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Cash Convergence: Enabling choice and independence through disability benefits and social care

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Executive Summary

What is the best way for society to support older people with cognitive and physical impairments? Two separate systems of state support operate in England and Wales seeking to do this: the disability benefits system (Attendance Allowance) and the social care system. The official objective of AA is money to help with the extra costs of living with disability. However, DWP has never provided a specific definition of what are the extra costs of living with a disability, which must ultimately be defined by individuals. But, the extra costs of living with a disability for individuals must be the cost of leading the life that multiple user consultations show they want to lead, i.e. a life characterised by independence, well-being, choice and control; it is these outcomes in the lives of users that arguably represent the ultimate objective of AA.

In the social care system, major changes in philosophy and design have occurred in the last decade: a ‘re-imagining’ of what social care is and what it is trying to achieve, conceptualised as outcomes for users: independence; well-being; choice and control. The key policy lever deployed has been Personal Budgets, and in particular, unrestricted Direct (cash) Payments, so that users can spend their entitlement in the way that they want to. In this way, changes in social care policy over the last decade have led to a convergence in strategic objectives across social care and disability benefits, and in the policy lever deployed to achieve these objectives. Both systems assume individuals are best placed to spend their resources through the provision of cash-payments, albeit with variations in the conditionality applied. If, as policymakers intend, every publicly-funded social care user is given a Personal Budget by 2013, there will be two separate arms of government making cash-transfers to largely the same target group, but with negligible coordination between the two systems.

What are the implications of this ‘cash convergence’? AA can no longer be considered distinct from the development of social care policy, and there is a need to think through the user experience across the two systems. The growth of Direct Payments may necessitate some re-thinking of AA, but conversely, the AA system has much that could be of value to the social care system, especially its reach among people who have no contact with their local authority. The key question is: what is the best way to support individuals achieve independence, well-being, choice and control given separate systems for transferring resources? Ten ideas are developed in this report to make AA and social care work better together: signposting; data sharing; joint assessments; AA as a social care gateway; soft conditionality; hard conditionality; opt-out Personal Budgets; a single brand; joint national entitlement framework; and, social care resource distribution via the AA system. Ultimately, the picture is one of opportunity. The assets of both systems, despite a different underlying ethos, can be integrated and coordinated to improve the outcomes of older people with cognitive and physical impairments.

What is the best way for society to support older people with cognitive and physical impairments? There are in effect two separate systems of state support operating in England and Wales that seek to do this: the disability benefits system administered by the Department for Work and Pensions (DWP), and the social care system operated by local authorities under a statutory Duty of Care.

Major changes in the philosophy and design of the social care system have occurred in the last decade, especially a belief that the best way to support individuals is to give them control over the resources allocated to them. If the challenge laid down by the Department for Health (DH) for every publicly-funded social care user to be given a Personal Budget by 2013 - preferably in the form of a Direct Payment - is met, this raises the prospect of two entirely separate arms of government making cash-transfers to largely the same target group, but with negligible coordination between the two systems.

As such, there is a compelling need to move beyond recent debate about transferring the resources of the AA system into social care, and instead examine the interaction and coordination of the two systems. That is the aim of this discussion paper.

Attendance Allowance

Attendance Allowance (AA) is a tax-free cash benefit payment for individuals aged 65 or over in the UK who need help with personal care or have difficulties with activities of daily living because they are physically or mentally disabled. AA is paid to directly individuals, and funded, by DWP.

The official, stated objective of AA is that it is: “money to help you with extra costs if you have a disability severe enough that you need someone to help look after you.” The critical component of this statement is “extra costs”; AA is for the extra costs of living with disability, rather than specifically for care per se.

However, DWP has never provided a specific definition of what the extra costs of living with a disability are. In part, this can be seen as deliberate: as a cash-benefit, claimants have total control over how to spend AA, and so themselves define what the extra costs of living with a disability are for them individually to achieve the life that they want to lead.

Personalisation: Independence, well-being, choice and control

In contrast to AA, the social care system in England and Wales has been characterised by radical change during the last decade: a complete re-think and ‘re-imagining’ of what

social care is and what it is trying to achieve, conceptualised in terms of the outcomes experienced by individuals. Although still a work-in-progress, there is universal acceptance and support of the strategic objectives for users of the social care system going forward: independence; well-being; choice and control.

In response to these changes, there has been a revolution in thinking about how the social care system helps users achieve these outcomes. The key policy lever has been the deployment of Personal Budgets, and in particular, ‘unrestricted’ Direct Payments, i.e. cash-payments, so that users can spend the public resources they are entitled to in the way that they want.

Cash Convergence

Although AA is paid to the population as a contribution toward the cost of disability, the extra costs of living with a disability for *individuals* must be the costs of leading the life that they want to lead, i.e. as numerous user consultations have found, a life characterised by independence, well-being, choice and control; these outcomes, by extension, must also comprise the ultimate strategic objective of AA.

In this way, changes in social care policy over the last decade have arguably led to a convergence in strategic objectives across

social care and disability benefits. Both systems are now seeking to achieve the same outcomes in the lives of users, i.e. the outcomes that users themselves want: independence, choice, well-being and control. There has also been a convergence in policy levers to achieve these objectives. Both systems assume that individuals are best-placed to spend their resources through the provision of cash-payments, albeit with variations in the conditionality applied to them.

The implications of cash convergence

What are the implications of this ‘cash convergence’? First, social care policy and AA are interdependent and must be jointly evaluated. AA can no longer be considered distinct or separate from the development of social care policy. By extension, policymaking in relation to both must be formulated jointly and strategically across DWP and DH.

The interdependency of outcomes across the AA and social care systems also means that measures to improve the efficacy of one system will also improve the other. This is particularly true in relation to two agendas in social care policy: information and advice services; and, ‘market development’, i.e. guiding and stimulating the development of plural, innovative local markets in care and support services. Where successful, these endeavours have potentially benefited

hundreds of thousands of AA recipients who have no contact with their local authority or social care system.

There is a need to think through the user experience across two parallel cash-based systems. Is it tenable to operate parallel needs assessment systems targeting the same individuals with cash payments?

The growth of Direct Payments may necessitate some re-thinking of AA, the merits of which must inevitably be compared to the operation of Direct Payments in social care. This is particularly true in relation to helping people get the most out of the resources that they have available to them. It is not clear that the 'entitlement principle' embodied by AA is wholly adequate to justify a 'hands-off' approach that limits help and guidance for AA claimants when users confront a significantly under-resourced adult social care system, and poor spending decisions by individuals will have a directly negative effect on their outcomes. The people who are potentially suffering from the 'hands-off', "it's their money" rationale of AA are the target group of the policy.

Conversely, the AA system has much that could be of value to the social care system. From the point of view of social care policy, the key asset associated with the AA regime is arguably its reach and brand, given the social care system struggles to identify

vulnerable individuals and bring them 'into the system'. As such, the AA *system* is arguably too valuable an asset to consider discarding. Blind to both means and the availability of informal care, it does not possess the 'allocative efficiency' of local authority social care services, which prioritise need, but reaches and provides a contact point with over one million older people experiencing disability.

These different approaches across disability benefits and social care have co-existed for decades. In recent times, some social care policy analysts have responded to the limited allocative efficiency of the AA system by arguing that public spending on disability benefits should instead be transferred to the social care system where allocative efficiency is higher.

However, the convergence in the objectives and policy levers deployed across the social care and AA systems means that debate now should focus on integration and coordination.

The ultimate question for policymakers is: what is the best way to support individuals with cognitive and physical impairments achieve independence, well-being, choice and control in the context of two separate systems for transferring resources to individuals?

Beyond Convergence: 10 ideas to make Attendance Allowance and social care work better together

This report develops ten ideas for improving the way in which the AA and social care systems work together.

Signposting - increase the volume of signposting across both systems. Individuals making contact or claims with either adult social care or AA system are also provided with full details about the other system, as well as information on the local care market, advice, advocacy and brokerage services.

Data sharing - full data sharing across adult social care and the AA system. Local authorities are able to identify high-risk individuals in their area who may be entitled to support using DWP data. The DWP is able to use local authority data to identify potential AA claimants.

Joint assessments - local authorities incorporate AA assessments into community care needs-assessments, in order to passport claims.

AA as social care gateway - AA formally positioned as the gateway into a reformed social care system, such that AA claims are the entry point for the full range of social care interventions, such as re-ablement, telecare,

informal care support and community care assessments.

Soft conditionality - to improve expenditure decisions around AA, soft conditionality is applied to claims. For example, AA claimants could receive a phone call from an adviser to tell them about their other rights, local care and support services that are on offer, help with budgeting that is available, etc.

Hard conditionality - receipt of AA made conditional on being able to demonstrate how the money has been spent effectively. In effect, AA becomes a non-means tested Direct Payment, i.e. a payment with some conditions attached, but that is not subject to a means-assessment.

Opt-out Personal Budgets - to improve spending decisions, but without having to impose hard conditionality, DWP takes the reins of the Personal Budgets agenda, and AA is distributed via Personal Budgets and Direct Payments. The underlying principles of AA are retained by giving individuals the option to opt-out of a local authority managed Personal Budget to take AA as an unrestricted cash payment.

Single brand - both AA and adult social care are re-branded with a single brand covering both forms of support, despite the retention of two separate systems. In effect, a reformed

system would have ‘a single shop-front but two shopkeepers’.

Joint national entitlement framework – the social care system adopts a national eligibility framework explicitly built around AA, which is reframed as a universal, low-level payment for all individuals with qualifying care and support needs, on top of which, individuals can request means-tested community care assessments in order to access higher levels of support.

Resource distribution - social care interventions and resources are distributed via the AA system. For example, information included in an AA claim triggers receipt of a telecare voucher, which individuals are then able to use to purchase telecare devices and services.

Ultimately, the picture is one of opportunity. The assets of both the AA and social care systems, despite their different underlying ethos, can be integrated and coordinated to improve the outcomes of older people with cognitive and physical impairments.

1. Introduction

What is the best way for society to support older people with cognitive and physical impairments?...

What is the best way for society to support older people with cognitive and physical impairments? There are in effect two separate systems of state support operating in England and Wales that seek to do this: the disability benefits system administered by the Department for Work and Pensions (DWP), and the social care system operated by local authorities under a statutory Duty of Care.

Both systems are structured differently, funded differently, have a different set of underlying principles and, to a surprisingly large degree, have different users.

In the context of multiple problems associated with funding older people's social care – including the incidence of 'catastrophic costs', under-funding and means-testing - the last few years has seen a policy debate on whether public expenditure on disability benefits for people aged 65 and over should be transferred into the social care system.

This proposal in large part reflects a judgement that the 'allocative efficiency' of the social care system – and the outcomes of users – is potentially superior to that of the disability benefits system, particularly if such a transfer of public expenditure were combined with significant improvements to the organisation of the social care system.¹ Such arguments have proved to be highly resonant with policymakers developing a vision for a new, comprehensive, integrated, national social care system in the future.²

However, for a variety of practical, administrative and political reasons, the prospect of such a major reform occurring now appears to have subsided.

Yet in the background to this debate, major changes in the philosophy and design of the social care system have occurred, which merit a significant re-examination of how disability benefits support individuals, and the way in which the disability benefits and social care systems interact. In particular, a belief in the social care system that the best way to support individuals is to give them control over their own resources.

Indeed, as this report explores, under the aegis of the so-called 'personalisation agenda', there has arguably been a convergence in the strategic objectives of both systems, and in the mechanisms – cash allocations – that seek to achieve these objectives.

As a result, there is a compelling need to move beyond a debate about transferring resources and merging the systems, to instead examine the interaction and coordination of the two systems in light of this convergence.

