implying lengthening average durations and higher prevalence. It is possible that other changes to the benefits system may also have played a role. For example, receipt of child DLA exempts families from the benefit cap (which limits the total amount of certain benefits received to £20,000 a year, and to £23,000 in London), so take-up could have risen among larger families.

Inflows

5.9 For each benefit, we forecast inflows to the caseload. For AA, these are based entirely on trends in administrative data by age. For working-age DLA and PIP, assumptions are made about the ‘full PIP rollout’ schedule that determines the extent to which the working-age caseload receives DLA or PIP. A similar methodology is employed for forecasting child DLA but absent the full PIP rollout. For PIP, the principal assumptions we need to make include:

- the lag from **registration of a claim to referral to one of DWP’s contractors** for a medical assessment;
- the lag from **referral to a contractor to referral to the department**;
- the lag from **referral to the department to an award decision**;
- the **proportion of claims that will be successful** in receiving a PIP award;
- the **composition of PIP rates that will be awarded** to successful cases; and

- **any subsequent changes to awards**, including whether any award is made at all, that will result from the mandatory reconsideration and appeals processes.

Each step can be observed in the administrative data, allowing us to monitor each set of assumptions at each forecast. This relatively comprehensive modelling of the operation of PIP is warranted because it is still a relatively new benefit. It would be unnecessarily cumbersome for more mature benefits like child DLA or AA for pensioners.

5.10 Applying this chain of assumptions gives a forecast for the number of new cases flowing onto the PIP caseload. But this is only one way that cases flow onto PIP. They represented 53 per cent of all inflows to PIP in April 2018. Other inflows relate to children in receipt of DLA that are reassessed for PIP as they reach age 16 and working-age claimants currently receiving DLA that are reassessed as part of the continuing rollout of PIP. On the basis of DWP's prevailing plans and administrative data relating to the performance and outcomes achieved by DWP's assessment providers, we assumed that the full PIP rollout would finish in January 2020 in our October forecast. This was later than assumed in DWP's prevailing plans, but has already proved too optimistic. DWP has since told Parliament that some reassessments planned to take place in 2019-20 will now be moved into 2020-21.¹ We will revisit our rollout assumptions for our next forecast.

Outflows

5.11 Outflows from the disability benefits caseload are the result of:

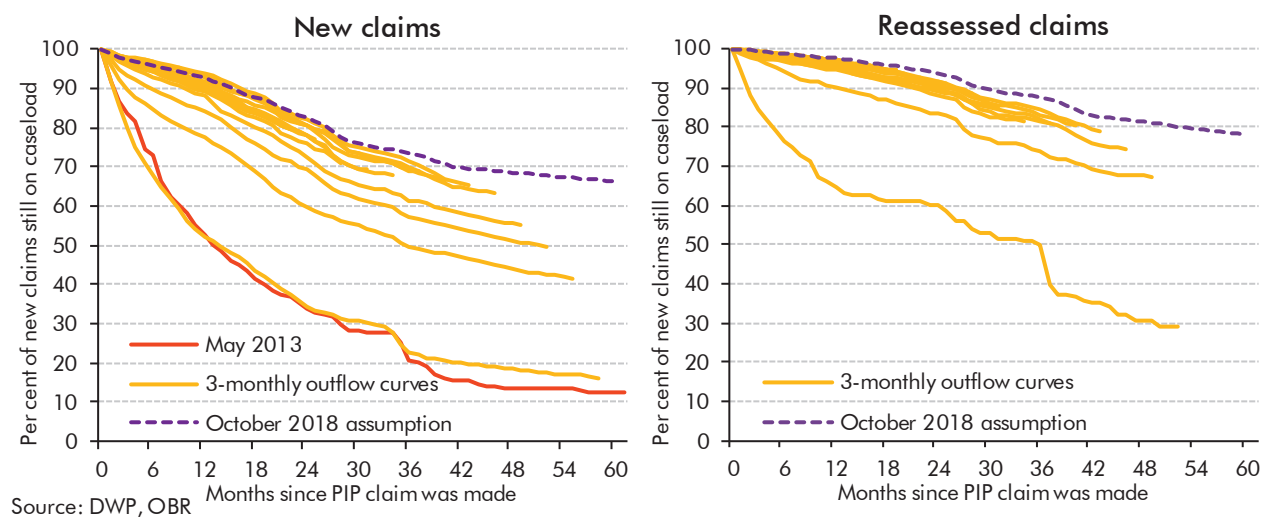
- **Natural exits** – these comprise claimants whose condition improves and they inform DWP of this, those whose fixed-term award comes to an end and they choose not to renew their claim, and those who die (which is likely to be the main cause of outflows for pensioner disability benefits).
- **Coming of age exits (for child DLA only)** – these relate to children in receipt of DLA that reach age 16, but either choose not to be reassessed for a working-age PIP claim, or are not successful when making one.
- **Award review exits (PIP only)** – these are the result of a scheduled PIP award review or a reassessment prompted by the PIP rollout.

5.12 For child DLA and pensioner AA exits, we project forward average exit rates by single year of age, based on administrative data. For PIP exits, the modelling is more complex, drawing on analysis of exit rates by type of exit and by cohort of PIP claimant. An approximate representation of the cumulative effect of these assumptions can be given by 'cumulative outflow curves' (Chart 5.5). These curves indicate what our assumptions imply for the proportion of each cohort of claims (defined by date of claim) that will still receive a PIP award in each subsequent period, split by new claims and reassessed DLA claims.

¹ Personal Independence Payment Written statement – HCWS1224, 20 December 2018.

5.13 In the early period of PIP’s operation, exit rates were particularly high because a relatively large proportion of new cases were terminally ill people claiming via the accelerated ‘special rules’ route. As more ‘normal rules’ claims came onto PIP, exit rates fell and for a period were significantly below those seen in DLA. More recently, exit rates increased as award reviews started to have an effect, and have begun to stabilise, as can be seen by the clustering of the outflow curves for later cohorts for both new and reassessed claimants. The flattening of the curves over time also suggests that the average duration of claims is lengthening over time. Assumptions about the average duration of PIP claims are both important and highly uncertain at this stage of the benefit’s operation. In our latest forecast, our assumptions regarding future PIP exit rates aggregate to a cumulative outflow rate close to the observed average of the most recent 24 cohorts for which data was available.

Chart 5.5: Cumulative outflow curves



Source: DWP, OBR

Average awards

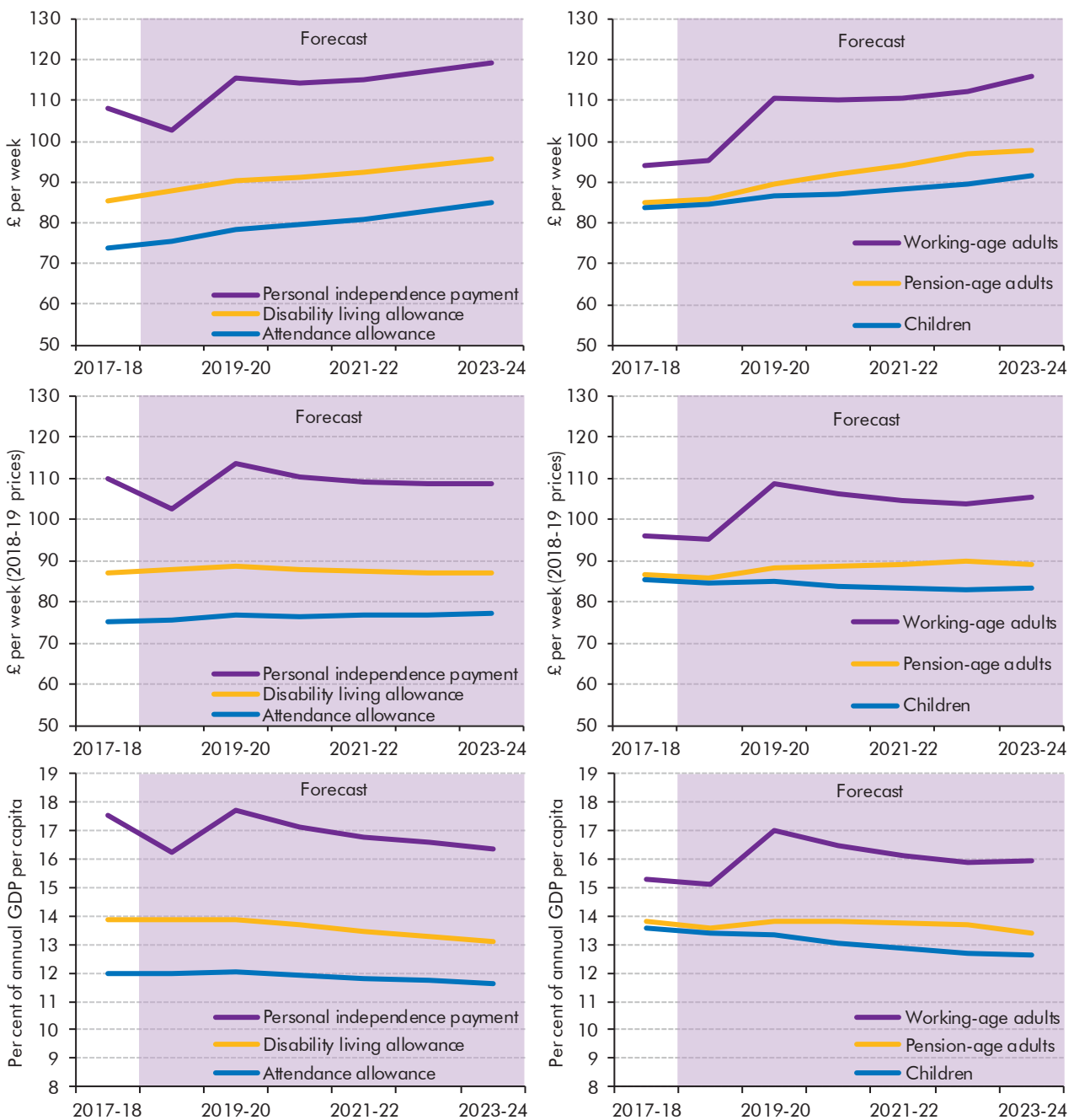
5.14 For DLA and AA, we forecast average awards by projecting forward recent trends in the relevant administrative data. For PIP, we make assumptions about the composition of the caseload by rate, then derive the average award as the weighted average of the statutory rates. Chart 5.6 shows how we expect average awards to evolve between 2017-18 and 2023-24 across the different benefits and age groups on three different bases:

