

A Briefing

# DISABILITY BENEFITS

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December 2016



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## Summary

- The UK introduced its first nationwide programme of sickness benefits in 1948. It initially cost around £2 billion per year in today's prices. The UK now spends over £37 billion annually on various disability-related benefits, a figure which is still rising. More than 5 million people are in receipt of at least one such benefit.
- The majority of disabled people are economically inactive, and only about one in three is in full-time work. This is a problem because inactivity has been shown to lead to further deteriorations in health status, particularly for mental health.
- A lot of research has been conducted into the causes of the long-term increase in disability benefit claimant counts, but it has not come up with many conclusive findings. What is safe to say, though, is that genuine increases in disability prevalence have not been the main driver.
- Local economic factors and socio-economic characteristics of recipients, on the other hand, have been shown to have a big impact. Receipt of disability benefits is more common in areas with high unemployment and among the low-skilled. This suggests that disability benefits often act as a substitute for long-term unemployment benefits.
- The empirical evidence on 'what works' in helping disabled people into employment is even more inconclusive than the evidence on the drivers of disability benefit rolls. This calls for a trial-and-error process in which different approaches can be tried and tested – the exact opposite of the UK's highly centralised approach. The current system is also overly complex, with too many different transfer instruments that serve overlapping purposes.
- Disability policy should be decentralised, simplified, and where possible, outsourced to the independent sector. This would lead to a range of competing approaches, enabling learning from best practice.

# Introduction

The UK's first nationwide programme of sickness benefits was introduced in 1948, as part of the Attlee government's social reforms. The programme initially cost around £2 billion per annum when expressed in today's prices (DWP 2016), a remarkably low figure given that this was just a few years after World War 2. But from about the mid-1950s onwards, costs began to rise steeply.

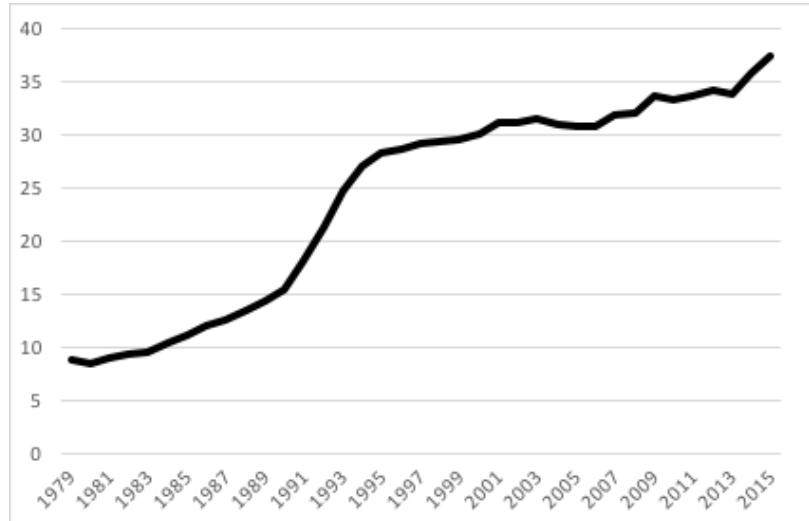
Today, the UK spends £37.3 billion on various incapacity- and disability-related benefits, a figure which still shows a rising trend (see Table 1).<sup>1</sup> Over 5 million people are in receipt of at least one disability-related benefit (ibid.).<sup>2</sup>

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1 Some UK datasets distinguish between 'incapacity benefits' and 'disability benefits'. Broadly speaking, the former are income-replacement benefits that compensate sick and disabled people for their reduced ability to work, while the latter are meant to compensate them for the additional costs associated with disability. In this paper, we will use 'disability benefits' as a summary term.

2 2.6 million people receive incapacity benefits, and 5.2 million people receive disability benefits, with some overlap between these groups.

**Table 1: Spending on disability- and incapacity-related benefits, 1979–2015, £ billion, current prices**



Based on DWP (2016).