Indeed, if the challenge laid down by the Department for Health for every publicly-funded social care user to be given a Personal Budget by 2013 - preferably in the form of a Direct Payment - is met,³ this raises the unprecedented prospect of two entirely separate arms of government making cash-transfers to largely the same target group, but with negligible coordination between the two systems.

This report therefore seeks to inform a much-needed debate on the aims, means and interaction of the disability benefits and social care systems that support older people with cognitive and physical impairments.

In the next chapter, Attendance Allowance (and Disability Living Allowance) is subject to a thorough strategic review of its objectives, efficacy, pros and cons. The chapter looks at the design of AA, how it operates in practice, and the outcomes for public policy that result.

The disability benefits system and the social care system are structured differently, funded differently and have a different set of underlying principles...

In Chapter 3, the changes in the philosophy and design of social care services are explored, together with a detailed examination and evaluation of Personal Budgets and Direct Payments. The chapter looks at how the personalisation agenda has evolved, its distinctive rationale and the wide-ranging support it has accrued among policymakers and stakeholders.

The fourth chapter draws out the implications of ‘cash convergence’ for the social care and disability benefits systems, looking at each system through the lens of the strengths and weaknesses of the other.

In Chapter 5, ten ideas for improving the interaction and coordination of the social care and disability benefits systems are set out. As the chapter argues, debate in recent years on whether public expenditure on disability benefits should be transferred to the social care system has arguably obscured and ignored a potentially much more fruitful examination of how the two systems could be made to work better together.

Chapter 6 concludes the report with key messages for policymakers.

Throughout this report, the focus is on disability benefits paid to older people, rather than individuals of working-age. This focus is entirely deliberate, given the existence of an entirely separate reform agenda relating to the disability benefits of working-age adults, that at the time of writing is subject to ongoing consultations and discussion.⁴ This agenda results from different strategic objectives and distinct problems perceived to confront disability benefits for working-age adults. Rather than confuse these two debates, this report therefore concentrates solely on older people.

Key points:

- ▶ What is the best way for society to support individuals with cognitive and physical impairments? Two separate systems of state support operate in England and Wales: the disability benefits system (DWP), and the social care system operated by local authorities under a statutory Duty of Care.
- ▶ Major changes in the philosophy and design of the social care system have occurred in the last decade, which merit a significant re-examination of how disability benefits support individuals, and the way in which the disability benefits and social care systems interact.
- ▶ Under the aegis of the so-called ‘personalisation agenda’, there has arguably been a convergence in the strategic objectives of both the AA and social care systems, and in the mechanisms – cash allocations – that seek to achieve these objectives.
- ▶ As such, there is a compelling need to move beyond a debate about transferring resources from the AA system into social care, to instead examine the interaction and coordination of the two systems in light of this convergence.

2. Attendance Allowance: A review

Attendance Allowance is a cash payment that, together with DLA, is received by around 2.16 million people in England aged over 65...

This chapter examines and evaluates the operation of the Attendance Allowance system in the UK.

The chapter describes the basic features of the system, its objectives, and subsequently evaluates its strengths and weaknesses.

Background

► What is Attendance Allowance?

Attendance Allowance (AA) is a tax-free cash benefit payment for individuals aged 65 or over in the UK who need help with personal care or have difficulties with activities of daily living because they are physically or mentally disabled. AA is paid to individuals, and funded, by the Department for Work and Pensions (DWP).

AA is paid at two different levels (rates) depending on a person's disability and how it affects them. For 2011-12, the lower rate is £49.30 per week and the higher rate is £73.60 per week. AA has increased in value over time to make some allowance for inflation. For example, in 2007-08, the lower rate was £43.15 and the higher rate was £64.50.⁵

AA is received as a cash payment, and individuals who claim it are entirely free to spend it how they wish.

AA can only be claimed by individuals who are not in receipt of Disability Living Allowance (DLA), which is a functionally equivalent benefit payable to claimants below the age of 65, but for which entitlement and receipt can continue beyond the age of 65. Individuals in receipt of DLA at the point of retirement would not normally be transferred on to AA.

► Cost

In England, around 2.16 million individuals aged over 65 received AA and DLA in 2009-2010. The total cost to the public purse was around £7.5 billion.⁶

In the UK as whole, in 2009, there were 0.81 million DLA recipients aged 65 and over, and 1.62 million AA recipients, comprising 8.3% and 16.5% of the over-65 population respectively.⁷ For the UK as a whole, the cost of these benefits for individuals aged over 65 is estimated to be around £9.2 billion per year.⁸

How does Attendance Allowance work?

► Entitlement

As well as being aged over 65, in order to be entitled to claim AA, a person must:

- Have a physical disability (including sensory disability, such as blindness), a mental disability (including learning difficulties), or both;
- Need help caring for themselves or someone to supervise them, for their own or someone else's safety.

The Department for Work and Pensions (DWP) defines help with personal care as requiring help with basic activities of daily living, identified as: washing (or getting into or out of a bath or shower); dressing; eating; going to or using the toilet; telling people what you need or making yourself understood.⁹

In relation to supervision, DWP defines this as a person needing someone to watch over them to avoid substantial danger to themselves or other people. This could be in relation to taking medicines or having treatment, keeping away from danger that a person may not realise is there, avoiding danger that results from a person not being able to control the way they behave, and stopping a person from hurting

Unlike the social care system, AA is blind to both means and the availability of informal care...

themselves or other people.¹⁰

Entitlement to lower rate AA is based on someone needing help with personal care or supervision either during the day *or* during the night. Individuals entitled to higher rate AA must need help with personal care or supervision both during the day *and* during the night.

In addition to being 'blind' to means, AA is also – crucially - 'carer-blind', i.e. awards are not made on the basis of whether or not informal care is available or received. The AA claim form does ask if informal care is received, and if so, who the informal carer is and what their contact details are. However, in measuring need, the AA claim form asks individuals if they "have difficulty or... need help", i.e. it is an assessment of need measured in terms of having difficulty doing something or requiring help to do it, not whether needs are being met. The AA assessment form is therefore different to the 'Fair Access to Care Services' (FACS) assessment used by local authorities to assess claims, which explicitly assesses whether needs are being met by informal care.

Overall, claims assessments for AA are best regarded as an assessment of disability, whether in terms of cognitive or physical functioning, rather than need. The 'extra costs' of living with a disability are used as an indicator of that disability.

▶ Claiming Attendance Allowance

Individuals are normally only able to claim AA when they have required help for six months. To claim AA, an individual or someone acting for them must complete the claim form and send it to the DWP. The AA claim form asks individuals for a range information, including:

- Name of illnesses and disabilities experienced and how long they have been experienced;

- Medicines or treatments that have been prescribed for this illness or disability, dosage and frequency;
- Basic details about a person's home, e.g. location of toilet;
- Visits to hospital and other recent medical treatment;
- Use of home adaptations;
- Information on ability to undertake activities of daily living such as getting out of bed and using the toilet;
- Difficulties communicating with other people;
- Whether someone usually needs help from another person to actively take part in hobbies, interests, social or religious activities;
- Activities and help needed from another person when the individual goes out and the nature of this help;
- Type of help required during the night, how often help is required, and how long (minutes) each time this help is needed for.

Upon receiving a claim, the DWP evaluates the information provided and makes a judgement as to whether or not to award AA on that basis. If the DWP cannot obtain a clear picture of how a person's illnesses or disabilities affect them, a medical examination and report may be required. However, doctors are only required to give details of medical facts, and are not required to provide an opinion on problems with activities of daily living or whether someone should receive AA. In 2001, the NAO reported that medical assessments were used in 16% of cases.¹¹

▶ Attendance Allowance and other forms of public support

AA is not means-tested, so is not affected by the total value of the claimant's income and wealth. It is paid irrespective of a person's total National Insurance contributions, is not subject to income tax, and does not affect receipt of other benefits and tax credits.

The official objective of AA is to help with the extra costs of living with a disability, but DWP does not define what these costs are, which ultimately are defined by individuals and the life they want to lead...

Importantly, receipt of AA may enable someone to receive other benefits. In particular, for an informal carer to claim Carer's Allowance, the person they care for must be in receipt of AA or DLA.

Local authorities are able to take account of receipt of AA in calculating how much an individual will receive as means-tested council support. However, the extent to which AA is taken account of is discretionary, and councils may reduce notional 'assessable income' by an amount reflective of disability related expenditure.¹²

The Objectives of Attendance Allowance

The official, stated objective of AA in the relevant materials for claiming it is that it is: "money to help you with extra costs if you have a disability severe enough that you need someone to help look after you."¹³ This is repeated in technical documents from the DWP, which state that:

"The purpose of Disability Living Allowance and Attendance Allowance is to provide a financial contribution towards the generality of extra costs experienced by severely disabled people as a direct result of their disabilities"

(DWP: 2010¹⁴)

The critical component of this statement is "extra costs"; AA is for the extra costs of living with disability, rather than specifically for care per se, even though individuals are free to use AA to purchase personal care if they so choose. In this regard, AA is broadly similar to DLA.

The objective of AA has remained consistent over time. For example, in 1970, as Secretary of State for Social Services, Sir Keith Joseph stated:

"It was never suggested that £4 a week provided for in the Bill would be enough to provide professional help ... It would be a valuable additional cash resource for the long

haul of chronic severe disability for households which had to bear the financial burden."

(Hansard: 1970¹⁵, quoted in Berthoud R and Hancock R: 2008¹⁶)

However, the DWP has never provided a specific definition of what the extra costs of living with a disability are. In part, this can be seen as deliberate: as a cash-benefit, claimants have total control over how to spend AA, and so themselves define what the extra costs of living with a disability are for them individually to achieve the life that they want to lead.

Nevertheless, this lack of clarity regarding what the extra costs of living with a disability are does not solely represent a deliberate strategy by DWP. It also reflects the fact there is no agreed methodology for measuring the extra costs of living with a disability with which to calculate these costs, and so set levels of AA and disability benefits.

A review by Tibble (2005) for DWP identified four methodological approaches that have been deployed in academic research on the extra costs of living with a disability:¹⁷

- "The subjective approach
Studies using this approach ask disabled people (or experts) to estimate what their additional expenditure is or would be (if they were to meet their needs to an extent) and on what items. Estimates of extra costs are then derived from respondent's answers.
- The comparative approach
This approach compares the spending patterns of disabled people with those of 'similar' non-disabled people. Studies ask both populations about how much they spend on individual items and the differences show where disabled and nondisabled people's priorities differ.
- The standard of living approach
The standard of living approach is based on the

Ultimately, AA represents a choice by policymakers that the best way to help a lot of people with different needs and resources is to deploy a ‘yardstick’ approach...

assumption that disabled people experience a lower standard of living than non-disabled people with the same income, because of diversion of money resources to goods and services required because of their disability. A range of indicators of standard of living (unrelated to disability) is used and disabled and non-disabled people’s standard of living at the same income is compared. For a given standard of living it is possible to compare what incomes disabled and non-disabled people have, the difference being the extra costs incurred by disability.

- The budget standards approach
The budget standards approach... is similar to the subjective approach, in that disabled people are asked directly to state what their needs are. However, respondents do not answer in terms of expenditure required. Instead, focus groups develop an exhaustive list of items required for a reasonable standard of living... It does not measure extra costs, instead presenting the income needed to achieve a certain standard of living.”

(Tibble M: 2005)

Crucially, studies using these different approaches have yielded very different figures for what the extra cost of living with a disability is.

This lack of an agreed methodology for calculating the extra costs of disability is therefore very significant: decisions by policymakers on the appropriate levels of AA must be set using broader considerations – stakeholder lobbying, inflation, the fiscal environment - rather than on the basis of a scientific analysis of what extra costs individuals living with a disability confront.