- **In cash terms**, average PIP awards are expected to rise by 10.4 per cent, average DLA awards by 12.0 per cent and average AA awards by 15.2 per cent. But thanks to the caseload shifting towards PIP, where average awards are higher, average overall disability benefit awards rise faster than any of the three benefits on their own, by 18.3 per cent. By age group, average awards rise fastest among working-age adults (22.9 per cent) and pension-age adults (14.7 per cent), while those among children rise by only 9.5 per cent.
- **In 2018-19 benefit rate terms** – i.e. stripping out the effect of CPI-inflation uprating, which is broadly equivalent to ‘real terms’ but focuses on the inflation rate in September each year that is used for uprating. On this basis, changes in the

composition of the caseload by rate mean that average AA and DLA awards rise by 3.0 and 0.1 per cent, respectively. But average PIP awards fall by 1.3 per cent. By age group, average awards increase for the working- and pension-age – by 9.9 and 2.5 per cent respectively – while child average awards fall by 2.1 per cent.

- **Relative to GDP per person** – the relevant metric when considering whether average awards cause spending to rise or fall as a share of GDP – average awards fall across all three benefits and among children and pension-age adults, but rise among working-age adults thanks to the caseload shifting to PIP where awards are higher.

Chart 5.6: Forecast disability benefits average awards

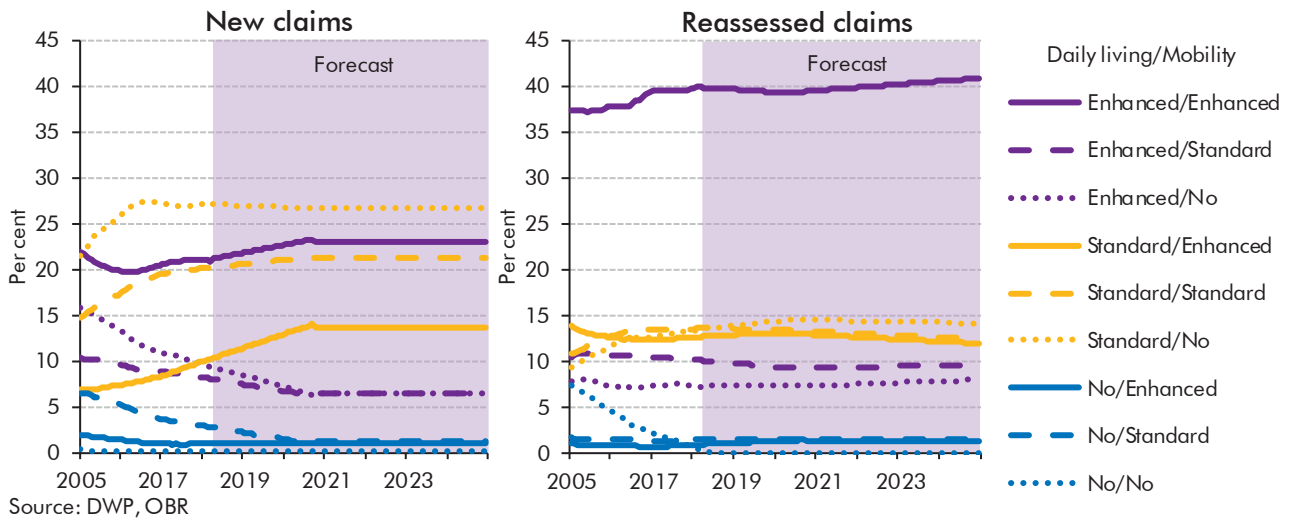


Source: DWP, OBR

The disability benefits forecast

- 5.15 As noted, we forecast PIP average awards by projecting the proportions of new and reassessed caseloads in receipt of each rate. Recent outturns and our October assumptions for each are shown in Chart 5.7). We do this at the level of each combination of statutory award rates – e.g. individuals in receipt of ‘enhanced’ rates for both daily living and mobility or ‘standard’ for daily living and nothing for mobility – to match the administrative data. The analysis is conducted from the start of 2015-16 onwards, to abstract from the effect on the early PIP caseload of a high proportion of recipients being terminally ill and receiving the highest rates. Awards for each group are calculated using the statutory rates in each year, uprated by CPI inflation in accordance with PIP uprating policy.
- 5.16 For new claims, the chart shows a downward trend in the outturn proportion receiving ‘enhanced daily living and standard mobility’, ‘enhanced daily living and no mobility’ and ‘no daily living and standard mobility’ awards. Together these made up 20 per cent of the new claims caseload in July 2018, the latest data available at the time of our October forecast. There has been an upward trend in the proportions receiving ‘standard daily living and enhanced mobility’, ‘enhanced daily living and enhanced mobility’ and ‘standard daily living and standard mobility’ awards. Together these made up 52 per cent of new claims. Only the proportion receiving ‘standard daily living and no mobility’ awards have been relatively stable. These account for the largest proportion of awards (27 per cent).
- 5.17 The net effect of these trends is that the proportion of new claimants receiving at least one enhanced rate in their award has increased over time, which has contributed to increasing average awards. In our October forecast, these trends in the proportions receiving different award rates continue until the assumed end of the full PIP rollout in January 2020, from when PIP is assumed to reach a steady state and the proportions receiving each type of award stabilise. We will need to review these assumptions in light of the latest delay to the PIP rollout timetable – and the latest administrative data – for use in our next forecast.
- 5.18 The assumption about new claims proportions by rate – and therefore the trend in average awards for new claims – is highly uncertain but we judge it to be central at this time. Aside from issues around the delivery of the PIP rollout, several other factors could affect trends in these proportions. For example, the duration of PIP claims could push average awards higher if a maturing caseload is more likely on average to be eligible for more assistance. As PIP is still a relatively new benefit, there is little that can be said about this yet.
- 5.19 The chart shows that the proportion of reassessed claimants receiving each award type has been relatively stable over the past three years. This is largely because claimants who are being reassessed for PIP typically have a long-term condition for which they have been claiming DLA. We assume this stability will continue over the course of the forecast.

Chart 5.7: Average award assumptions



Source: DWP, OBR

Box 5.1: Approaches to modelling PIP and DLA spending on working-age adults

Since working-age disability benefits reform was first announced in 2010, we have used three different approaches to forecasting its cost: a microsimulation model; an aggregate ‘bottom-up’ approach focusing on claims, inflows, outflows and benefit amounts; and a ‘top-down’ approach focusing on the prevalence of benefit receipt in the population, disaggregated by age and sex. In many of our forecasts, we have used more than one of these approaches.

We assess our fiscal forecasting models regularly against five criteria:^a

- **accuracy** – how well does the model match outturns?
- **plausibility** – how well do the model outputs align with theory and experience?
- **transparency** – how easily can the model outputs be understood and scrutinised?
- **effectiveness** – how well does the model capture the tax or spending system?
- **efficiency** – is the model capable of providing outputs to short deadlines?

As well as meeting these criteria, the challenges posed by the PIP reform, and experience here and with other areas of welfare spending, suggest the modelling infrastructure also needs to:

- **Integrate the past and the forecast.** Although PIP is a ‘new’ benefit, information from the DLA system is nevertheless valuable. Long average durations spent in receipt of disability benefits mean that fully representative PIP caseload data will not be available for many years, so currently the DLA experience is the best information available. This can be adjusted for known differences where that is supported by evidence. Because of the migration of claimants from DLA to PIP, which will continue indefinitely in the case of children reaching age 16, integration of DLA and PIP forecasting models will remain desirable to ensure consistency of assumptions across them.
- **Account for continuing claims among pension-age adults.** As with DLA in the 1990s, the number of PIP claims among pension-age adults will rise rapidly as the benefit matures

and claims made by working-age adults continue past the cut-off age for new claims. This will be an important contributor to caseload and spending growth in the coming years. This is illustrated by the rise in PIP claims among those aged 65 and over between May 2017 and May 2018 – up 52 per cent – outstripping overall caseload growth of 29 per cent as the PIP rollout continues. The number of 69-year olds in receipt of PIP increased from 3,700 in May 2017 to 57,000 in May 2018. A similar rise in 70-year olds in receipt of PIP can be expected between 2018 and 2019, and so on.

- **Provide the necessary outputs for dependent forecasts.** Box 3.1 outlines the interdependencies between different benefits that together provide support for disabled people. In forecasting these benefits it is necessary to ensure that the methodology enables us to assess and model these interactions. In particular, this has implications for the way benefit awards are modelled.