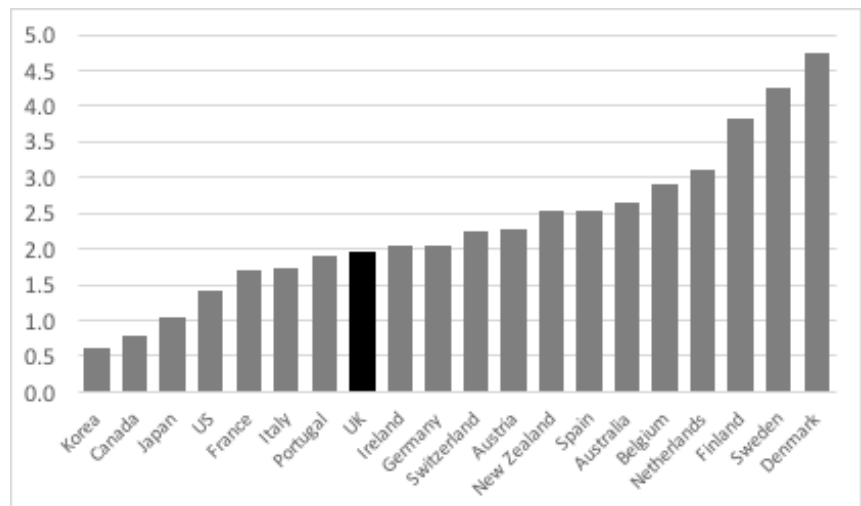
Of course, as a society becomes more prosperous, we would expect it to become more generous to its least fortunate members, both in the sense of dedicating more resources to each disabled individual, but also in the sense of defining 'disability' less strictly. Sustained economic growth allows the goals of disability policy to broaden from ensuring subsistence to enabling full social inclusion, and to broaden the circle of eligible people from those with the most severe disabilities to those with less obvious, but still debilitating conditions.

But it remains a paradox that a society which is so much healthier overall classifies so many more people as disabled. Since 1948, average life expectancy at birth has increased from 68 years to 81 years (Roser 2016). Measures of life expectancy adjusted for health status, such as Healthy Life Expectancy (HLE) or Disability-Free Life Expectancy (DFLE), show a similar if slightly slower trend (ONS 2014).



This paradox – much healthier populations, many more disabled people – is far from unique to the UK. Spending on disability/incapacity benefits<sup>3</sup> amounts to 2 per cent of GDP, about the same as in Ireland and Germany, and comparable to Switzerland and Austria (see Figure 1). The Nordic countries seem in a league of their own, although this could be distorted by the fact that these countries tax income from government transfers, which inflates recorded levels of welfare spending. Most OECD countries (especially the more populous ones) fall into a range from just under 1.5 per cent of GDP to just over 2.5 per cent.

**Figure 1: Spending on disability- and incapacity-related benefits, % of GDP, 2014 or latest available year**



Based on OECD (2016).

The employment rate of disabled people in the UK is around 45 per cent (OECD 2010: 50-52), which is about in line with the OECD average. Overall, however, the UK has one of the better-performing labour markets in the OECD, and an employment rate of over 80 per cent among non-disabled people. This should give the UK a head start when it comes to integrating disabled people into the labour market, at least when compared to countries with marked structural problems in this area. With this in mind, being 'about average' in this category is not particularly impressive.

3 For the remainder of this briefing, the distinction between disability and incapacity benefits will be dropped. 'Disability benefits' will be used as the summary term.

Trends over time are less clear. MacInnes et al. (2014: 34-35) compare time trends in the disability employment gap – the gap in employment rates between the disabled and the non-disabled – using two different measures of disability: the Work-Limiting Disability (WLD) measure and the Limiting Longstanding Illness (LLSI) measure. Both are based on self-assessment, but the LLSI measure asks people whether a health condition interferes with their daily life, while the WLD measure asks specifically whether it limits their ability to work. According to the LLSI measure, the disabled have slowly but steadily been catching up with the non-disabled in terms of employment since the late 1990s. This would suggest improvements for this group, over and above what can be explained by generally benign labour market conditions. However, the WLD measure shows no such catch-up trend, or indeed any discernible trend at all. It is not clear what causes the difference.