Ultimately, the observation of Berthoud (1998) that there are two options for assessment of extra costs, remains valid: assess each case individually, or identify groups of people with impairments or disabilities judged to be of the sort to impose additional costs and pay fixed rates.¹⁸ Rather than try to undertake detailed assessments of the extra costs that individuals confront as a result of living with a disability

that is severe enough for them to require care or supervision – whether or not they receive it – AA instead embodies a ‘yardstick’ approach.

In this context, AA could be judged to have four potential objectives:

- *Supporting additional expenditure* recognises that one of the effects of disability is that some people have to spend more (than non-disabled people) on specific items, such as personal care, household services, heating, food, medical expenses, or transport.
- *Improving specific outcomes*, i.e. reflecting the distinction between spending per se and the effect of that spending, for example whether buying additional fuel makes the benefit recipient warm enough.
- *Generalised compensation for additional expenditure*, i.e. referring to the practice of some disabled people of cutting back on some items of expenditure in order to pay for the additional costs generated by disability. So, for example, someone might cut back on food or clothing in order to pay for additional heating costs. Hence, DLA and AA can be seen as compensating people for those additional costs.
- *Countering the effects of being disabled*, i.e. in ways not directly associated with the additional costs of disability, such as paying for activities that enhance social participation.”

(Corden A et al.: 2010¹⁹ quoting Berthoud R: 2009²⁰)

Evaluating the Effectiveness of Attendance Allowance

As noted in academic commentary,²¹ there has previously been astonishingly little research into the impact of AA, given the importance of these benefits both for public expenditure and for the resources available to disabled people. Nevertheless, using the evidence available, how effective is AA in terms of take-up, targeting and outcomes?

The take-up rate of AA is estimated to be high, and appears to be slanted toward lower-income groups, resulting in a form of ‘accidental targeting’...

▶ Take-up

How effective is AA in terms of achieving take-up among the population of potential claimants?

Reliably measuring the efficacy of the AA regime in eligible potentially eligible older people using administrative and other non-survey data is extremely difficult.²² However, recent analysis of the Family Resources Survey (FRS) for 2002-05 found evidence that as many as 30% or more of the over-65 household population had not pursued potentially successful AA claims.²³ Nevertheless, this analysis had to rely on an approximation of likely eligibility for AA to estimate take-up.

Analysis of the FRS for 2004-5 in relation to AA and the care component of Disability Living Allowance (DLAc) found that:²⁴

- Among respondents to the FRS survey reporting no impairment, less than 1% said they were receiving AA;
- However, among the sub-group of FRS respondents who do receive AA, as many as 6% report no impairment;

Importantly, AA does not have to be spent on care, and individuals in receipt of AA may not be in receipt of care. As such, only 54% of individuals receiving AA or DLAc report receiving formal (or informal) care.²⁵ This aspect of AA is important: the AA system has the potential to reach more individuals than the local authority administered social care system.

However, there is some evidence that AA does not reach everyone who could claim, and that this includes people receiving care. Only around 61% of adults who report receiving care in the FRS are receiving either AA or DLAc.²⁶

The validity of these findings as estimates of take-up for AA and DLAc clearly depends on the efficacy of the FRS survey and the reliability of the responses.

▶ Targeting of need: level of disability

Among potential claimants of AA, are those with the highest need more likely to receive AA?

Academic analysis of the British Household Panel Survey (BHPS) found that individuals aged over 65 with higher needs are more likely to claim AA, where need is measured by the number of activities of daily living (ADL) problems such as washing, dressing and feeding that people report.²⁷ The research found that uptake rates increase steadily with ADL count up to three ADL problems, but declines thereafter. It is speculated that this decline may be due to very high need people being in care homes where council funded residents lose entitlement to AA.

▶ Targeting of need: resources

In addition to take-up among potential claimants, how effective is AA at targeting individuals with more limited financial resources whose need for AA would therefore proportionally be greater?

As a non-means tested benefit, AA is officially blind to a person's income and wealth. However, analysis of the British Household Panel Survey (BHPS) found a relationship between the income of individuals aged 65+ and uptake of AA. Among income deciles 1-3 (the poorest), take-up of AA peaks at over 20%. However, among income deciles 8-10, take-up is still broadly over 5%.²⁸

Considered in terms of the whole older population, analysis of the FRS has found that among recipients of AA and over-65 DLA claimants, average incomes are about one third less than over 65s not receiving disability benefits.²⁹ Interestingly, there are no

Research has found claimants use AA to relieve financial pressures, meet costs, improve quality of life, and enhance physical and mental health...

substantial differences in the economic circumstances of AA and DLA recipients among those aged over 65.³⁰ This finding is important because differences in employment histories between DLA (claims for which begin before retirement age) and AA recipients do not apparently result in differences in retirement incomes.

Further analysis of the FRS for the early 2000s found that the pattern of receipt of Attendance Allowance was similar to a means-tested system in that there was higher probability and level of receipt for low-income people.³¹ It is argued that this outcome reflects two factors: the higher incidence and severity of disability among poorer people and the lower propensity of higher-income people to claim Attendance allowance, at any given level of disability. It is surmised that this latter factor may be reflective of the fact that lower-income households have a greater financial incentive to claim higher-rate AA.

Indeed, academic research has found that around 40% of both elderly and working-age AA/DLAc recipients depend on means-tested financial support, i.e. pension credit or income support. The same research found that the proportion receiving means-tested benefits rises to more than half (52%) if housing benefit or council tax benefit is taken into account.³²

A range of studies using different data sources have therefore found that take-up of AA is higher among poorer households, whether because of higher need or a greater propensity to claim. The role of factors such as propensity to claim and stigma of benefits is borne out by analysis of the FRS that found that there is a substantially lower propensity to claim AA among owner-occupiers, by up to a third for people with moderate levels of disability.³³ As the authors note, this could be related to social norms, as well as more limited contact with advice services.

► Outcomes

What outcomes does AA result in?

As described above, it is effectively impossible to evaluate whether AA is achieving outcomes commensurate with its objectives because there is no clear definition of what the “extra costs” of living with a disability are, and the extent to which claimants find that AA is sufficient to cover these extra costs.

Nevertheless, AA must clearly have some impact upon the lives of recipients. What are these outcomes? Qualitative research with DWP advisers, local authority staff and other professionals in contact with recipients of AA found that that AA (and DLA) have a major positive impact.

“Relieving financial pressures:

- Providing regular money to spend on what was needed;
- Making substantial difference to overall financial situations, especially when people accessed additional premiums on income-related benefits, paid less council tax and used ‘passports’ to local services.

Meeting costs:

- Enabling access to home care;
- Increasing mobility and safety;
- Supporting family caring situations, by reducing pressure on relatives for caring tasks, and enabling people to ‘give back’ in money gifts.

Improving quality of life:

- Enabling a major purchase such as a responsive chair, a wide-screen television, washing machine or fridge/freezer, or more suitable vehicle;
- Increasing social participation and inclusion, and interaction with other people;
- Increasing quality of life for families with disabled children;
- Enabling tidier gardens for older people, thus reducing frustration and embarrassment.

The advantages of AA include: flexibility; choice and control, and the absence of means-testing...

Enhancing physical and mental health:

- Improving meals and nutrition;
- Warding off depression caused by financial struggle and anxiety;
- Helping to maintain physical health;
- Enabling warmer, cleaner, more comfortable homes, with less anxiety about meeting fuel bills.”

(Corden A et al.: 2010)

This study also undertook qualitative research with recipients of DLA and AA. It found that these benefits were used for expenses relating to: personal care; transport; food; fuel; home maintenance, including cleaning, gardening and small jobs; health care, medical equipment and supplies; telephones and computers; social activities; as well as, giving presents, gifts and ‘treating’ as a token of thanks to those providing care and support.

These results were borne out by a 2008 survey by Age UK of 700 older people who had recently begun claiming AA. The research found that:

“The majority (60 per cent) of respondents spent their Attendance Allowance on help in the home, for example, cleaners and gardeners. Just over a quarter (27 per cent) spent their Attendance Allowance on household repairs and decorations and a quarter (25 per cent) bought care services. Those surveyed were able to spend more money on essentials. 46% spent extra money on heating their homes. 36% spent extra money on food. This might be more or better quality food or food relating to a special diet or having pre-prepared or cooked meals delivered. 14% used the money to buy clothes and shoes. 13% also spent some of their extra money on travel, for example, buying a mobility scooter or adapted car, paying petrol money to people who gave them lifts and hiring taxis when public transport was not an option.”

(Age UK: 2008)

Advantages of the Attendance Allowance Regime

The previous sections have provided an overview of the costs, workings and objectives of Attendance Allowance. In this context, what are the advantages and disadvantages of AA from the point of view of policymakers and disabled users?

► Flexibility

AA can be used to pay for formal care, taxis, home adaptations and many other types of care and support. In particular, AA may be used to support an informal carer in their caring role toward a recipient of AA. In short, AA is a very flexible form of public support for older people with cognitive and physical impairments.

► Reach and take-up

The reach of the AA system literally extends to millions of older people. Take-up among potential claimants is very hard to measure, but analysis of social survey data has produced an estimate of around 70%.³⁴ This is broadly in line with Pension Credit, a means-tested retirement income benefit, for which DWP estimates take-up of between 62% and 73% for 2007-08.³⁵

► Absence of means-testing

Surveys of older people have consistently shown a dislike of means-testing. Indeed, the means-testing of Pension Credit and other retirement income benefits results in sub-optimal rates of take-up, which have required ongoing research³⁶ and concerted policy responses by policymakers.

As such, the absence of means-testing in relation to AA can be seen as a positive aspect of the policy in and of itself. It is also reasonable to surmise that – notwithstanding any stigma effects of being a benefit payment – take-up rates of AA are higher precisely because of the absence of means-testing.

Research has found that AA recipients report that it gives them independence...

▶ Effective targeting

Despite the absence of means-testing, take-up of AA is higher among poorer households, whether because of the behaviour of potential claimants or covert biases in the assessment system. Public expenditure on AA is therefore slanted toward poorer households.

Academic analysis of the FRS has also found that the probability of receiving higher-rate AA varies by income and assets, and also appear to be negatively related to the chances of receiving higher-rate AA, despite AA not being means-tested.³⁷

▶ Simplicity and consistency

AA is a relatively simple benefit to understand. It is for individuals requiring care and supervision. The lower rate is for the cost of help in the day or the night, and the higher rate is to cover both.

AA is also consistent in both a geographical sense – it is the same across the country – and in terms of awards, i.e. individuals assessed as having similar needs receive the same amount. In effect, AA has a nationally consistent assessment and entitlement framework.

▶ Choice and control

Although it is not written “on the tin”, AA does possess a number of positive characteristics that are widely recognized as valuable in the context of care and support needs.

Individuals typically value choice and control, and AA affords claimants total choice and total control over how they spend the money. In particular, this enables individuals to deploy the resources most effectively in conjunction with other financial resources and sources of informal care. It can be argued that AA implicitly

embodies a belief that individuals are best-placed to decide how to use resources to support themselves.

Analysis of the FRS found that only 54% of adults getting care-related benefits report receiving any care.³⁸ This arguably represents a success for AA: claimants appear to correctly recognize and understand that AA does not have to be spent on care, and that they do not have to receive care to claim it.

▶ Independence

AA enables individuals to achieve independence in a way that other forms of conditional support may not. For example, qualitative research with disability benefit recipients found that for many:

“managing daily living also depended on finding solutions and working out ways of doing things which reduced the amount of direct help they needed, and enabled them to maintain control and some independence. Life was managed by being able to afford market prices for housework, laundry, garden maintenance, odd jobs and taxi rides; by buying frozen meals or buying hot meals outside the home; by relying on frequent use of telephones, and by running private vehicles.”