Microsimulation modelling

Initially PIP was forecast using DWP's 'integrated forecasting model' (INFORM), a dynamic microsimulation model that projects forward data recorded in the 'work and pensions longitudinal study' (WPLS), which encompasses most benefits. The likelihood of a claimant changing benefit status in each month was modelled based on past experience. New PIP claims were 'cloned' in the model based on recent claims in proportions set by assumption. The model covered DLA in full – including child claims – despite INFORM being a working-age forecasting model. From our December 2012 forecast, PIP was modelled based on the likelihood of a DLA claimant receiving PIP, using the evidence then available (which, as Chapter 4 set out, has not proved reliable). The model met most of the required criteria, being fully integrated and delivering a forecast by award rate, and worked well prior to PIP introduction. But the size and complexity of INFORM – and the fact that it was not tailored to the needs of PIP forecasting – meant there were some significant disadvantages to its use:

- **'Black box' processing** meant it was not obvious how changes to input assumptions resulted in forecast outputs. Links with changes in other benefits were insufficiently clear. Exploring and clarifying these linkages was not feasible during the compressed timetables and resource pressures that characterise a Budget forecast process.
- **Relative inflexibility in changing the structure**, such as splitting DLA inflow assumptions between children and adults when the two started to show substantially different trends.
- **Inability to apply time-varying assumptions**, which became important in the new system, particularly when significant processing backlogs arose.
- **Difficulty in overriding unrepresentative data** generated by the processing backlogs.

Aggregate 'bottom-up' modelling

As PIP-specific data became available, in a different format and with more functionality than the WPLS, use of INFORM was superseded by aggregate 'bottom-up' modelling based on the new data. This was independent of other benefits, and modelled the 'customer journey' through the system from claim registration to initial decision, reconsideration and appeal, and ultimately exit from PIP. Additional modelling using the same data estimated the amount of arrears paid. This

model enabled the forecast to be compared against the emerging data almost in real time, and allowed the key assumptions on provider capacity and claim success rates to be included directly in the model. This modelling evolved as more data became available, particularly on the managed migration from DLA to PIP and on award reviews. The main disadvantages were:

- The modelling was heavily dependent on duration assumptions, but there is very **little information to inform how PIP durations will evolve** in the longer term.
- **The large number of detailed assumptions** required meant that it was very difficult to take a holistic view of the caseload, and the interdependencies between assumptions.
- The different sources of data meant that **the DLA and PIP models were entirely separate**.

'Top-down' prevalence approach

The third approach, used more recently, is a 'top-down' prevalence approach – projecting forward receipt of PIP and DLA by age for adults aged 16 to 64. This approach proved better than the other two for taking an overall view of future caseload growth, with the main judgement being about how prevalence would evolve over time, implicitly reflecting underlying trends in disability and the impact of unspecified future legal cases in expanding coverage of disability benefits. This type of model is more appropriate for forecasting a broad path of caseloads over the medium term, but it proved difficult to calibrate to outturn data or to determine whether differences between forecast and outturn reflected temporary deviations from the assumed medium-term path or shifts to a lower or higher trend.

In the aggregate 'bottom-up' and 'top-down' models, average amounts were forecast separately, although with only four rates payable it would be possible to integrate them into the 'top-down' approach fully. Our October 2018 forecast was the first time we had included specific assumptions about the trends in individual rates of PIP paid. Further work is needed to consider how these evolve as the caseload matures and average durations rise.

The main lesson from this experience is that no single model ticks all the necessary boxes. In an environment still subject to significant change, running a detailed 'bottom-up' model alongside a simpler 'top-down' model is likely to be appropriate, with useful insights to be gained from operating each methodology separately. We will work with DWP to improve each of these models, in particular to achieve greater integration between different aspects of the forecast.

^a More detail is given in Chapter 4 of our October 2016 *Forecast evaluation report*.

Risks and uncertainties

5.20 In all our forecasts we aim to present a central view of the outlook for the public finances, based on stated Government policy and all the available information. Forecasting disability benefits involves the consideration of many factors, both in the context of wider trends in the population – such as perceptions of disability and diagnoses – as well as in the administration of the benefits system. This is especially the case with PIP, given the new eligibility rules and medical assessments, early legal cases and operational fluctuations that have all affected spending. We need to make numerous assumptions and judgements, so our estimates are inevitably subject to a range of risks and uncertainties, as discussed in this

section. Although we focus on medium-term issues, some are also relevant for the longer term. And while the focus of this discussion is on working-age adults, many issues also apply to spending on children and pension-age adults.

Trends in prevalence

- 5.21 Our caseload forecasts assume that the upward trend in the prevalence of child and working-age claims and receipt will continue over the medium term. The prevalence of receipt is a function of the prevalence of disability in the population, the eligibility criteria for disability benefits and take-up behaviours among individuals that are eligible. Disability prevalence is largely determined outside the benefits system, while eligibility and take-up are largely driven by the administration of the system.
- 5.22 We discuss specific risks and uncertainties relating to trends in disability prevalence and to disability benefits administration, but it is not possible to quantify the relative importance of each. The sensitivity of spending to changes in prevalence is linear (as long as the composition of the caseload does not change), so a 10 per cent change in prevalence (e.g. from 5.9 to 6.5 per cent among 16-to-64-year olds in 2023-24) would, all else equal, increase spending by 10 per cent (from £15.2 billion to £16.8 billion). This would involve working-age prevalence rising twice as fast as currently assumed between 2017-18 and 2023-24, the same increase as we currently expect for child prevalence.

Trends in disability prevalence

- 5.23 Chapter 2 notes that survey-based reported disability prevalence has risen over the past 50 years, but that the prevalence of disability benefit receipt has risen more rapidly. It also notes the contribution of the rising prevalence of mental health conditions to the overall trend, which is reflected in the types of conditions reported by disability benefits claimants.
- 5.24 Although we are unable to decompose the changes in the prevalence of disability benefits receipt quantitatively into changes in disability prevalence, benefit eligibility and take-up, we consider the trend in the prevalence of disability to be an important driver. Our assumption that prevalence of benefit receipt will continue to rise is key to the profile of our spending forecast. There is uncertainty around the pace of the increase, but the evidence discussed in Chapters 2 and 3 suggests little uncertainty over the direction.
- 5.25 Changes in disability benefit receipt due to changes in trends in reported disability are likely to take hold relatively slowly over longer periods given their reliance on factors such as changes in diagnoses and preventative or curative medicine. In the context of a five-year forecast, changes to the administration of disability benefits that consequently affect eligibility or take-up are therefore likely to present the greatest risks to the forecast.

Disability benefits policy: reform and legal challenges

- 5.26 The history of disability benefits spending described in this report shows how each major reform has placed upward pressure on spending. With the introduction of DLA in 1992, this reflected a deliberate intention to widen the scope of disability benefits for children and

working-age adults, but the eventual cost was greater than expected at the time. The introduction of PIP in 2013 was designed to curb spending, but has failed to do so (Chapter 6). This reflects a range of factors, including subjectivity in assessing PIP eligibility.

- 5.27 Legal challenges to the disability benefits systems have also expanded eligibility over time. Cases relating to one system often set the precedent for others. And policy reform itself has created the space for legal challenges to new sets of rules. For example, the Mallinson (1994) and Halliday (1994) rulings both served to widen the interpretation of activities affected by disability that should be taken into consideration for DLA, but were largely possible because of the expansion of eligibility criteria under DLA itself. These cases can then be seen to have influenced the design of PIP. And PIP itself has also been subject to several cases that have widened the benefit's scope. Most recently, a High Court judgement on the treatment of mental health conditions in the PIP regulations added £0.2 billion on average to our March 2018 forecast for spending between 2018-19 and 2022-23.
- 5.28 We are required by Parliament to forecast in the basis of current policy, so any future policy changes would lead to a change in our spending forecast. With respect to legal challenges, we aim to incorporate their effects in our forecast where a case is concluded (as we did in March 2017 in respect of judgements relating principally to the mobility component of PIP), but also where a case is still proceeding but the judgement is deemed likely to find against the Government and the effects of such a judgement can be quantified. (This is similar to the approach we take with tax litigation cases against HMRC.) There is clearly a risk that future legal challenges to the Government's interpretation of benefits legislation could expand coverage of the system further, increasing caseloads or average awards.

Trends in the average duration of awards

- 5.29 The average amount of time spent in receipt of a disability benefit is a key driver of our caseload and spending forecasts. The pre-2013 DLA system showed an upward trend in the average duration of claims, but it is uncertain how this will carry over to PIP since it is yet to reach a steady state and given the different mix of characteristics of claimants. Interpreting how the design of the benefit – in particular, the greater frequency of reviews and their consequences – might result in different average durations to those observed in DLA is also complex. As discussed above, our assumptions about the duration of PIP awards are based on 'cumulative outflow curves' fitted to outturn data for new and reassessed PIP awards from the 24 most recent PIP cohorts. There is considerable uncertainty surrounding these assumptions, particularly over longer time horizons.
- 5.30 All else equal, a longer average duration of awards would serve to increase PIP spending through higher caseload prevalence. During a period of *rising* average duration, exit rates would be lower than entry rates and caseload prevalence would therefore also rise. Longer average durations could also affect average awards if disabling conditions become more severe the longer they persist, leading to a higher proportion of claimants receiving higher award rates. The proportion of claimants reassessed for PIP in each award grouping (shown in Chart 5.7) is suggestive of this. The majority of claimants reassessed for PIP are those that have a longstanding DLA claim and around 70 per cent receive at least one enhanced

component. Tracking an individual's award grouping over time is complex – particularly given the move from DLA to PIP – so causality is not easy to establish.²