A lot of research into the causes of this long-term increase in disability benefit rolls, as well as possible solutions, has been conducted, but researchers have not come up with many conclusive findings. Given that the evidence in this area is so tentative and inconclusive, this briefing will not try to assess particular policies, or come up with strong policy conclusions. It is more of a stage-setting briefing, which highlights problems and raises questions rather than providing answers. But it is intended to counter simplistic narratives about this policy area which have been gaining ground for a while, and which, especially since the release of Ken Loach's movie, *I, Daniel Blake*, are fast becoming the conventional wisdom.

In this narrative, attempts to get disabled people back into work and/or to halt the increase in the disability benefit rolls are presented as mean-spirited. After a financial collapse caused by greedy bankers and financiers, the story goes, politicians have tried to balance the books on the backs of the poor and the disabled.

Whether successive government have come up with the right solutions or not is debatable, but the increase in disability rolls, and the low employment rates among disabled people, are a real problem – and not just a financial one. Firstly, one of the few safe conclusions that can be drawn from the literature is that economic inactivity leads to further deteriorations in the health of disabled people, and that moving back into work has a positive impact on their health (Waddell and Burton 2006; OECD 2010: 46-47). As MacInnes et al. (2014: 40) point out: 'Being out of work had caused further ill-health for many: some had left work because

an acquired physical impairment could not be accommodated but being out of work had then led them to develop mental health conditions such as depression and anxiety'. A system that fails to reflect this is not 'kind' towards the disabled.

Secondly, the system's impersonal nature, as critiqued in *I, Daniel Blake*, might well be just another consequence of the fact that this branch of the welfare state has simply grown too big. A system which classifies such a significant proportion of the working-age population as 'disabled' cannot, at the same time, offer personalised and tailor-made support to every one of them.

And thirdly, it is not illegitimate to worry about the system's growing fiscal cost, especially at a time when the pension system, the healthcare system and the social care system are under pressure due to population ageing.

## Growth in disability rolls: what do we know?

There are several reviews of the literature on the determinants of disability benefit claimant counts. The OECD (2010: 27-39) gives an international overview, and McVicar (2007; 2008) focuses more specifically on the UK and the US. The literature is ultimately not conclusive enough to allow a detailed breakdown of the different factors by their relative importance. But a few findings stand out.

Firstly, the possibility that the trend in disability rolls simply follows the trend in disability incidence – i.e., that more people claim disability benefits, because there are more disabled people – can be ruled out. Some studies find a moderately strong relationship between claimant counts and disability status, others find almost none, but there is agreement that this factor cannot by itself explain the increase. The problem here is that ‘disability incidence’ is hard to measure. We have measures based on self-reporting, but they suffer from what is known as ‘justification bias’: once a person is in receipt of a disability benefit, it would be difficult for them *not* to report any work-limiting illnesses or disabilities in a labour force survey.

The related possibility that increases in disability rolls simply reflect changing demographics has also been ruled out. Among working-age people, disability prevalence rises with age in all OECD countries, so an ageing population must necessarily lead to an increase in disability rolls. But this compositional effect can be isolated, and it does not fully explain the long-term increase in claimant counts. For a number of countries, the OECD models by how much claimant counts would have increased if disability incidence within any given age group had remained constant since 1990. This demographics-only increase accounts for between one sixth and one half of the increase that has actually taken place, with most countries

being closer to the lower end. Population ageing could still lead to large increases in disability rolls in the future, but it is not the main explanation for past increases. The share of disability benefit recipients has increased across *all* age groups.

Especially in studies of within-country variation, local economic factors, such as local unemployment rates and local wages, play an important role. In places with worse employment opportunities and/or lower wage levels, rates of disability benefit receipt are higher. This remains the case when various other characteristics are controlled for, but even a look at the crude rates already gives a first hint (see Table 2).