(Corden A et al.: 2010)

▶ Political resilience

From the point of view of individuals with functional and cognitive impairments, AA and the disability benefits system are politically resilient: their national reach, transparency and simplicity have ensured that any attempt to amend entitlement is subject to high levels of public and political scrutiny.

Disadvantages of AA include: vague official objectives; arbitrary outcomes among users; and, the fact that take-up appears no higher than means-tested Pension Credit...

Disadvantages of the Attendance Allowance Regime

▶ Achievement of objectives

There is no formal statement from DWP regarding what the “extra costs” of living with a disability are, and no academic agreement on how to measure these costs. As such, disability benefits, by their nature, cannot be deemed successful in relation to their stated objectives, as there is no definition of what the extra costs of disability are or how to measure them, and policymakers cannot know the extent to which AA contributes toward the extra costs of disability.

It is in this context that some commentators have observed that it is remarkable that the government spends in excess of £7 billion per year on disability benefits for older people without being able to say with proper clarity whether this money is achieving its objectives. Although AA undoubtedly improves the lives of hundreds of thousands of people, as any form of extra income would be expected to, the uncertainty of outcomes resulting from AA is undesirable in the context of a fiscal constraints and under-funding characteristic of public expenditure on individuals with care and support needs.

▶ Arbitrary outcomes

The flat-rate nature of AA means that it is commonly perceived to provide the same support to all claimants. However, AA is a cash payment and the support that it results in will depend on how the money is spent and – crucially - what it can be spent on.

Although a contribution toward the extra costs of living with a disability, AA does not take account of regional variations in costs of formal care and support services, how different disabilities result in different levels and types of costs, nor an individual’s need related to their

individual characteristics and capabilities, financial resources and availability of informal care.

As such, it could be argued that AA results in somewhat arbitrary outcomes among vulnerable individuals, and makes no attempt to address existing inequalities in private income and wealth, capabilities and the availability of informal care. In this sense, although all claimants receive the same amount, AA does not advance equity of means nor outcomes.

▶ Reach and targeting

Analysis of the FRS for 2002-05 found evidence that as many as 30% or more of the over-65 household population had not pursued potentially successful AA claims.³⁹ Although this finding needs to be treated carefully, and is purely an estimate, it does suggest that around one in three older people with care and support needs are potentially not receiving a non-means tested cash benefit that could be used to support them.

Indeed, academic analysis of the FRS has also found that the probability of receiving higher-rate AA varies by certain characteristics, which officially, should be entirely independent of receipt of AA.⁴⁰ First, it was found that the probability of receiving higher-rate AA declines with age. It is speculated that this could be reflective of implicit discrimination in the assessment system, or because older individuals with a disability are slow to apply to have their payments updated.

Second, as described above, income and assets also appear to be negatively related to the chances of receiving higher-rate AA, despite AA not being means-tested. Receipt of AA was also found to be correlated with home-ownership, which is commonly linked to limited contact with, and knowledge of, the benefit system.

Some wealthier claimants arguably do not need the money, and research has found the name “Attendance Allowance” puts some people off or confuses them...

▶ Receipt by wealthier households

Notwithstanding the correlation found in academic research between income and receipt of AA, there will inevitably be some AA claimants – i.e. wealthier households – for whom receipt of AA makes no difference to their disability-related expenditure. In short, their private resources means that whether or not they receive AA is independent of how much they spend on the ‘extra costs’ of living with a disability.

▶ Name

Qualitative research with DWP advisers has found that many felt the name of “Attendance Allowance” misled potential claimants into thinking that they must be in receipt of help or care from another person in order to be entitled to claim.⁴¹ The same research found that some potential claimants thought that if they made a claim, someone unwanted would visit them. As such, it appears that the name “Attendance Allowance” may depress take-up rates among potential claimants and requires extra time and effort from advisers to correct misperceptions.

▶ Knowledge of Attendance Allowance

There is an awareness and knowledge gap among potential AA claimants as to its existence and their potential right to claim. Qualitative research with DWP advisers found that many had to be proactive in encouraging individuals – or their relatives – to make claims, in the context of low initial levels of knowledge.⁴²

▶ Bias in assessments

Academic analysis of the FRS found for 2002-05 found a strong systemic bias in favour of claimants with physical rather than cognitive disability, given similar care needs measured by reported receipt of care.⁴³

▶ Error

There has been no research into the rate of errors in AA assessments and awards. However, it is worthwhile citing a 2005 study by DWP involving a random sample of applications for DLA, which found a 19.1% error rate excluding fraud.⁴⁴

▶ Reliance on private expenditure decisions

As described above, there is no clear specification of what the objectives of AA are, and no reliable evidence of what outcomes it is achieving. Nevertheless, it can be surmised that owing to the reliance of AA on private expenditure decisions by individuals and households, various outcomes are possible that cannot be ignored in any evaluation of AA:

- Inappropriate expenditure decisions: individuals may spend AA on goods and services that do not reflect the extra costs of living with a disability, and do not improve their outcomes;
- Inefficient expenditure decisions: the efficacy of AA will depend on how effective individuals are at securing value for money in the goods and services they procure, and the outcomes that these result in for individuals. This aspect of AA is worth putting in the context of longstanding concerns by campaigners at the exploitation of vulnerable, low-income older people by providers of goods and services;
- Poor quality financial management: it is worth quoting qualitative research on the experience of benefit help-line staff, Pension, Disability and Carers Service (PDCS) visitors and local authority staff who:

“had all been in touch with some older people who had forgotten, or never realised that AA was being paid into their account. They drew money as they needed it, and some accumulated savings. Some had passed most

AA also relies on individuals spending their money well, which inevitably is not always the case, as some vulnerable older people may be exploited by providers of goods and services...

financial responsibilities to family members, and lost touch with income and spending.”

(Corden A et al.: 2010)

- ▶ Subsidy of other forms of public support and entitlement

Qualitative research has found that as well as personal care, transport and cleaning, disability benefits are spent on food, as well as health care, medical equipment and supplies.⁴⁵ While these may not result in negative outcomes for the individual, such expenditure effectively represents a subsidy or ‘leakage’ to the NHS and Pension Credit systems from the disability benefits system.

Discussion

This chapter has provided an overview and evaluation of the AA system in the UK, looking at cost, entitlement, claims, achievement of objectives, advantages and disadvantages. On this basis, what are the areas of potential improvement for AA?

- ▶ Improve take-up rate

Estimates of take-up for AA using analysis of the FRS are around 70% of potential claimants. This is around the same take-up level as Pension Credit. However, Pension Credit is means-tested. As such, it is reasonable to expect AA to have a higher take-up rate, particularly given the need of potential claimants. A clear area of concern for AA would therefore be the improvement of take-up rates.

In particular, it is a strange anomaly of public spending that a large proportion of individuals receiving care and support from local authorities are not claiming AA, despite apparently being in contact with public agencies regarding their care and support needs.

- ▶ Improve how individuals spend AA

DWP spends over £7 billion each year on disability benefits for over 2 million older people, but makes almost negligible attempt to ensure that this money is spent effectively. To a large extent, the AA system relies on charities and other groups offering advice services, and local authorities. However, given the high number of recipients, the welfare gain represented by, for example, a 10% average improvement in household decisions on how to spend AA would be potentially very significant aggregated across the population.

Improved decision-making could focus on: knowledge and procurement of local care and support services; improved procurement of general goods and services, such as taxis and cleaning, through researching different options; effective financial management; and, pooling of resources with other individuals in a local area.

- ▶ Change name

As a name, “Attendance Allowance” arguably suggests dependency and the provision of care from another person. Given evidence from qualitative research that some individuals are put off by the name, and others mistakenly believe that it is only for individuals receiving (in)formal care, there is a very compelling argument that the name of AA should be changed. “Independence Allowance” or “Independence Payment” may be more appropriate.

Ultimately the AA system cannot be evaluated in isolation, and must be looked at in the context of changes in the social care system, which are explored in the next chapter.

Key points

- ▶ Attendance Allowance (AA) is a tax-free cash benefit payment for individuals aged 65 or over in the UK who need help with personal care or have difficulties with activities of daily living because they are physically or mentally disabled. AA is paid to individuals, and funded, by the Department for Work and Pensions (DWP). In England, around 2.16 million individuals aged over 65 received AA (and DLA) in 2009-2010. The total cost to the public purse was around £7.5 billion.
- ▶ The official, stated objective of AA in the relevant materials for claiming it is that it is: “money to help you with extra costs if you have a disability severe enough that you need someone to help look after you.” The critical component of this statement is “extra costs”; AA is for the extra costs of living with disability, rather than specifically for care per se, even though individuals are free to use AA to purchase personal care if they so choose.
- ▶ DWP has never provided a specific definition of what the extra costs of living with a disability are. In part, this can be seen as deliberate: as a cash-benefit, claimants have total control over how to spend AA, and so themselves define what the extra costs of living with a disability are for them individually to achieve the life that they want to lead. However, this lack of clarity regarding also reflects the fact there is no agreed methodology for measuring the extra costs of living with a disability with which to calculate these costs, and so set levels of AA and disability benefits.
- ▶ As such, decisions by policymakers on the appropriate levels of AA must be set using broader considerations – stakeholder lobbying, inflation, the fiscal environment - rather than on the basis of a scientific analysis of what extra costs individuals living with a disability confront.
- ▶ Qualitative research with claimants has found that AA is used for relieving financial pressures, meeting costs, improving quality of life and enhancing physical and mental health.
- ▶ Academic research has estimated that the take-up rate for AA is around 70%. Academic analysis has also found that individuals aged over 65 with higher needs are more likely to claim AA, where need is measured by the number of activities of daily living (ADL) problems such as washing, dressing and feeding that people report. Research also found a relationship between the income of individuals aged 65+ and uptake of AA. Among income deciles 1-3 (the poorest), take-up of AA peaks at over 20%. However, among income deciles 8-10, take-up is still broadly over 5%.
- ▶ The advantages of the AA regime include flexibility; extensive reach and take-up; absence of means-testing; effective targeting; simplicity and consistency; choice and control for recipients; facilitation of independence
- ▶ Disadvantages of AA include: lack of clarity about whether objectives are being achieved; the fact that it results in arbitrary outcomes among claimants; take-up rate is no higher than means-tested Pension Credit; receipt by wealthier households who do not need the money; the name appears to put off some claimants; and, limited knowledge of the benefit among the target group. In addition, AA is only as effective as the private expenditure decisions of claimant households, who may have poor financial management, or may be unadapt at securing value-for-money, etc.
- ▶ Issues for policymakers in relation to AA therefore include: improving the take-up rate, improving how individuals spend AA; and, potentially, changing its name.

3. Personalisation in Social Care: Direct Payments and Personal Budgets

The last decade has seen new strategic objectives for the social care system, and new policy levers to achieve these objectives, built around a belief that individuals are best placed to decide how their resources are spent to support them...

The previous chapter described the Attendance Allowance system operating in the UK, the key tenets of which have remained consistent for several decades.

In contrast to Attendance Allowance, the social care system in England and Wales has been characterised by radical change during the last decade. In particular:

- ▶ New strategic objectives of social care policy

The last decade has witnessed a complete re-think and ‘re-imagining’ of what social care is and what it is trying to achieve, conceptualised in terms of the outcomes experienced by individuals with cognitive and physical impairments.

- ▶ New policy levers

In response to the changed objectives of social care policy, there has been a revolution in thinking about the design of social care policy around how outcomes are achieved through the delivery of social care.

This chapter therefore charts these changes in social care policy. It traces the evolution in the strategic objectives of social care policy observable in multiple policy documents. It then reviews the progress of changed delivery models embodied in the personalisation agenda, and the transition to Direct Payments and Personal Budgets.