Trends in average awards

- 5.31 Our average awards forecast is determined by the proportion of claimants in each award group. For new claims, we assume that these proportions stabilise following the end of the PIP rollout. Setting aside risks to the rollout timetable, there is clearly uncertainty around the assumed proportions. They implicitly include assumptions about the types of conditions reported by claimants and how they translate into PIP awards. For example, claimants receiving PIP in respect of a psychiatric disorder are more likely than the average to receive the enhanced daily living component, but less likely than average to receive a mobility component. But these are not modelled explicitly, so it is not possible to say how these implicit assumptions align with outturn data or other assumptions on the prevalence of conditions and how they relate to the points system used to determine PIP award types.
- 5.32 More generally, there is uncertainty as to whether we can expect PIP awards to reach a steady state with the end of the PIP rollout. After stripping out the effect of uprating, average DLA awards showed an upward trend between 1992-93 and 2012-13. Some of this will have reflected policy and other administrative changes, but changes in the composition of the caseload could have played a role too. These reflect differences in the characteristics of those joining and leaving the caseload. Exits from the caseload will reflect both deaths, where average awards could be higher if they are concentrated among those who are more severely disabled receiving the highest rates, and recoveries, where average awards could be lower if they are concentrated among those with less severe conditions. The relationship between the composition of exits and average awards is not currently modelled explicitly.
- 5.33 The sensitivity of our spending forecast to changes in average awards is linear, so for every 5 per cent increase in average working-age disability benefits awards (e.g. from £115.85 to £121.64 a week in 2023-24) spending would also increase by 5 per cent (from £15.2 billion to £16.0 billion).

Operational performance and the continued rollout of PIP

- 5.34 Chapters 3 and 4 highlighted some of the difficulties in administering both DLA and PIP, and how our forecasts changed in the light of developments as PIP became more established. Even with a more mature system, as with DLA for children, changes in operational performance can affect claims, awards, outflows and benefit amounts, and therefore spending. The risks from operational performance can be divided into two types:
- **Those affecting underlying spending**, where operational pressures mean that decisions on awards are different to those that would pertain were those pressures not to exist. This is likely to occur where insufficient capacity to process the necessary claims or assessments results in a lower level of scrutiny and is more likely than not to result in decisions erring on the side of being more generous to the claimant.

² For example, it could be the case that many longstanding claimants had severe conditions from the outset of their claim, so would always have received the highest rates rather than that they have drifted into the highest rates over time.

- **Timing effects**, which again arise from operational pressures, but simply move spending to later years, with more payments being in arrears.

In practice these often crystallise at the same time, which means separating timing effects from underlying ones can be difficult. Timing effects frequently mask the signal in the data, making it more difficult to distinguish news from noise when making forecast judgements.

- 5.35 A key operational risk relates to whether there are sufficient healthcare professionals available to providers. This risk is particularly pertinent given the significant increase in capacity required to complete the full PIP rollout on the timetable assumed in our October forecast, which DWP has already moved back once more. The direct expenditure effects of further slowing the PIP roll out are fairly small, since those affected would simply stay on DLA for longer. But experience with both PIP and employment and support allowance (ESA) has shown that a rapid increase in reassessment volumes adversely affects scrutiny of new claims. Monitoring this will be a key forecast issue over the coming year.
- 5.36 A specific provider risk relates to the future re-contracting of health assessments. The current contracts, having already been extended once, are due to expire in July 2019. But DWP has suggested that it will look to extend contracts for a further two years.³ Uncertainty around the future position is likely to affect staff recruitment and retention. As in the case of the ESA contract, subsequent recovery of capacity can take a long time. Chapter 4 highlights several other risks that could affect provider capacity, while capacity in DWP and HM Courts and Tribunals Service could also affect decisions.

Risks from elsewhere in the welfare and wider public sector

- 5.37 Disability benefits can be affected by changes elsewhere in the system, such as where receipt of a disability benefit offers an exemption from a particular change (as with the benefit cap), or where they seek to replace lost income, or where a policy change simply brings people back into contact with the system. As of now, most of the substantial welfare reforms announced by recent Governments have been implemented, although some have yet to have their full effect and could still induce further risks to disability benefits spending.
- 5.38 The main benefit-related risk is from the further rollout of universal credit (UC), particularly the managed migration phase (the timetable for which is subject to its own uncertainties). A large proportion of managed migration claimants will be those receiving ESA. Many of these will be longer-term claimants who may not have had much recent contact with DWP. The proposed migration approach, requiring an active claim to be made by those being migrated at DWP's discretion, could prompt additional claims for disability benefits, particularly if the advice and help of welfare rights organisations is sought.
- 5.39 Spending on disability benefits could also be affected by future policy changes to other benefits, for similar reasons. In estimating the cost of any such changes, we will need to consider the consequences for disability benefits and include them where their scale and timing can be quantified. Evidence from past changes will influence such judgements.

³ Personal Independence Payments Written statement – HCWS733, 5 June 2018.

The disability benefits forecast

5.40 Policy and operational changes in other parts of the public sector could also affect disability benefits. Social care policy affects disability benefits directly, but could also have indirect effects, depending on how policy evolves in future. Up until the point at which the reforms were shelved, we assumed that the Dilnot reforms to adult social care would result in higher spending on AA as they brought more people into contact with local authorities.

Data and modelling risks

5.41 The quality of the data underpinning our forecasts is another source of uncertainty, particularly where there are gaps or where deficiencies produce misleading results. We have highlighted the difficulties caused by assessment backlogs clouding the signal from administrative data. Extended processing times due to mandatory reconsiderations and appeals mean that it takes a several months before a 'final' assessment can be made of how a particular group of claims has evolved (in terms, for example, of the proportion of claims ultimately receiving an award and the rates that are awarded).

5.42 No single modelling approach dominates for all parts of the forecast. The gradual evolution of the modelling described in Box 5.1 has been accompanied by some fragmentation within the modelling infrastructure. This creates potential for inconsistencies and double-counting or omission of some part of spending. But simply bringing different parts of the forecast together can create its own problems if it reduces modelling flexibility. So all approaches necessarily represent a degree of compromise.

5.43 The main modelling issues in focus over the coming year are average benefit amounts, the composition of leavers from the benefit, and the gradual extension of PIP across claimants of pension age. This will be in addition to the usual scrutiny of individual forecast assumptions, particularly the more uncertain ones discussed in this section.

Scottish devolution

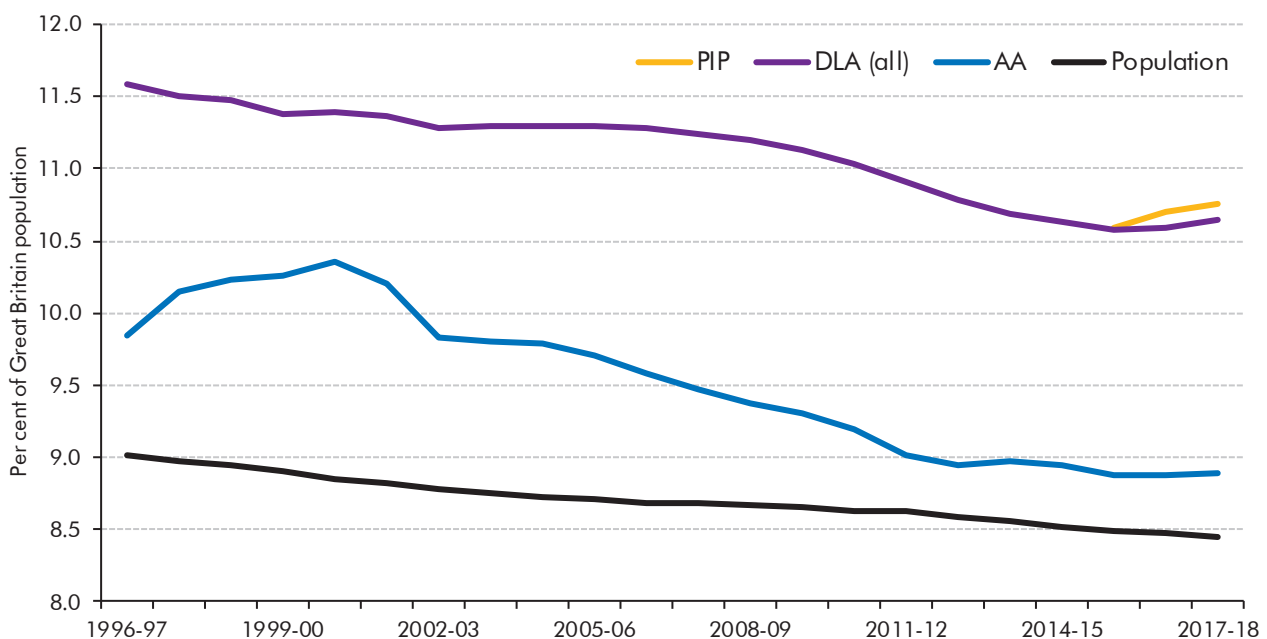
5.44 The Scotland Act 2016 set out the various benefits to be devolved to the Scottish Government, including the main disability benefits covered in this report: DLA, PIP and AA.⁴ Firm dates have not been set for when DLA, PIP and AA will be devolved. We have not yet produced a full devolved disability benefits forecast, but could need to do so relatively soon. This section reviews differences in disability benefits spending in Scotland relative to the rest of Great Britain (GB) and the issues that are raised by forecasting Scottish spending. It also provides an illustrative projection of spending in Scotland that is consistent with our October 2018 GB-level forecast described above.