The chapter finishes with an evaluation of how effective the new direction in models of social care delivery are being in achieving the new objectives for social care.

As background, Appendix 1 contains a description of the basic framework of the social care system in England and Wales – community care assessments – and how resources are allocated.

The Objectives of the Social Care System: Before and after

What is social care and what is the objective of social care system? For many decades, social care was framed in terms of protection and dependency. However, during the last decade, a radical change of ethos and approach has emerged, which has seen a complete reimagining of what social care, its role in supporting individuals and communities.

This section charts some of the key milestones in this evolution.

- ▶ Independence, Well-Being and Choice (2005)

This Department of Health White Paper began from an assertion that everyone in society has the right to control their own lives. It followed a nationwide consultation on the future of adult social care, from which emerged the key themes of independence, empowerment and choice.

The White Paper’s view of social care services was that they should “support independence, not dependence and allow everyone to enjoy a good quality of life, including the ability to contribute fully to our communities.” In relation to users of social care services, this meant:

- Ensuring they have more control;
- Giving them more choices and helping them decide how their needs can best be met;
- Giving them the chance to do the things that other people take for granted; and
- Giving the best quality of support and protection to those with the highest levels of need.

To achieve these outcomes, the White Paper envisioned:

- Changing the ways social care services are designed. We

The personalisation agenda prioritises achieving independence, well-being, choice and control for individuals, and has received widespread support among social care stakeholders and political parties...

will give people more control over them through self-assessment and through planning and management of their own services;

- Developing new and innovative ways of supporting individuals;
- Building and harnessing the capacity of the whole community to make sure that everyone has access to the full range of universal services.”

The key transition envisioned was a move from a system “where people have to take what is offered to one where people have greater control over identifying the type of support or help they want, and more choice about and influence over the services on offer.”

The White Paper anticipated that this would be achieved by giving everyone better information and signposting of services, putting people at the centre of the assessment process and creating individual budgets that give them greater freedom to select the type of care or support they want.

- ▶ Putting People First: A shared vision and commitment to the transformation of Adult Social Care (2007)

The significance of this ‘concordat’ between a variety of organisations was that it revealed that the government’s vision for social care was shared across the social care sector, and specifically, across the range of organisations that would be involved in delivering these objectives.

The document set out the relationship between the old and new visions of social care thus:

“In the future, we want people to have maximum choice, control and power over the support services they receive... We will always fulfill our responsibility to provide care and protection for those who through their illness or disability are genuinely unable to express needs and wants or exercise control. However, the right to self-determination will be at the heart of a reformed system

only constrained by the realities of finite resources and levels of protection, which should be responsible but not risk averse.”

The document set out a very specific list of outcomes that, regardless of disability, individuals should be able to achieve:

- “Live independently;
- Stay healthy and recover quickly from illness;
- Exercise maximum control over their own life and where appropriate the lives of their family members;
- Sustain a family unit which avoids children being required to take on inappropriate caring roles;
- Participate as active and equal citizens, both economically and socially;
- Have the best possible quality of life, irrespective of illness or disability;
- Retain maximum dignity and respect.”

- ▶ A Vision for Adult Social Care (2010)

This document set out the vision for social care of the Coalition Government that was elected in May 2010. This vision built on that of the previous government, with the principal difference being a determination to go even further and faster. In particular, the vision set out an expectation that everyone eligible would be given a Personal Budget by 2013.

The document stated: “Our vision starts with securing the best outcomes for people. People, not service providers or systems, should hold the choice and control about their care.” Elsewhere, it reaffirmed: “Our focus is not on the process but on the outcomes of greater choice, control and independence, and ultimately better quality of life.”

The significance of this vision document is that it underlined the political consensus behind a view of social care focused on independence, choice and quality of life.

Although Direct Payments and Personal Budgets have been around for some years, since 2005, they have been centre-stage in social care policy...

► Think Local, Act Personal: Next Steps for Transforming Adult Social Care (2011)

Following on from *Putting People First*, this document represented a 'statement of intent' by key social care organisations, including umbrella bodies representing care providers from the private, independent, voluntary and community sectors.

The document asserts that councils, health bodies and providers need to work more collaboratively to personalise and integrate service delivery across health and adult social care; and make vital public funding go further.

► Adult Social Care (2011)

In May 2011, the Law Commission issued final recommendations following an historic review of the legal framework for providing social care, which dates back to 1948. The Commission was careful to recommend the creation of a neutral legal framework that can accommodate different practices and policies in the future.

Nevertheless, the Commission recommended that a new statute for social care should establish that the overarching purpose of adult social care is to promote or contribute to the well-being of the individual. Under the framework proposed by the Commission, those undertaking assessments for social care would be required to:

- “Assume that the person is the best judge of their own well-being, except in cases where they lack capacity to make the relevant decision;
- Follow the individual’s views, wishes and feelings wherever practicable and appropriate;
- Ensure that decisions are based upon the individual circumstances of the person and not merely on the person’s age or appearance, or a condition or aspect of their behaviour which might lead others to make

unjustified assumptions;

- Give individuals the opportunity to be involved, as far as is practicable in the circumstances, in assessments, planning, developing and reviewing their care and support.”

With its focus on well-being and control, the Commission therefore proposed that some of the outcomes envisioned for social care in *Independence, Well-being and Choice* (2005) should be given formal legal expression.

Discussion

This review shows how in less than a decade, the view of what social care is for underwent a radical shift among policymakers, political parties and the social care sector. Although in terms of implementation, this transition is still a work-in-progress, the key point is the universal acceptance and support of the outcomes that the social care system – and by extension, social care policy – is seeking to achieve: independence; choice; control and well-being.

Achieving the New Objectives for Social Care

The revolution in thinking about the objectives of social care policy in the last decade has been accompanied by new thinking and an evolving policy agenda as to how these outcomes are best achieved.

Although Direct Payments had been in existence for some years prior to 2005, and Personal Budgets originated in 1996, *Independence, Well-being and Choice* effectively moved them to centre stage, locating them as the key lever for achieving the objectives set out for a reimagined social care system:

“We want to give people greater choice and control over how their needs should be met. In talking to people who use services and to carers, it is clear that direct payments give people that choice and control, and we think that this

The Coalition Government is committed to seeing every local authority funded social care user given a Personal Budget by 2013...

is a mechanism that should be extended and encouraged where possible.

We would therefore like to encourage more people to consider whether direct payments are right for them, particularly in groups where take-up has been low, such as older people, people with mental health problems and young people moving to adult services.

We also want to consider ways of extending the benefits of direct payments to those currently excluded, by using an agent for those without the capacity to consent or unable to manage, even with assistance.”

Over time, this has come to be known as the ‘personalisation agenda’. However, even in 2005, it was recognised that simply giving individuals control of resources would only be effective alongside a competitive market in services and other systemic changes:

“Giving people an individual budget should drive up the quality of services. The ability of people to ‘buy’ elements of their care or support package will stimulate the social care market to provide the services people actually want, and help shift resources away from services which do not meet needs and expectations.”

Putting People First (2007) conceived of Personal (Individual) Budgets in terms of levelling the playing field between self-funders and those with public funding:

“Personal Budgets will ensure people receiving public funding use available resources to choose their own support services – a right previously available only to self-funders. The state and statutory agencies will have a different not lesser role – more active and enabling, less controlling.”

By 2010, the Coalition Government also saw Direct Payments and Personal Budgets as the principal lever for achieving independence, well-being, choice and

control for individuals, in its Vision for Adult Social Care. It envisioned that personal budgets, preferably as direct payments, would be provided to all eligible people, but recognised:

“A personal budget alone does not in itself mean that services are automatically personalised. This requires a wholesale change - a change of attitude by councils and staff, reform of financial and management and information systems, and reduction of inflexible block contracts. People should get personal choice and control over their services -from supported housing through to personal care. Even those with the most complex needs can benefit from personalised services.”

How do Personal Budgets work?

Following a local authority community care assessment of need – based on means and the provision of informal care - a Personal Budget can be taken by an individual eligible for public support as a direct (cash) payment (Direct Payment); as an account held and managed by the council in line with the individual’s wishes; or as an account placed with a third party (provider) and called off by the individual; or as a mixture of these approaches.⁴⁶ However, the availability of Personal Budgets varies widely among local authorities.

A Personal Budget is therefore the money allocated to someone by their local authority to meet their care and support needs. Individuals may opt to receive their Personal Budget as a Direct Payment, which are for people who would like to arrange and pay for their own care and support services instead of receiving them directly from the local council.

Direct Payments

Direct payments are made directly into a bank, building society, Post Office or National Savings account. A cheque can also be used if required.

Direct Payments are Personal Budgets in the form of a cash-payment, which can be spent on anything that improves outcomes...

Direct Payments are for a person to use to pay for the services and equipment that will meet the needs the local council has assessed them as having. The government states that as a general principle, councils should let a person choose how best to meet their assessed needs as long as they are satisfied that agreed support arrangements are being met.

Direct Payments cannot be used to pay for permanent residential accommodation, although they can occasionally be used for short spells in a residential facility.

Importantly, Direct Payments cannot be used – apart from under exceptional circumstances – to pay for a spouse, civil partner, partner or close relative. However, although informal carers cannot be paid using Direct Payments, informal carers can benefit directly and indirectly from the services bought using a Direct Payment, particularly if this provides respite to a carer (e.g. telecare), or relieves a carer from undertaking particularly challenging aspects of the caring role.

Individuals receiving Direct Payments are required to account for the money they spend, for example, through timesheets signed by personal assistants, or receipts for services from agencies. More widely, a council has to be satisfied that the needs for which Direct Payments are being provided are being met. However, the flexibility afforded to users of Direct Payments by some local authorities should not be underestimated, and has included cleaners, gardeners, dog walkers and trips to social clubs.

Personal Budgets in other forms

The Department of Health advises local authorities that where a Personal Budget is not taken as a direct cash payment, planning for how this money is spent should be: “person-centred, exploring what is important to the individual concerned and how they can spend their personal budget to organise and create support in order to achieve their aims.”⁴⁷

The guidance continues:

“A council should ensure that all service users in its area with similar eligible needs receive support packages that are capable of achieving a broadly similar quality of outcome, even though the particular forms of help offered may differ and be tailored to individuals concerned.”

In this way, among eligible individuals, councils are responsible for ensuring broadly equitable outcomes among sets of users of similar need. To provide clarity, “local authorities are expected to develop up-front and transparent methods for the allocation of resources to eligible people. There is no formal requirement to have a Resource Allocation System (RAS). However, most local authorities are adopting this approach, and commercial solutions are being developed.”⁴⁸

Issues in the use of Personal Budgets and Direct Payments

Various issues have emerged in the implementation of the personalization agenda over the last decade.

▶ Availability and take-up

Some commentators have suggested that the take-up of Personal Budgets has been slow, owing to variation among local authorities in availability. A recent survey of local authorities found that most councils hit a target to have 30% of users and carers on Personal Budgets by 2011, but wide variations remain in take-up between authorities. An estimated 35% of eligible users and carers - those receiving council-funded support in a community setting - were on personal budgets as of April 2011, with the number of budget holders, almost 340,000, doubling since April 2010.⁴⁹

Although take-up and availability of Personal Budgets has been slower than some hoped, recent surveys have shown a 35% take-up rate...

▶ Suitability

Direct Payments may not be suitable for all types of users.

▶ Financial management

The efficacy of Direct Payments relies on private expenditure decisions. As such, financial capability and financial management skills among users directly determines the outcomes they experience.

▶ Bureaucracy

Some qualitative research has noted that some users of Direct Payments resent the bureaucracy associated with them, in relation to keeping receipts and demonstrating how money has been spent. Conversely, some social workers are reportedly unhappy with the bureaucracy that Personal Budgets have entailed.

Evaluating Personal Budgets and Direct Payments: Are they achieving independence, choice and control?

In evaluating Personal Budgets and Direct Payments, two important caveats need to be highlighted.

First, the personalization agenda is still a relatively recent framework that is still bedding down in implementation terms. In particular, Direct Payments are most effective in the context of active local markets in care and support services, which in turn depend on take-up of Direct Payments. Arguably, the take-up of Direct Payments and Personal Budgets is still too low to properly evaluate this agenda. It is essential to distinguish teething problems from which to draw lessons, from potential fundamental flaws in the whole policy framework.

Second, it is too early for the emergence of robust data

with which to evaluate Personal Budgets and Direct Payments. The number of available, relevant social science studies is limited, primarily to the findings of the Individuals Budgets Evaluation Network (IBSEN), which published its conclusions in 2008. Indeed, as the Social Care Institute for Excellence has noted, many local authorities are not yet routinely monitoring personal budget costs and outcomes.⁵⁰

Nevertheless, given the adoption of new strategic objectives for what social care in England and Wales is seeking to achieve, what are the pros and cons of Personal Budgets and Direct Payments?

Advantages of Direct Payments and Personal Budgets

▶ Choice and control

Direct Payments give individuals high levels of choice and control regarding how resources are used to support them, and what outcomes available resources are used to achieve.

▶ Put person at centre of both assessments and service development

By transferring social care resources directly to the user, assessments and services are forced to be organised around the user, their needs and preferences.

▶ Efficiency and savings

A literature review by the Social Care Institute for Excellence (SCIE) noted some evidence to suggest that self-directed support and personal budgets could lead to improved outcomes in individual cases for the same cost if implemented efficiently and effectively.⁵¹

The advantages of Direct Payments and Personal Budgets include choice and control, efficiency and savings, and user satisfaction...

▶ User satisfaction

As well as being goods in themselves, there is some evidence that where individuals are given choice and control over the services they receive, users are happier with those services.⁵²

▶ Benefits for informal carers

Many people in receipt of formal care are also in receipt of informal care. The receipt of Direct Payments enables individuals with care needs to purchase services that interact optimally with the care provided by family carers, as well as the carer's own preferences, needs and capabilities.

Disadvantages of Direct Payments and Personal Budgets

▶ Monitoring costs

Although Direct Payments are subject to very limited conditions in how money is used, individuals nevertheless have to be able to demonstrate that the money is being used effectively to achieve agreed outcomes. This imposes monitoring costs on local authorities.

▶ Burden on individuals

Some care and support users have rejected Direct Payments on the basis that they do not like the extra burden associated with managing and commissioning their care particularly, for example, if this involves 'hiring and firing' of care workers. For this reason, official guidance has seen Personal Budgets managed by local authorities as being an essential opt-out option.

▶ Reliance on local care market development

Direct Payments are only as effective as the

functioning of local care and support markets.

However, a recent SCIE review noted increasing evidence from the independent provider sector and from micro services that local authority commissioning practice is not yet facilitating the type of market development and diversification needed for personal budgets to be used effectively and efficiently.

▶ Loss of economies of scale

Services commissioned at scale by local authorities are able to secure the benefits of economies of scale for users, i.e. lower costs. However, many of these economies of scale are effectively lost in the context of Direct Payments, as a necessary expense of achieving personalized services.

▶ Inappropriate implementation

Qualitative research has unearthed some instances of inappropriate implementation of Direct Payments, for example, in which users had not been offered the option of a council-managed personal budget by social workers.⁵³

Discussion

The social care system in England and Wales has over the last decade effectively sought to reinvent itself. It has refreshed and updated its objectives. It has accepted, and increasingly adopted, a radically different, disruptive, and transformative model of social care delivery. It has blurred the lines between what is care and support and what is not. Its ambitions have moved beyond supporting and protecting individuals, to giving them the life that they want to lead.

Although the Personal Budgets and Direct Payments regime is still 'bedding down', with policy evolving frequently through trial and error at a local level, there is widespread acceptance that cash transfers in the form of Direct Payments are the most effective

Disadvantages include reliance on the existence of active, plural local care markets, and the burden of bureaucracy for users and social workers...

mechanism to achieve the objectives of the social care system.

In contrast to the AA system, which has remained broadly unchanged for several decades, the social care system is continuing to be transformed. The implications of these changes for AA and the social care system are explored in the next chapter.

Payments include: monitoring costs for individuals and local authorities; reliance on the (sometimes patchy) development of local care markets; and, potential loss of economies of scale.

Key points:

- ▶ In contrast to Attendance Allowance, the social care system in England and Wales has been characterised by radical change during the last decade: a complete re-think and 're-imagining' of what social care is and what it is trying to achieve, conceptualised in terms of the outcomes experienced by individuals.
- ▶ Although still a work-in-progress, there is universal acceptance and support of the outcomes that the social care system is seeking to achieve for users: independence; choice; control and well-being.
- ▶ In response to these changes, there has been a revolution in thinking about the design of social care policy around how outcomes are achieved through the delivery of social care. The key policy lever to achieve these outcomes has been the deployment of Personal Budgets, and in particular, 'unrestricted' Direct Payments, i.e. cash-payments.
- ▶ Issues for policymakers in the personalization agenda have included: the limited availability and take-up of Personal Budgets; suitability for the population in need of care and support; dealing with financial management and bureaucracy.
- ▶ The advantages of Personal Budgets and Direct Payments are: choice and control for users; placing the person at centre of both assessments and service development; potential efficiency and savings; user satisfaction and benefits for informal carers.
- ▶ The disadvantages of Personal Budgets and Direct

4. Cash Convergence: What are the implications for Attendance Allowance and social care?

Changes in social care policy over the last decade have arguably resulted in a convergence across social care and the AA regime...

The previous chapters have reviewed and evaluated the Attendance Allowance regime in England and Wales, as well the evolution of adult social care during the last decade.

The operation of these two separate systems for supporting older people with cognitive and physical impairments can be summarised as follows:

Form of Support	Attendance Allowance	Direct Payments	Personal Budgets
Reach	In the UK as whole, in 2009, there were 0.81 million DLA recipients aged 65 and over, and 1.62 million AA recipients, comprising 8.3% and 16.5% of the over-65 population respectively. ¹	In England and Wales in 2009-10, 610,000 over-65s were in receipt of publicly funded community care. Although figures specifically on the retired population are hard to obtain, a local authority survey found around 22% received a Personal Budgets, of whom around half took Direct Payments. ¹	
Conditions on Use	100% unconditional expenditure	Mostly unconditional (no payments to informal carer), but must be used to achieve agreed outcomes	Guided expenditure on agreed outcomes
Proportional to private means	No	Yes	Yes
Proportional to informal care received	No	Yes	Yes
Proportional to costs of care and support in local area	No, both value of AA and level of support that can be purchased are arbitrary	Yes	Yes
Evaluation of effectiveness	None	Ongoing monitoring of use; re-evaluation of needs once per year	Direct management of use by councils; re-evaluation of needs once per year

Given that the costs of living with a disability are ultimately defined by individuals and the life they want to lead, it these outcomes – often characterised as independence, well-being, choice and control – must arguably represent the ultimate strategic objective of AA...

The previous chapter explored how the last decade has witnessed a revolution in thinking about the purpose of social care services, and an ongoing evolution in the delivery of services, with a much greater role for cash-based transfers. In light of the objective of social care policy for every publicly-funded social care user to be given a Personal Budget by 2013,⁵⁴ it appears that stated government policy creates the prospect of two distinct areas of government making cash-transfers to largely the same target group.

This form of ‘cash convergence’ has significant implications for both the social care system and the Attendance Allowance regime. This chapter draws out the implications of this convergence.

1) There has been a convergence in strategic objectives across social care and disability benefits

Assessments for AA assess care need as a proxy for the level and ‘extra costs’ of living with a disability. AA provides a contribution toward these costs, which may or may not see an individual purchasing orthodox care and support services.

The stated strategic objective of AA is therefore to meet some of the extra costs of living with disability, even though, as explored in Chapter 2, it is effectively impossible to define across the population what the extra costs of living with a disability are and how they vary among the population of AA claimants.

But what are the costs of living with a disability for *individuals*? It is individual AA recipients and the outcomes they seek to achieve in their lives that ultimately define what the extra costs of living with a disability are. In many cases, this can be framed as the outcomes of an equivalent non-disabled person.

At an individual level, the strategic objective of AA is not therefore to meet the extra costs of living with a disability, but instead, the achievement of the outcomes that users want for their lives. The extra costs of disability, however users determine them, result from disabled individuals seeking to achieve these outcomes.

Every AA recipient person will value different outcomes in their own unique way. However, extensive research by the Department of Health over the last decade into what outcomes individuals with cognitive and physical impairments value has identified several common themes: independence; well-being; dignity; choice, and control.

Since AA enables recipients to determine what outcomes they seek to achieve through spending AA, it can be argued that the strategic objective of AA must also be the achievement of these outcomes for disabled individuals. Whether using a Direct Payment or AA, individuals with care and support needs will use the cash-support available to them to lead their life they want to lead.

Following a complete re-thinking of social care among policymakers, these outcomes – independence, well-being, dignity, choice and control – also now comprise the clear strategic objective of the adult social care system.

As such, there has been a convergence of strategic objectives across adult social care and the disability benefits system. Both systems are now seeking to achieve the same outcomes in the lives of users, i.e. the outcomes that users themselves want.

This convergence should not be a surprise. It would be odd for two different support systems for individuals with care and support needs to seek incoherent outcomes. Instead, the convergence can be seen as an indication of progress of the way in which society

Both social care and AA policy also now display a firm belief that the best way to support individuals lead the life they want to lead is to give them control over their own resources...

and policymakers think about how best to support disabled individuals.

2) There has been a convergence in policy levers

As described in the previous chapter, the last decade has witnessed a complete 'reimagining' of what social care is and what it is trying to achieve. At every level of the social care system, there is now clarity about the user-defined objectives of adult social care: independence, well-being, choice and control.

Since 2005, the personalisation agenda has been the principal policy response to achieve these outcomes. The principal policy levers deployed have been Direct Payments – which afford users a high level of discretion and control – and Personal Budgets, for which administration and procuring of services is undertaken with the support of local councils. A clear preference within adult social care policy is observable toward the use of Direct Payments – i.e. maximum choice and flexibility - over Personal Budgets.

In short, cash-transfers, in the form of Direct Payments, are the principal lever by which the adult social care system is attempting to achieve its strategic objectives for users: independence, well-being choice and control.

As such, not only are the AA system and adult social care attempting to achieve the same outcomes, both are now attempting to achieve these outcomes through the same policy tool: cash transfers.

With take-up of Direct Payments increasing each year, the process of 'cash convergence' is increasingly incrementally. Although there remains some way for the personalisation agenda to go, and many users continue to receive a traditional model of support services, the direction of travel is clear, and future policy debate needs to take account of this

convergence in how the AA and social care systems are attempting achieve their objectives.

3) Social care and AA are interdependent and must be jointly evaluated

If two areas of public policy are attempting to achieve the same outcomes through largely identical means, it becomes untenable to measure their efficacy or evaluate each in isolation, particularly if some individuals are clients of both policy domains.

The interdependency of AA and social care policy is already explicit given the propensity of local authorities to take account of AA in community care needs assessments. More broadly, Direct Payments will achieve more for users if they are already in receipt of AA, and vice versa.

As such, it can be argued that any evaluation of social care policy and AA must now be undertaken jointly, rather than separately. In particular, AA can no longer be considered different or separate from the development of social care policy. By extension, policymaking in relation to both must be formulated jointly and strategically across DWP and DH.