⁴ The Scotland Act 2016 set out the following other benefits to be devolved: carer's allowance (which was devolved in September 2018, but is still administered by DWP), industrial injuries disablement benefit, severe disablement allowance, cold weather payments, funeral payments, sure start maternity grant, winter fuel payments and discretionary housing payments. The Act also provides for other areas to be devolved to the Scottish Government, including payments made under the Scottish welfare fund, the healthy start vouchers scheme and employability programmes, and powers to vary certain aspects of universal credit. The Scottish Government also has the power to top-up reserved benefits and create new benefits in areas other than pensions. We set out our forecasts for devolved social security spending in the *Devolved tax and spending forecasts* publication that accompanies each *Economic and fiscal outlook*.

Recent trends

5.45 In 2017-18 expenditure on DLA, PIP and AA in Scotland was £2.4 billion (10.3 per cent of the GB-wide total). Chart 5.8 shows that for most of the past two decades the Scottish share of DLA and AA spending has been declining slowly, although somewhat more quickly than the decline in Scotland's share of the British population. The decline in the Scottish share of spending reversed in 2015-16, but Scotland's share of the population has continued to fall. In all years, the Scottish share of spending has been higher than the Scottish share of the population, which means that expenditure per person is higher in Scotland than in GB as a whole. In 2017-18 it stood at £446 per person in Scotland versus the GB-wide figure of £364. The Scottish share of PIP spending has been broadly similar to the Scottish share of DLA spending, and has also risen slightly over the past few years.

Chart 5.8: Scottish share of population and expenditure on DLA, PIP and AA



Source: DWP, ONS

Forecast methodology

5.46 When producing a forecast of Scottish receipts or expenditure, we typically start by taking the estimated Scottish share from the most recent year of outturn and applying this to our relevant UK- or GB-level forecast. We then adjust the resulting forecast to account for any factors that we think will raise or reduce the Scottish share. The only social security forecast that we have produced for Scotland so far is for carer's allowance, where the only further adjustment we currently make is to reflect slower growth in Scotland's population relative to Great Britain as a whole, based on the Office for National Statistics 2016-based principal population projections. This adjustment results in the Scottish share of spending decreasing slightly over the forecast period, with a modest effect on spending.

5.47 Table 5.1 sets out an illustrative projection for DLA, PIP and AA based on the latest Scottish share of spending, adjusted for slower population growth in Scotland. Implicit in this projection is an assumption that Scottish expenditure per person neither converges nor

diverges from that in the rest of GB. This is an issue that we will explore further before publishing a full Scottish disability benefits spending forecast. For example, it does not take account of differences in the future evolution of the age structure of the population, which is potentially material given the older age distribution in Scotland relative to GB and the upward sloping age profile of disability benefits prevalence. We will also look into the switch from a declining to a rising trend for the Scottish share around 2015-16 to see whether it is possible to discern different trends in prevalence more generally or the composition of the caseload by rates received that should be factored into a central forecast.

Table 5.1: Illustrative projection for Scottish spending on DLA, PIP and AA

	£ billion, unless otherwise stated						
	Outturn	Forecast					
	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24
Disability living allowance (DLA) and personal independence payment (PIP)							
Great Britain	17.5	18.7	20.2	20.7	21.5	22.5	23.6
Scottish share (per cent)	10.7	10.7	10.7	10.6	10.6	10.6	10.6
Scotland	1.9	2.0	2.1	2.2	2.3	2.4	2.5
Attendance allowance (AA)							
Great Britain	5.5	5.7	5.9	6.1	6.3	6.6	6.8
Scottish share (per cent)	8.9	8.9	8.9	8.8	8.8	8.8	8.8
Scotland	0.5	0.5	0.5	0.5	0.6	0.6	0.6
Total							
Great Britain	23.0	24.4	26.1	26.8	27.8	29.0	30.4
Scottish share (per cent)	10.3	10.3	10.2	10.2	10.2	10.2	10.2
Scotland	2.4	2.5	2.7	2.7	2.8	3.0	3.1
<i>Memo: per cent Scotland DLA PIP</i>	10.7	10.7	10.7	10.6	10.6	10.6	10.6
<i>Memo: per cent Scotland AA</i>	8.9	8.9	8.9	8.8	8.8	8.8	8.8

Future policy changes and other risks

5.48 The illustrative projection set out above does not incorporate any changes the Scottish Government might make to the structure, rules or administration of these benefits. There will be administrative changes, as new executive agency – Social Security Scotland – will take over from DWP and will have different operational practices that are likely to affect spending. For example, it proposes to run services in-house rather than using contractors, and will have as explicit aims for reducing the number of face-to-face assessments and increasing take-up.⁵ Less use of face-to-face assessments is likely to increase spending and any success in increasing take-up would do the same. It is not possible to say in advance what effect bringing assessments in-house might have.

5.49 At this stage, we have insufficient information on any of these changes to quantify the magnitude or timing of their effects on our spending forecast. Some, such as efforts to increase take-up, could affect spending before administration has been devolved. We will work closely with analysts in the Scottish Fiscal Commission on these and related issues.

⁵ See Disability Assessments (Private Contractors), Meeting of the Scottish Parliament, 7 September 2017, for a discussion of the Scottish Government's plans for administering disability benefits. In reference to take-up, Section 3 of the Social Security (Scotland) Act states that Scottish Ministers must "keep under consideration what steps they could take to ensure that individuals are given what they are eligible to be given through the Scottish social security system".

6 The public spending impact of PIP

Introduction

- 6.1 In this report we have shown that spending on the personal independence payment (PIP) – like spending on disability living allowance (DLA) before it – differed greatly from initial predictions. Our spending forecasts differed materially and consistently from outturns, almost always understating the amount spent. To improve our future forecasts it is important to learn the lessons from this experience and to document them for future forecasters.
- 6.2 In Chapter 4 we discussed how the assumptions underpinning our PIP forecasts changed in light of actual experience. In this chapter we quantify the effect of these differences on welfare spending, attributing them to differences in caseloads and average amounts received. We also present our main conclusions and lessons learned.

Assessing the public spending impact of PIP

- 6.3 Estimating the effect that PIP has had on public spending is difficult, especially as the rules are subjective in their application and likely to have prompted changes in behaviour. It is impossible to say with confidence how much DLA would have cost had it continued – i.e. to generate a counterfactual against which to compare actual experience under PIP. For example, how much would spending have risen due to the help now available via the internet and social media to assist people in making a successful claim? But has the volume and effectiveness of such assistance been influenced by the introduction of PIP?
- 6.4 So we adopt two simpler approaches to assessing the effect of PIP on public spending:
- **Alternative scenarios:** This is a variation of the approach used in our 2016 *Welfare trends report (WTR)* whereby we identify and control for changes in spending arising from demography and benefit uprating. We then generate scenarios using ONS population projections, our own inflation forecasts and different plausible paths for prevalence of benefit receipt. Other than the introduction of PIP and the switch to uprating policy announced in June 2010 (which the methodology controls for), policy changes affecting the number of DLA claimants in the past 16 years (the period of comparable data available to us) have been relatively minor. We focus on claimants aged 16 to 64, in line with the parameters of DLA and PIP to date.
 - **December 2012 costing:** We can now compare the estimated May 2018 caseloads and spending that underpinned our December 2012 PIP forecast with outturn data.

Alternative scenarios

6.5 Building on the detailed analysis of trends since 2002 described in Chapter 3, we consider three alternative scenarios for spending, starting from a May 2013 base (i.e. end 2012-13):

- **Constant prevalence:** this scenario assumes that prevalence by rate, single year of age and sex are unchanged from 2013 onwards. Prevalence had been relatively stable at the aggregate level from 2010 to 2013.
- **Five-year rise in prevalence:** this scenario assumes that prevalence from 2013 onwards rises in line with the trend observed between 2008 and 2013 for men and women, and for each rate.
- **Ten-year rise in prevalence:** this scenario uses the same methodology as the previous one, but is based on the trend seen between 2003 and 2013.

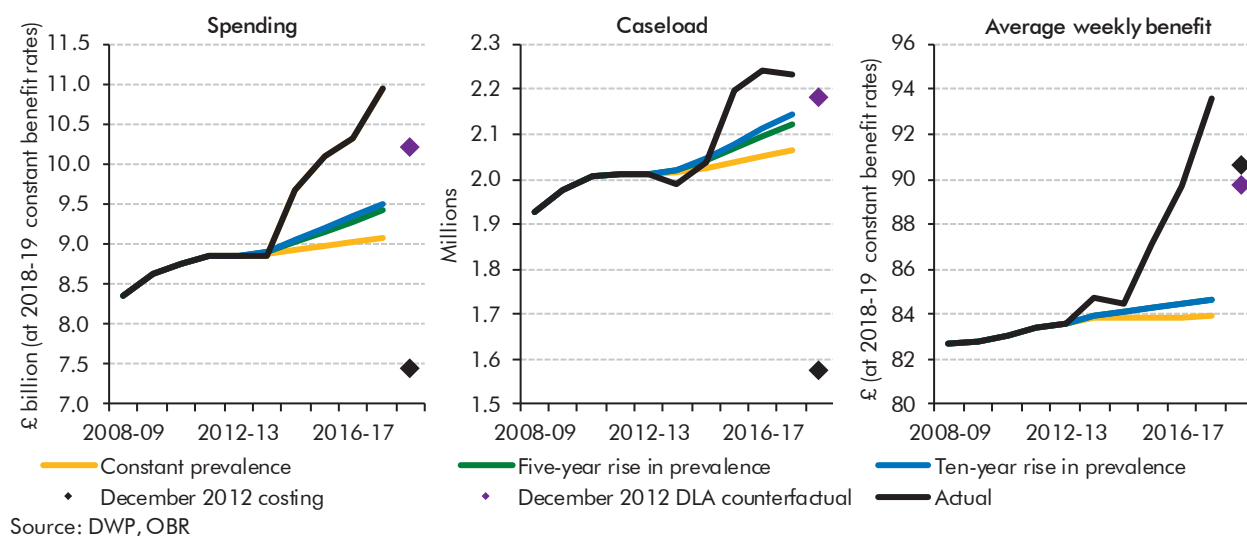
We also compare our latest forecast to a scenario assuming flat prevalence from May 2018.