4) Reforms will have effects across both social care and AA

The interdependency of outcomes across the AA and social care systems also means that measures to improve the efficacy of one system will also improve the other. This is particularly true in relation to two agendas that have been actively pushed forward in the context of social care policy, but not the AA system.

First, information and advice services that have been promoted by the social care system will also help recipients of AA spend their money effectively, so that the efficacy of AA improves because of actions within the social care system.

This ‘cash convergence’ creates a number of issues, such as the need to review the user experience of two, cash-based, assessment systems, and the interdependency of both policy domains...

Second, the DH and local authorities have invested significant time and effort in ‘market development’, i.e. guiding and stimulating the development of plural, diverse, flexible, innovative local markets in care and support services. Where successful, these endeavours have increased choice for social care users and brought down unit costs. However, these markets can also be accessed by, and benefit, the hundreds of thousands of AA recipients who have no contact with the social care system. The efficacy of AA as a policy measure is therefore improving directly as a response of actions within the social care system.

Indeed, there is a marked contrast between the work of DH to improve the diversity, quality and availability of care and support services, and the absence of effort by the DWP to improve the outcomes of AA recipients in the same way.

5) There is a need to think through the user experience across two parallel cash-based systems

A range of issues stem from the operation of two support systems for individuals with care and support needs, that feature the same objectives and measures to achieve these objectives.

First, is it tenable to operate parallel needs assessment systems targeting the same individuals with cash payments? Ultimately, users themselves are likely to question why they must undergo two assessments and engage with two different systems to receive cash payments from each. Arguably, such duplication is also wasteful.

Second, how long is it tenable to maintain two parallel systems based on cash payments to individuals with care and support needs that have inconsistent rationales and mechanisms for allocating resources? While the full range of state support to individuals with care and support needs is not coordinated, the

experience for some users may be one of confusion and dissonance.

6) The growth of Direct Payments may necessitate some re-thinking of AA

As explored in Chapter 2, the AA system in England and Wales has some key advantages for users, and for policymakers.

However, the merits of AA must inevitably be compared to the operation of Direct Payments in social care. Indeed, it can be argued that policy developments around the roll-out of Direct Payments ultimately casts a shadow over AA.

This is particularly true in relation to helping people get the most out of the resources that they have available to them. It is not clear that the entitlement principle is wholly adequate to justify a ‘hands-off’ approach that limits guidance - or indeed conditionality - when users confront a significantly under-resourced adult social care system, and poor expenditure decisions by individuals will have a directly negative effect on their outcomes. Put simply, the people who are potentially suffering from the ‘hands-off’, “it’s their money” rationale of AA are the potentially vulnerable people who are the target group.

The AA system could arguably learn lessons to improve efficacy from the experiences of the adult social care system with Personal Budgets and Direct Payments.

7) The AA system has much that could be of value to the social care system

From the point of view of social care policy – and notwithstanding academic evidence that there may be up to a 30% non-take up rate - the key asset associated with the AA regime is arguably its reach and brand. Like the Post Office network, AA deals in

The growth of Direct Payments may necessitate some rethinking of AA, but conversely, the AA system has much that could be of value to social care policy, such as its reach among vulnerable people who have no contact with their local authority...

small sums but its' reach and profile is second to none. It is widely recognised among policy analysts that one of the key problems associated with the social care system is its limited reach: the social care system struggles to identify vulnerable individuals and to bring them 'into the system'.

In this context, from the perspective of social care policy, the AA system is arguably too valuable an asset to simply discard. Blind to both means and the availability of informal care, it does not possess the 'allocative efficiency' of local authority social care, but nevertheless reaches and provides a contact point with over one million older people experiencing disability and need.

Indeed, if the AA system provides a lesson for social care policymakers, it is that a simple, non-means tested cash payment represents an excellent 'hook' to get people into a system. An anomaly within broader social care policy is that the AA system is not used more as a central locus with which to engage people with prevention, telecare, information and advice.

This characteristic of the AA system has arguably been lost in recent debate over how public expenditure allocates resources on care and support between the disability benefits system and the social care system. Evaluation of AA should not be limited to how public money is allocated proportional to means and need, but should consider the wider assets of the AA system, and its *potential* value in future for a reformed social care system.

In this context, there is a clear need for disability policymakers and proponents of AA to revisit and re-evaluate the efficacy of the AA system and explore how it can be improved.

The next chapter seeks to begin this process.

Key points:

- ▶ 'Cash convergence' between the social care and AA systems has significant implications for policymaking. In particular:
- ▶ There has been a convergence in strategic objectives across social care and disability benefits. Both systems are now seeking to achieve the same outcomes in the lives of users, i.e. the outcomes that users themselves want: independence, choice, well-being and control.
- ▶ There has been a convergence in policy levers. Cash-transfers, in the form of Direct Payments, are the principal lever by which the adult social care system is attempting to achieve its strategic objectives for users: independence, well-being choice and control.
- ▶ As result, social care policy and AA are interdependent and must be jointly evaluated. AA can no longer be considered different or separate from the development of social care policy. By extension, policymaking in relation to both must be formulated jointly and strategically across DWP and DH.
- ▶ The interdependency of outcomes across the AA and social care systems also means that measures to improve the efficacy of one system will also improve the other, for example, social care policy measures relating to information and advice services; and, 'care market development'. These endeavours have potentially benefitted hundreds of thousands of AA recipients who have no contact with the social care system.
- ▶ There is a need to think through the user experience across two parallel cash-based systems. Is it tenable to operate parallel needs assessment systems targeting the same individuals with cash payments?
- ▶ The growth of Direct Payments may also necessitate some re-thinking of AA, which must inevitably be compared to the operation of Direct Payments in social care. This is particularly true in

Indeed, AA shows that a simple, non-means tested cash-payment is an excellent 'hook' to identify and provide support to older people with a disability...

relation to helping people get the most out of the resources that they have available to them. It is not clear that the entitlement principle is wholly adequate to justify a 'hands-off' approach that limits guidance when users confront a significantly under-resourced adult social care system, and poor expenditure decisions by individuals will have a directly negative effect on their outcomes. The people who are potentially suffering from the 'hands-off', "it's their money" rationale of AA are the potentially vulnerable people who are the target group.

- ▶ Conversely, the AA system has much that could be of value to the social care system, particularly its reach and brand. One of the key problems associated with the social care system is its limited reach: difficulties in identifying vulnerable individuals and bringing them 'into the system'. In this context, from the perspective of social care policy, the AA *system* is arguably too valuable an asset to simply discard.
- ▶ This characteristic of the AA system has arguably been lost in recent debate over how public expenditure allocates resources on care and support between the disability benefits system and the social care system. Evaluation of AA should not be limited to how public money is allocated proportional to means and need, but should consider the wider assets of the AA system, and its *potential* value in future for a reformed social care system.

5. Beyond Convergence: 10 ideas to make Attendance Allowance and social care work better together

What is the best way to support older people with cognitive and physical impairments achieve independence, well-being, choice and control in the context of two separate systems for transferring resources to individuals?...

The previous chapter explored the implications of the convergence in strategic objectives and policy levers across the Attendance Allowance and adult social care system.

Despite its under-funding, the social care system in England and Wales embodies the principle of 'allocative efficiency'. Means-assessments and needs-assessments enable local authorities to allocate resources according to means and need, i.e. resources are targeted according to pre-defined criteria - greatest need – that maximises allocative efficiency.

The AA system embodies a different, entitlement-based, approach. Allocating resources purely on the basis of disability in the system does have attractions for policymakers, notably take-up/participation, transparency, but also results in some take-up by individuals who don't need the money, and unmet need. AA represents a sacrifice of allocative efficiency for the sake of other positive outcomes, notably the opportunity to support more – and frequently different - people than are supported through the social care system.

These different approaches across disability benefits and social care have co-existed for decades. In recent times, some social care policy analysts have responded to these limited allocative efficiency of the AA system by arguing that public spending on disability benefits should instead be transferred to the social care system where allocative efficiency is higher.⁵⁵

However, the convergence in the objectives and policy levers deployed across the social care and AA systems means that debate now should focus on integration and coordination, rather than the merging of systems.

The ultimate question for policymakers is: what is the best way to support individuals with cognitive and physical impairments achieve independence, well-being, choice and control in the context of two separate systems for transferring resources to individuals?

This chapter therefore concludes this report by developing and evaluating 10 ideas for making the two systems work better together.

Signposting

Summary: Increase the volume of signposting across both systems. Individuals making contact or claims with either adult social care or AA system are also provided with full information about the other system, as well as information on the local care market, advice, advocacy and brokerage services.

Why? At present, the only real signposting occurs when local authorities tell individuals to make AA claims, frequently with a view to incorporating AA into a need-assessment. Yet there are multiple opportunities for signposting between the AA and social care systems. For example, at present, the official information booklet on AA produced by DWP for potential claimants contains no reference whatsoever on the right to a local authority needs assessment, despite the fact that some individuals reading this leaflet may be experiencing substantial or critical levels of (unmet) need.

Pros

- ▶ Improvement in outcomes for users, notably from identification of high-risk individuals for whom high-level needs can be prevented.

Cons

- ▶ Cost – claims on both disability benefits and social care system would likely increase as a result of improved signposting; however, this may be offset

Potential ideas to make the two systems work better together include signposting, data-sharing, joint assessments...

by reduced incidence of 'crises' and hospital admissions.

Data sharing

Summary: Full data sharing across adult social care and the AA system. Local authorities are able to identify high-risk individuals in their area who may be entitled to support using DWP data. The DWP is able to use local authority data to identify potential AA claimants.

Why? At present, some AA claimants would potentially be entitled to local authority support, and vice versa. Academic research described in earlier chapter has explored the large number of people in one system but not the other.

Pros

- ▶ Reduce unmet need in the system, and improve targeting in the social care system, given far more people claim AA than are known to local authorities.

Cons

- ▶ Confidentiality – rules on data confidentiality may be an issue, but this could be overcome through the inclusion opt-out questions in assessments in both systems.
- ▶ Cost – data sharing would likely lead both the social care and AA systems to identify more individuals entitled to make claims.

Joint assessments

Summary: Move beyond data sharing to harmonise assessment and eligibility criteria deployed. Although the AA system is not equipped to undertake community care assessments (which require assessments of informal care and private means), local authorities could easily incorporate AA assessments into community care needs-assessments, so that individuals would become

eligible to receive AA solely on the basis of a local authority needs-assessment.

Why? Local authorities are already collecting most of the information required for an AA claim, so there is extensive, wasteful duplication of assessments.

Pros

- ▶ Enabling local authorities to process an AA claim on the basis of a community care needs assessment would reduce duplication of assessments, and reduce the number of assessments that individuals have to go through.
- ▶ Reduction of waste arising from duplication of assessments.

Cons

- ▶ Local authorities may use increased take-up of AA among social care users as a lever to divert resources.

AA as social care gateway

Summary: AA formally positioned as the gateway into a reformed social care system, such that AA claims are the entry point for the full range of social care interventions, such as re-ablement, telecare, informal care support and community care assessments.

Why? The issue of encouraging individuals with cognitive and physical impairments to identify themselves to the social care system has long been recognised as a substantial problem, reflected in persistently high levels of unmet need. An excellent 'hook' to encourage people to make themselves known to the social care system would be a non-means tested, unrestricted cash payment for people with care needs. Since this already exists in the form of AA, the DWP and AA become the first touch-point for individuals experiencing care needs and the principal gateway to the social care system.

Positioning AA as an entry point to a reformed social care system, applying soft conditionality to AA...