6.6 To determine the spending impact, we multiply the caseloads by weekly benefit rates and adjust for other factors that affect spending, such as the payment of arrears. This enables us to compare actual spending on PIP and DLA, and our October 2018 forecasts, with the alternative projections of the cost of DLA had it continued.

6.7 Chart 6.1 shows these scenarios relative to recent outturns, along with the annualised point estimates for May 2018 made in December 2012. We have made the following adjustments to the published figures:

- For spending in 2017-18, we take account of **the consequences of the ruling in *MH v Secretary of State for Work and Pensions***. DWP's outturn data include a provision in respect of payments for 2017-18 that are expected to be made in later years as a result of the 'legal entitlements and administrative practices' (LEAP) exercise. As this falls outside the National Accounts definition of spending we remove this provision from 2017-18, and include in its place the expected payments for that year underpinning our October 2018 forecast. This reduces the outturn by £240 million.
- We take out **the effect of changes in benefit rates by expressing figures in 2018-19 benefit rate terms**. Spending on DLA claimants aged 16 to 64 was £8.0 billion in 2012-13. Benefit rates were increased by 10.5 per cent between then and 2018-19, so spending in 2012-13 was £8.9 billion in 2018-19 benefit rate terms.

Chart 6.1: PIP and DLA spending: outturns, scenarios and costings



Outturns versus alternative scenarios and the December 2012 costing

Spending

- 6.8 Spending at 2018-19 benefit rates rose from £8.9 billion in 2012-13 to £10.9 billion in 2017-18 – that is £1.9 billion (21 per cent) higher than the constant prevalence scenario; £1.6 billion (17 per cent) higher than the five-year trend scenario; and £1.5 billion (16 per cent) higher than the ten-year trend scenario.
- 6.9 The December 2012 costing projected that DLA spending would have increased by more than any of these alternative scenarios had it continued, as it also assumed higher average awards. Even so, our latest forecast for spending in 2018-19 is £1.4 billion (15 per cent) higher than the annualised DLA counterfactual for May 2018 used in the costing.
- 6.10 Based on these comparisons, PIP appears to have increased spending on disability benefits significantly – by perhaps £1 billion to £2 billion a year as of now. This compares with the planned *saving* of around £1.5 billion in 2015-16 that accompanied the original announcement. Our latest forecast for spending in 2018-19 is £4.2 billion higher than the grossed-up forecast made in December 2012 for May 2018.
- 6.11 Relative to the scenario where prevalence is fixed at May 2018 rates, our October 2018 forecast shows further substantial increases in spending in the next five years. This is driven entirely by higher average awards up to 2020-21 as the rollout of PIP is completed, with subsequent growth reflecting caseloads rising as a share of the population.

Caseloads

- 6.12 Caseloads show a smaller gap between outturn and the different scenarios. They increased from 2.01 million in 2012-13 to 2.23 million in 2017-18, after a small year-on-year fall in

The public spending impact of PIP

measured caseloads last year.¹ The December 2012 estimates of the DLA counterfactual are slightly above the ten-year rise scenario. This is unsurprising as the DLA modelling at that time relied on data from 2002 to 2008 to avoid any recession-related distortions.

- 6.13 The scenarios suggest that PIP has increased caseloads by around 90,000 to 170,000 (4 to 8 per cent) in 2017-18, compared with a predicted reduction of around 600,000 (28 per cent) in May 2018 when PIP was fully costed in December 2012.
- 6.14 We expect the caseload to fall slightly in the short term as the PIP rollout is completed, as we assume that around 15 per cent of DLA claimants will not be successful in receiving a PIP award (once the reconsiderations and appeals process is complete). Once PIP is fully rolled out, the 16 to 64 caseload rises much more rapidly than it would if prevalence remained constant. This reflects a combination of both rising new awards and lengthening durations.

Average amounts of benefit received

- 6.15 Average awards explain most of the growth in spending between 2012-13 and 2017-18. They rise by almost £10 a week (12 per cent) in 2018-19 benefit rates terms over those five years and by a further £2 a week by May 2018. The scenarios suggest that there would have been some upward drift in average amounts relative to uprating alone if prevalence had followed previous trends, but only by around a tenth of that seen under PIP.
- 6.16 In contrast to the scenarios, the 2012 costing assumed a higher proportion of people in receipt of higher rates would raise average DLA awards by around £6 a week (7 per cent) in constant terms by May 2018. PIP was expected to increase awards by around £1 a week (1 per cent) above that (the gainers and losers, excluding those who would no longer be entitled to any benefit, being broadly balanced). In fact, average awards in May 2018 were around £5 a week (5 per cent) higher than predicted in December 2012.
- 6.17 Our latest forecast assumes a sharp increase in average awards in 2018-19 and 2019-20, after which awards stabilise before falling slightly. The final stage of the PIP rollout explains much of the increase as claimants who are awarded PIP receive around £15 a week (16 per cent) more than they did in DLA. There is also substantial growth in awards for other PIP claims as they undergo award reviews and the average duration of the caseload increases.

Detailed comparisons with the December 2012 costing

- 6.18 The December 2012 costing of PIP included detailed forecasts of the PIP caseload in May 2018, alongside a counterfactual DLA caseload. With outturn data for May 2018 now available we can compare the December 2012 assumptions with what has transpired, and identify the various factors contributing to the large underestimate of spending.
- 6.19 An important caveat is that the December 2012 estimates assumed that PIP would be fully rolled out to 16-to-64-year olds by May 2018, whereas in fact 665,000 claimants were still in receipt of DLA (equivalent to around 30 per cent of the 'DLA counterfactual'). We cannot

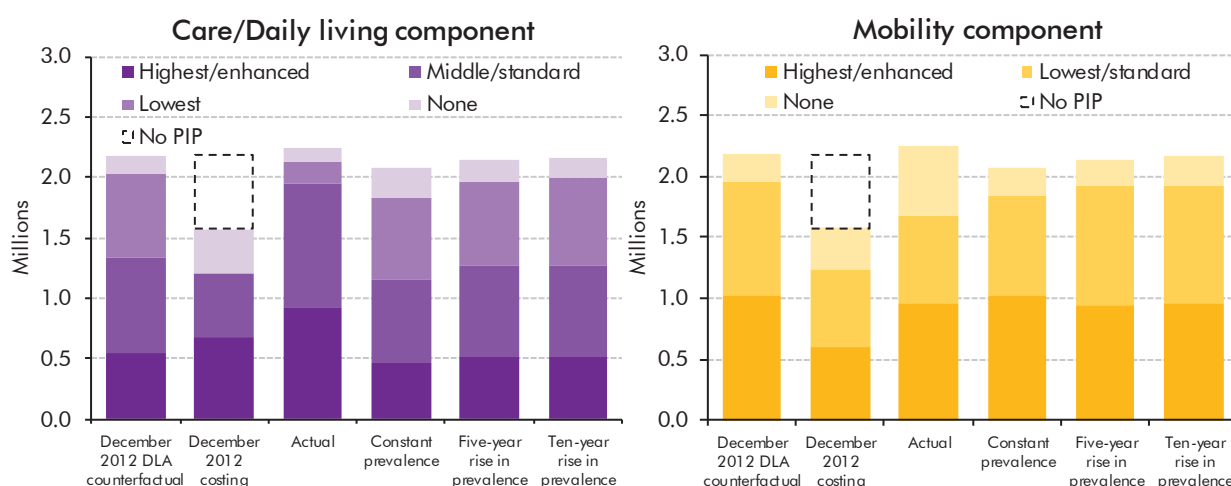
¹ The caseload falls by just over 10,000 cases in 2017-18. This could be due to measurement error, as discussed in Box 4.1.

say for certain what effect the migration of these remaining cases would have had on the comparison, but experience of PIP to date suggests that substantial reductions in caseloads or average amounts of benefit would be unlikely.²

6.20 Chart 6.2 shows the caseload of DLA and PIP in May 2018, split between the different rates of benefit paid for the care/daily living and mobility components. For each, it shows the December 2012 estimates of the 'DLA counterfactual' and PIP first, then the actual outturn, and finally figures that are consistent with the three scenarios modelled previously.

6.21 We compare the December 2012 costing with the actuals in aggregate terms, but recognise that this does not say what individuals' respective entitlements would have been under DLA compared to PIP (which is discussed in more detail in Chapter 4). Although the costing assumed that PIP would achieve a substantial overall saving, almost 30 per cent of claimants were expected to receive a higher award as a result of the policy change.

Chart 6.2: Comparisons of projections and actual caseloads by rate



Source: DWP, OBR

6.22 PIP was assumed to reduce the 16-to-64-year old caseload by 606,000 (28 per cent), with 816,000 (40 per cent) fewer people receiving the daily living component, 723,000 (37 per cent) fewer receiving the mobility component, and the number receiving both components falling by 933,000 (52 per cent).³ As regards the more detailed assumptions across the different components:

- **For the care/daily living component**, the assumed drop was in large part due to the removal of the lowest care rate that exists in DLA (accounting for 684,000 of the decline). A reduction of 132,000 in the numbers receiving the daily living component

² This is not the same as there being 30 per cent of those to be reassessed, since some of the transition to PIP occurs through natural turnover of claims, some through 'natural migration' as claimants' circumstances change, and only some through 'managed migration' or 'full PIP rollout'. So while reassessment of existing claimants (whether natural or managed) cannot increase the caseload – though it can increase rates – natural turnover of claimants could result in a further increase in claimants.

³ These figures are not mutually exclusive, nor do they give a full picture of the number of hypothetical losers, as they represent a net comparison between PIP and the DLA counterfactual, and the costing predicted some claimants would receive a higher amount. It is also possible for a claimant to receive more benefit while moving from receipt of both components to receipt of only one of them.

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of PIP relative to the equivalent care rates in DLA was also assumed. But within that, receipt of the highest rate was expected to rise by around 135,000 and the middle/standard rate to fall by 267,000.

- **For the mobility component**, the large assumed reductions came despite both rates in DLA being carried through to PIP. The assumed drop by May 2018 was large for both rates – 428,000 (42 per cent) for the higher rate and 295,000 (32 per cent) for the middle/standard rate.

6.23 Comparing these assumed falls with the outturn data for May 2018 shows that:

- **For the care/daily living component**, there has been no reduction in awards relative to the assumed DLA counterfactual. Instead the caseload is 100,000 (5 per cent) *higher* than assumed. This means in effect that the abolition of the lower care rate of DLA has been more than offset by increases in the continuing care rates in PIP. Awards of the highest rate are 255,000 (38 per cent) higher than assumed in the costing, while awards of the standard rate are 476,000 (89 per cent) higher than assumed.
- **For the mobility component**, some of the assumed drop has been realised, particularly among those on the lower rate. Higher rate awards are 79,000 (8 per cent) lower than the DLA counterfactual and lower rate awards are 195,000 (21 per cent) lower. However, both are still much higher than the costing assumed, by 349,000 (58 per cent) for the higher rate and 100,000 (16 per cent) for the lower rate.

Reassessment outcomes

6.24 The test results underpinning the 2012 costing related to a sample of existing claimants, so it is also worth comparing the assumed outcomes that flowed from these results with the outcomes of claims that have actually been reassessed. We have done this in two ways:

- **Comparing the December 2012 assumptions with the outcomes of all reassessments undertaken to October 2018.** This includes people who have subsequently moved off PIP but does not include the effect of reconsiderations and appeals.
- **Comparing the December 2012 assumptions with the outcomes of all reassessed cases still in receipt of PIP at May 2018.** This excludes any cases that have already moved off PIP, which are likely to have different characteristics to those remaining on the benefit, but does take account of any completed reconsiderations and appeals. These outcomes include reassessments of child DLA claims as recipients approach age 16 and any changes to entitlements that have occurred subsequent to reassessment.

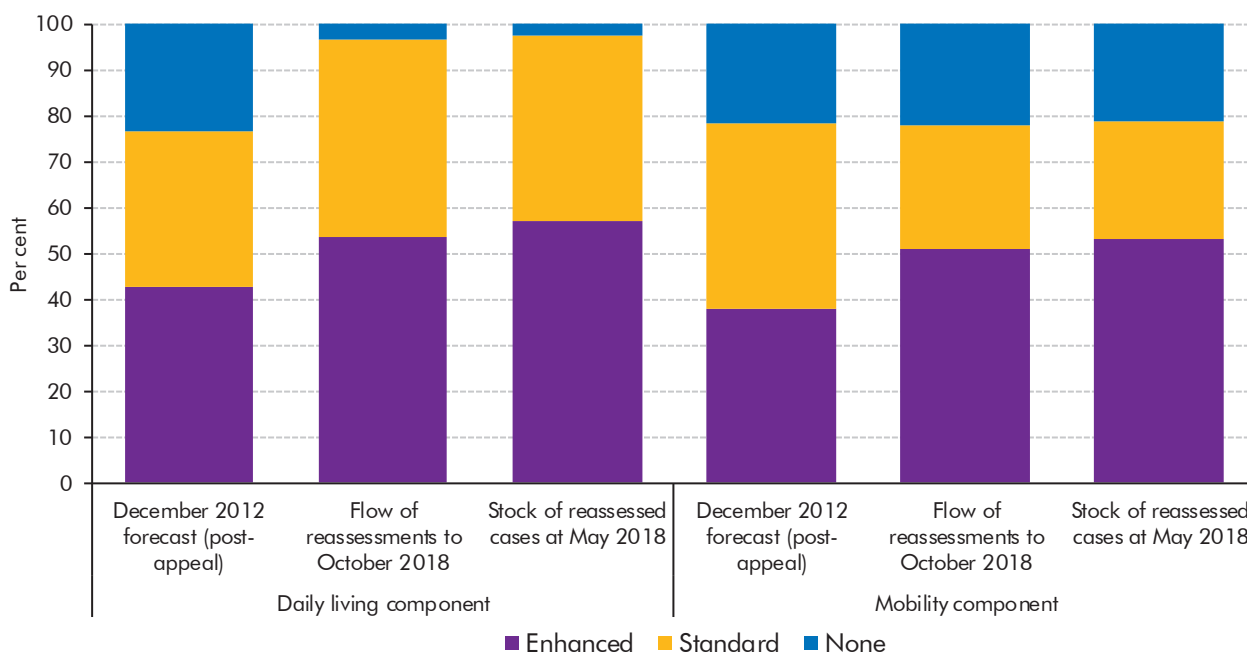
6.25 Neither comparison is on an exact like-for-like basis. The test results used in December 2012 are most similar to managed migrations than to a flow of natural reassessments but the modelling undertaken then included the impact of claimants flowing off the benefit after reassessment (i.e. those cases will have been excluded from the costing estimates). Also, the December 2012 estimates related to post-appeal outcomes, whereas the two comparisons above either exclude them entirely, or only include those completed by May 2018. Nevertheless, they give useful points of comparison for the December 2012 costing.

6.26 We can compare the ‘success rates’ for the flow of reassessments with the December 2012 assumptions, but we cannot do this for the stock at May 2018. The former shows 75 per cent of reassessed cases up to October 2016 received an award at their initial assessment – slightly more than the costing assumed for final awards (74 per cent). But as these results excluded those not responding to the invitation for an assessment, the true success rate is likely to be marginally lower. By contrast, the success rate after reconsiderations and appeals is around 80 per cent for the period where data are available.⁴ It is not possible to discern the effect of reconsiderations and appeals on the mix of rates.

6.27 Chart 6.3 shows the mix of rates for successful awards. The two different comparisons give similar results. Most notably daily living component awards differed significantly from the proportions assumed in December 2012. Only 3 per cent of reassessments did not receive this component, compared with the 23 per cent assumed in the costing. The higher-than-assumed share of reassessments receiving such an award was split roughly proportionately between the two PIP daily living rates. The stock of cases still receiving PIP in May 2018 were slightly more likely to receive the enhanced daily living component than the flow of reassessments. In contrast, the proportion of mobility component awards was largely as assumed in December 2012, but a higher proportion received the enhanced rate.

6.28 Applying 2018-19 statutory benefit rates to the outturn proportions awarded the different rates on either basis suggests that the average amount received by reassessed claims is around £19 a week (22 per cent) higher than was assumed in the costing.

Chart 6.3: Comparison of outcomes for reassessed cases



Source: DWP

⁴ The time taken for reconsiderations and appeals means it is about a year before the final outcomes can be known with any certainty.

Demographic and economic factors

6.29 Some of the difference between the predictions made in 2012 and outturn will have been due to demographic and economic factors. The main ones we can account for are:

- **Changes in the population size and structure.** The December 2012 estimates were based on models using the 2010-based ONS low migration population projection, consistent with our central forecast at the time. We now regard the 2016-based ONS principal population projection as the best estimate of the population in mid-2018. Adjusting for differences in the starting population – which would have been reflected in the model base data – faster-than-assumed growth in the population of 16-to-64-year olds and small differences in its structure by age and gender would add around 1.0 per cent to caseloads and spending.⁵
- **Inflation** has been lower than we forecast in December 2012. Consequently, benefit rates in 2018-19 are 2.9 per cent lower in cash terms than was predicted then.

The net effect of these factors would be to reduce spending by around 2 per cent (£200 million relative to the annualised DLA counterfactual in the costing).