Pros

- ▶ Enables social care system to exploit the brand, reach and 'unconditional' nature of AA payments so that more individuals are brought into the system, and benefit from prevention, telecare, etc.

Cons

- ▶ AA claims require individuals to have experienced six months of disability. However, to meet their Duty of Care, local authorities have to frequently respond to a crisis or hospital exit, so other gateway points would have to be retained.
- ▶ Although anecdotal evidence suggests that both local authorities and the disability benefits system suffer from stigma, those who may be put off by the idea of 'being on benefits' may be deterred from engaging with social care services.

Soft conditionality

Summary: To improve expenditure decisions around AA, soft conditionality is applied to claims. For example, AA claimants could receive a phone call from an adviser to tell them about their other rights, local care and support services that are on offer, help with budgeting that is available, etc. These phone calls could be repeated on an annual basis. To further drive improvements in expenditure decisions, conditionality could be made 'tougher', for example, with receipt of AA made conditional on a visit by a care adviser to talk about what services are available, the potential of telecare, etc.

Why? Despite the government spending billions of pounds each year on AA (and DLA) for the retired population, very little is done to improve expenditure decisions, and in the personalisation agenda, the social care system has arguably innovated and moved ahead of the AA regime in efforts to ensure money is well-spent and outcomes for users are maximised.

Pros

- ▶ Improved expenditure decisions will ultimately lead to improved outcomes for individuals.

Cons

- ▶ Some potential AA claimants may be put off by any hint of conditionality around receipt.

Hard conditionality

Summary: Receipt of AA made conditional on being able to demonstrate how the money has been spent effectively. In effect, AA becomes a non-means tested Direct Payment, i.e. a payment with some conditions attached, but that is not subject to a means-assessment.

Why? Given the large proportion of social care public expenditure embodied by AA, it is not unreasonable to impose some conditions on its use with a view to improving outcomes.

Pros

- ▶ Improved expenditure decisions will ultimately lead to improved outcomes for individuals.

Cons

- ▶ Monitoring of how AA is used by individuals would ultimately impose bureaucratic costs on individuals and the DWP.
- ▶ Increasing conditionality would ultimately be likely to reduce incentives for take-up, damaging a central benefit of the AA regime.

Opt-out Personal Budgets

Summary: To improve expenditure decisions, but without having to impose hard conditionality, DWP takes the reins of the Personal Budgets agenda, and AA is distributed via Personal Budgets and Direct Payments. The underlying principles of AA are retained by giving individuals the option to opt-out of a

Creating a single brand across the two systems, positioning AA as part of a national social care entitlement framework...

local authority managed Personal Budget to take AA as an unrestricted cash payment.

Why? By defaulting AA recipients into a framework in which they would be help to spend AA effectively, outcomes for users would improve.

Pros:

- ▶ Improved outcomes for AA recipients.

Cons:

- ▶ Loss of simplicity of AA entitlements and payments would likely have a negative effect on take-up.

Single brand

Summary: Both AA and adult social care are re-branded with a single brand covering both forms of support, despite the retention of two separate systems. In effect, a reformed system would have 'a single shop-front but two shopkeepers'.

Why? Even if AA and adult social care are retained as two separate systems 'behind the scenes', there is no reason that they should not present a single unified brand to users, which would improve the user experience, help promote awareness of entitlements and improve engagement.

Pros

- ▶ A single brand across AA and adult social care would help frame the offer to individuals from the state as a single, cohesive with clear objectives and aspirations for the lives of people with care and support needs.

Cons

- ▶ Potential for confusion given retention of two very different assessment systems in their treatment of means and need.

Joint national entitlement framework

Summary: Social care system adopts a national eligibility framework explicitly built around AA, which is reframed as a universal, low-level payment for all individuals with qualifying care and support needs, on top of which, individuals can request means-tested community care assessments in order to access higher levels of support.

Why? There is wide-ranging consensus that a clear national entitlement framework is required in the adult social care system, for example, if individuals are going to be able to plan ahead. However, it would be highly undesirable for two inconsistent national entitlement systems to operate side-by-side, one for AA and one for social care.

Pros:

- ▶ Implementation of a joint national entitlement framework would represent the true integration of AA and adult social care systems, even if they persist as separate systems.

Cons:

- ▶ Potential coordination problems – joint national entitlement framework arguably only really effective in the context of joint public spending decisions on AA and social care, i.e. a fundamental structural change. However, this would be hard to coordinate given involvement of different government departments (and the so-called DEL/AME split between the departments).

Resource distribution

Summary: Social care interventions and resources are distributed via the AA system, given its bigger reach and ability to identify disability among the older population. For example, information included in an AA claim automatically triggers receipt of a telecare voucher, which individuals are then able to use to

Ultimately, the picture is one of opportunity. The assets of both systems, despite their different underlying ethos, can be integrated and coordinated to improve the outcomes of older people with cognitive and physical impairments...

purchase telecare devices and services, with individuals encouraged to fund ongoing monitoring services – which typically £5 per week – from AA.

Why? The AA system reaches far more people with care and support needs than the adult social care system. As such, there is a compelling case to review whether some public expenditure on social care would be better distributed via the AA system. This is particularly true of preventative interventions.

Pros

- ▶ Significant potential for improvement in user outcomes if more entitlements, funding and support are distributed via the AA system, in the form of vouchers or other mechanisms.

Cons:

- ▶ Loss of targeting – any resources and interventions distributed via the AA system could not be targeted as effectively as in the social care system.

Conclusion

This chapter has concluded this report by developing and evaluating some ideas for making the AA system and social care system in England and Wales work better together.

Ultimately, the picture is one of opportunity. The assets of both systems, despite their different underlying ethos, can be integrated and coordinated to improve the outcomes of older people with cognitive and physical impairments.

The development of two separate disability benefits and social care systems is ultimately the result of incremental historical developments, over several decades. However, there is no reason not to see the positives in such an ‘accident of history’. Both systems can learn from each other, and improve their efficacy through closer working. The principles of both –

universal entitlements versus targeting of need - can be embodied in a new vision for how the state and society supports older people with care and support needs.

Key points:

- ▶ The different approaches to allocating resources across disability benefits and social care have co-existed for decades. However, the convergence in the objectives and policy levers deployed across the social care and AA systems means that debate now should focus on integration and coordination, rather than the merging of systems.
- ▶ The ultimate question for policymakers is: what is the best way to support individuals with cognitive and physical impairments achieve independence, well-being, choice and control in the context of two separate system for transferring resources to individuals?
- ▶ Ten ideas for making the two systems work better together include: signposting; data sharing; joint assessments; positioning AA as the gateway to the social care system; soft conditionality; hard conditionality; opt-out Personal Budgets; a single brand across AA and social care; a joint national entitlement framework; and using the AA system to distribute social care resources, e.g. information included in an AA claim triggers receipt of a telecare voucher, which individuals are then able to use to purchase telecare devices and services.

Appendix: How does the social care system allocate resources?

This Appendix provides some descriptive background information on the social care system in England and Wales, and how it allocates resources.

It is local authorities in England and Wales that are responsible – under a Duty of Care - for assessing people in their area with disability-related needs, and allocating publicly funded support to them on the basis of a community care assessment, comprising a *needs*-assessment and *means*-assessment. Public spending on social care in England and Wales is around £6.37 billion in relation to those aged 18-64 and £7.39 billion in relation to those aged 65+.⁵⁶

During 2007-08, around 1.75 million adults (including older people) used different social care services, either provided by their local council or purchased on their behalf from private and voluntary organisations. Of local authority social care expenditure, 59% was on services for older people in 2007-200, and 22% on adults aged 18-64 with learning disabilities.⁵⁷

In England and Wales 2009-10, the number of over 65s in receipt of publicly-funded community care was estimated at 610,000, and the equivalent number for residential care was 170,000.⁵⁸

There is no specific revenue allocated by the Government for adult social care. Resources for social care are wrapped up in the monies allocated to local authorities to deliver all of their various services and priorities. It is up to local authorities to decide how they allocate and spend their funding.⁵⁹

The critical feature of the needs-assessment within community care assessments is that it is ‘carer-sighted’ rather than ‘carer-blind’, i.e. takes account of care provided by informal carers.

Current guidance for local authorities in England for taking account of informal care is contained in: *Prioritising need in the context of Putting People First: a whole system approach to eligibility for social care:*

“Whilst determination of an individual’s need for assistance should take account of the support which carers, family members, friends and neighbours are willing and able to offer, the determination of presenting needs should identify all community care needs, regardless of whether and how they are being met.

If, for example, an individual cannot perform several personal care tasks, but can do so without difficulty with the help of a carer, and the carer is happy to maintain their caring role in this way, both currently and in the longer-term, then it is reasonable to record these as needs on the care plan, but that they are being fully met by the carer.

Where an individual has needs and a carer is willing to meet some but not all of these, then the council should provide a response to address those eligible needs, which are those needs not being met by the carer. However, during assessment, no assumptions should be made about the level or quality of support available from carers.

Inappropriate assumptions about how much support carers are willing or able to provide can lead to an underestimation of potentially eligible needs. An individual might be supported by a carer but still be eligible for community care services because of the nature of their needs and the level of support that both the individual and the carer require to maintain their independence and well-being.”

In this way, local authorities carry out ‘carer-sighted’ needs assessments for domiciliary care. The key points are that assessments should record all of a person’s needs regardless of whether they are being met by a carer, and that the receipt of informal care does not mean that individuals should not also receive support from the local authority. In this way,

community case assessment do not simply look at disability, but at need proportional to the availability of informal care.

Social workers are employed to undertake a skilful assessment of a family's individual circumstance, with an emphasis on judgement over merely 'ticking-boxes'.

Entitlement to home care from local authorities is also assessed on the basis of a person's *means*, i.e. their income and wealth. In relation to means-assessments, the same Department of Health guidance states:

“Once an individual's needs, and those of their carer(s) where appropriate, have been assessed and a decision made about the support to be provided, an assessment of the individual's ability to pay charges should be carried out promptly, and written information about any charges or contributions payable, and how they have been calculated, should be communicated to the individual.

This means that once a person has been identified as having an eligible need, councils should take steps to ensure that those needs are met, regardless of the person's ability to contribute to the cost of these services. An assessment of the person's ability to pay for services should therefore only take place after they have been assessed as having eligible needs.

A person's ability to pay should only be used as a reason for not providing services in circumstances where a person has been assessed as needing residential accommodation, the person has the means to pay for it and if the person, or someone close to them, is capable of making the arrangements themselves.”

Critically, a means-assessment must not precede a full needs-assessment; the emphasis in the guidance is on everyone receiving a needs-assessment. However, a 2008 Commission for Social Care Inspection (CSCI) survey found one third of people who failed to get a needs-assessment reported that they were told they did not meet their council's financial criteria.⁶⁰

Every local authority has different rules on charging for services, particularly related to income. In relation to capital, means-assessments for home care are required to exclude the value of a person's home.

The upper capital limit is the same as that used for residential care charging, i.e. £23,250. If a person has more than this amount in assessable capital, they may be asked to pay the full cost (up-front or deferred) of any care organised by the local authority, whether via direct provision or through a personal budget. As with residential charging rules, capital of between £14,250 and £23,250 is assumed for the purposes of the means-assessment to provide an income of £1 per week per £250 of capital.⁶¹ Care users can ask that any capital that is 'earmarked' for a specific purpose be disregarded in the means-test, although this is discretionary.

Disability benefits may be taken into account as part of a person's income when local authorities calculate how much to charge someone for any services received; however, the mobility component of DLA cannot be taken account of, and councils should also take account of disability-related expenditure in assessing disability related income. The charges that someone has to pay for local authority care services cannot take them below the Pension Guarantee Credit threshold plus a buffer of 25%.

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