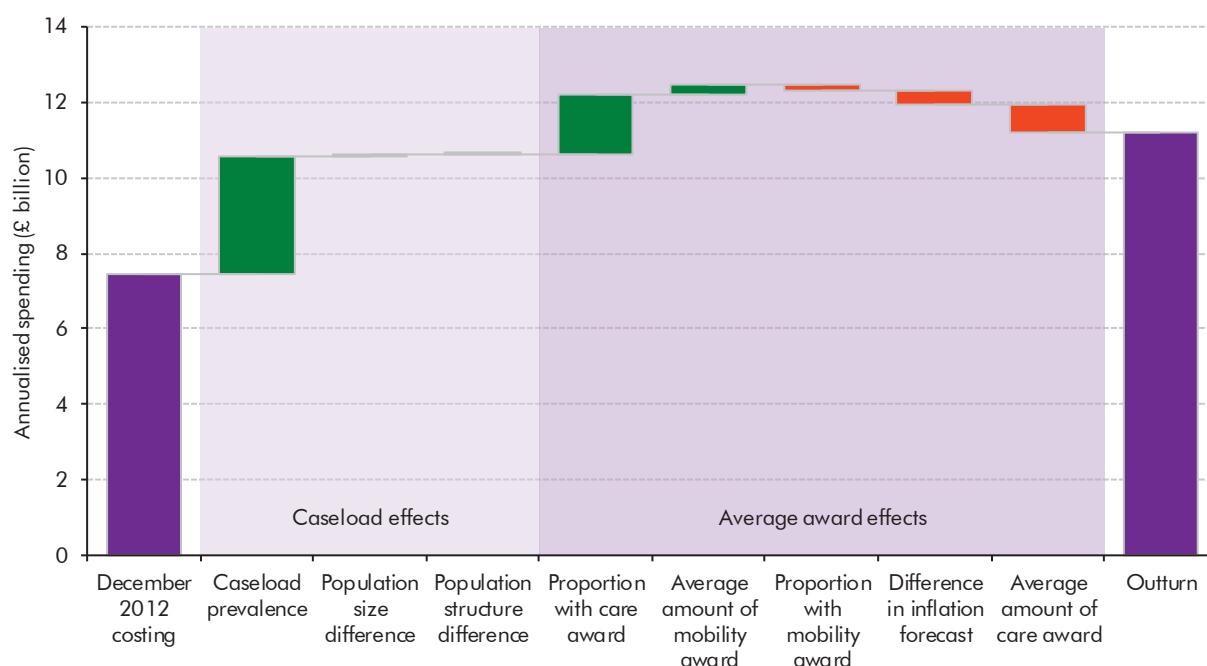
Decomposition of differences between December 2012 costing and outturn

6.30 Chart 6.4 shows how the different factors influencing spending on PIP contribute to the differences between forecast and outturn for annualised spending in May 2018:

- **Caseload differences** account for around 85 per cent of the spending difference. Almost all of this reflects higher-than-assumed prevalence of benefit receipt in the population, with changes in the size and composition of the population having only a small impact. This is because PIP was expected to reduce the caseload substantially but it has actually risen materially.
- **Differences in average awards** account for only 15 per cent of the difference, thanks to several larger effects that partly offset. PIP was expected to result in slightly higher average awards. In the event, they were around £5 a week higher than assumed.

⁵ The 2010-based and 2016-based population projections start with different base population estimates for 2010, as the former pre-dates the 2011 census results. As population estimates do not affect the administrative records the modelling is based on, what matters is how population growth between the base data and now differs between the two estimates.

Chart 6.4: Sources of differences between December 2012 costing and outturn



Source: OBR

Conclusions and lessons learnt

Broad conclusions

- 6.31 This report seeks to achieve two goals. First, to explain historical trends in spending on disability benefits, with emphasis on recent years. Second, to assess the effect that the introduction of PIP in 2013 has had on public spending and in doing so to understand what has driven the repeated under-forecasting of PIP and working-age DLA spending since then.
- 6.32 Evaluating past forecast performance in this way is always important. Without assessing why our forecasts differ from outturn we are far less likely to learn the lessons from significant differences like these. By documenting our findings, we can also help future policymakers and forecasters draw upon the evidence of our recent experience. In preparing this report, we drew on anecdotal evidence of how DLA performed after its introduction, but it was more difficult, and in some cases impossible, to obtain the hard evidence: this report helps avoid a repeat of that for PIP.
- 6.33 Key to understanding the difficulties in forecasting disability benefits is that fully objective measurement and assessment of eligibility for them is difficult. This sets them apart from most other components of the welfare system. For example, our 2018 WTR focused on universal credit (UC), where large-scale changes across a range of parameters result in modelling challenges and a great deal of uncertainty. But the main variables that determine UC entitlement – such as income or housing costs – can be measured more objectively.
- 6.34 The available data suggest there is likely to be a much larger number of people eligible for disability benefits than currently claim them, giving considerable scope for future growth in

the caseload through higher take-up. The introduction of DLA in 1992 and then PIP in 2013 both cost much more than expected – around 23 per cent higher for DLA by 1994-95 and 15 to 20 per cent higher for PIP by 2017-18. It took almost 20 years for the prevalence of DLA receipt to stabilise, so it is likely to be many years before the uncertainties around our PIP forecasts narrow materially.

Lessons learnt

- 6.35 The PIP reforms highlight the uncertainties associated with changes to a part of the benefits system where assessment has an element of subjectivity, where there is no fully objective measure of eligibility for either the existing system or the new rules, where behavioural responses can be significant and where operational capacity needs to be expanded considerably. With hindsight it is easy to identify areas where PIP served to increase spending pressures – not all of which were apparent during its development.
- 6.36 The costing of PIP, either in its original form or the December 2012 update assessed in this chapter, was only ever partial. It focused on the effect of introducing an external assessment into a previously self-assessed and largely uncorroborated system, but largely ignored the changes to the assessment criteria and the greater transparency the new system brought.

Costing the effect of policy changes

- 6.37 We have already acknowledged that certifying costings on the basis of very sparse policy detail, as was the case for DLA reform in June 2010, would not be repeated now. That said, the first evidence-based costing for PIP (produced when more specific policy detail was available) showed even greater savings from the reform that were even further removed from what has been observed in practice. From that costing the main lessons are:
- **To be more sceptical about the information gleaned from a single hypothetical test situation**, ensuring the details of the information are fully understood and considered, and placing less reliance on that single source. The details of the analysis using the sample results included a discussion of uncertainty. But too little consideration was given to this in forming our judgements. A key shortcoming was the application of the results to new claims when they could do little to inform assumptions about either volumes or success rates. We have shared our findings with DWP, which has been incorporated into internal guidance on trials.
 - **To consider all aspects of a policy change when estimating its effect on spending.** In the case of PIP, the gaps included the potential for the new rules and processes to extend eligibility and to encourage behavioural change and system learning among claimants. These issues are now routinely considered across all potential policies submitted to us for certification, as well as during forecast challenge processes. We discussed them at length when scrutinising the costing for the aborted PIP ‘aids and appliances’ measure announced in Budget 2016.

- **To draw on the expertise of DWP’s medical advisers** involved in the testing and the development of the new assessment criteria, rather than being solely reliant on analysts. This could have highlighted the necessarily subjective nature of the assessment, which was billed in the June 2010 Budget as the introduction of an “*objective medical assessment*” when in reality that is not feasible.
- **To require detail on the information that would be available to claimants and any associated publicity material.** For PIP this would have helped us to judge the extent to which claimants and their advisers might find the system easier to navigate. We have since sought out relevant material to inform our judgements on other welfare policy costings – for example, in our scrutiny of the introduction of tax-free childcare we have considered the impact of marketing plans (although these have frequently changed).
- **To consider what lessons can be learned from the historical performance of previous – or similar – systems.** The experience of the introduction of DLA should have carried more weight in considering the effects of PIP, while the substantial changes to ESA assessment outcomes at the time could have had more influence on the December 2012 costing. This report helps contribute towards the evidence base for the future.
- **To consider how quickly emerging evidence should be incorporated into our forecasts.** As information on actual experience of PIP became available, we could have brought our forecasts into line with the emerging data and applied it to other relevant parts of the forecast more quickly. Examples of this include the higher success rates for new claims indicating that the assumed reassessment success rates may also have been too low. We took account of unspecified operational activity aimed at restoring the original spending effects, but these should only have been included when sufficient detail and evidence was available to determine how they would achieve the intended effects.

Operational challenges and assumptions

- 6.38 As with many major reforms the rollout has taken much longer than expected. If the rollout of PIP is completed in January 2020 as assumed in our October forecast, it will have taken more than twice as long as originally planned. We have on occasion assumed that the rollout will take longer than DWP’s official plans, but even these assumptions have proved to be optimistic (as has again proved the case with our October assumption). Experience of incapacity benefit reassessment – which also took twice as long as planned – could have been brought to bear earlier as it pre-dated PIP introduction by two years.
- 6.39 Despite concerns about healthcare professional capacity expressed to the NAO in various studies, these risks did not come through in the forecasts and supporting material. We did not initially look at the overall requirement of healthcare professionals across all DWP’s activities, or draw upon the mid-2011 difficulties faced on the ESA contract when the number of assessments increased rapidly due to incapacity benefit reassessment. We now have stronger links with the NAO and its programme of work and routinely look at relevant information from other areas of welfare spending and the public sector. We have also used the experience of welfare reforms when considering the costing of tax reforms, notably

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HMRC's 'making tax digital' programme where we scrutinised the contingency margins built into delivery plans and only certified some of the yield that HMRC expected to achieve.

- 6.40 The operational difficulties faced by PIP were primarily associated with provider capacity, where there is a requirement for staff with specific skills that are known to be in short supply. This would be relevant again should the managed migration of ESA claimants to UC require a further assessment, over and above the existing capacity of the system.

Analytical issues

- 6.41 For much of PIP's history our forecast discussions focused on claims and success rates. Less attention was paid to average amounts of benefit received or to claim durations. For average amounts, analysing trends in the rates and components received by claimants – and subsequent changes to awards on review – could have led to a more accurate forecast earlier. Similarly claim durations and exit rates require more consideration as small changes in exit rates can have substantial impacts on longer-term caseloads. These will both be areas of focus in our forthcoming forecasts.

Knowledge management and statistics

- 6.42 One recurring theme that has emerged in producing this report is gaps in knowledge management and the loss of institutional memory. The PIP experience has highlighted the relevance of events 20 or more years ago when DLA was in its infancy. Scrutinising the policy as it was developed – as well as assessing its impact now in hindsight – would have been more effective if historical data and archived documents were more readily accessible. This would presumably be of benefit to policymakers developing such reforms too.

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