**Table 2: Share of the population with a long-standing limiting illness or disability**

<i>Local authority:</i>	
<b>Lowest</b>	
• Wandsworth	11.2%
• Richmond upon Thames	11.5%
• City of London	11.5%
<b>Highest</b>	
• Tendring	25.5%
• Blackpool	25.6%
• East Lindsey	26.0%
<i>By region:</i>	
<b>Lowest</b>	
• London	14%
• South East	16%
<b>Highest</b>	
• Wales	24%
• North East	25%

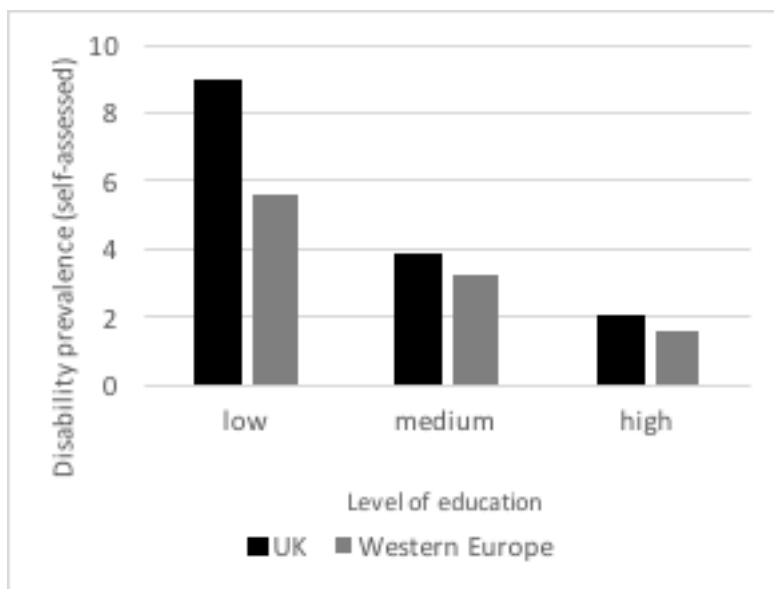
Based on Papworth Trust (2016).

Related to this, in time series studies, there is also a relationship between economic cycles and disability benefit rolls, although it is a very tenuous one. There are examples of recessions that have not led to accelerated increases in disability rolls, such as the UK and US recessions of the early 1980s. The early 1990s recession in the UK, meanwhile, did lead to such an acceleration, and where recessions have done that, they have given rise to a ratchet effect. Once the recession was over and employment growth resumed, claimant counts did not decrease again.

Changes in the generosity and accessibility of other benefits, which could act as potential substitutes for disability benefits, also seem to play a role. This effect is strongest in the US, where disability benefits have increased relative to earnings at the lower end of the wage distribution. But in different ways, it plays a role in the UK as well. Blundell and Johnson (1998, cited in McVicar 2008) find that people close to retirement age sometimes use disability benefits as an early retirement option. Disney and Webb (1991, cited in McVicar 2008) find that when eligibility criteria for unemployment benefits were tightened in the 1980s, disability benefits became a substitute for some recipients.

Socio-economic characteristics of recipients are also relevant. Self-reported disability is much more prevalent among low-skilled individuals than among those with average or high skill levels. This gap exists in all countries for which comparable data are available, and it is probably partly endogenous: people who have developed a disability later in life may already have suffered from health problems when they were of school age, and these problems may have lowered their educational attainment. But the gap varies between countries, and as MacInnes et al. (2014) show, it is particularly high in the UK, especially among the young and middle-aged. Among those with medium and high skill levels in that age group, the difference between the UK and the Western European average is less than a percentage point, but among the low-skilled, it is more than three percentage points (see Figure 2).

**Figure 2: Self-reported disability prevalence by level of education among those aged 16-44 (%)**



Based on MacInnes et al. (2014)

On a more general note, the OECD (2010: 37) also claims that ‘changes in technology and globalisation may have affected labour markets in ways that are further deteriorating the employment prospects for people with disability’, but this claim is highly speculative and rather doubtful. It is true that skill-biased technological progress has increased labour market inequalities (OECD 2011). Insofar as disability benefits are used as substitutes for unemployment benefits, especially by the low-skilled, skill-biased technological progress will also increase the disability benefit caseload. However, technological progress more broadly also has the potential to improve disabled people’s chances of labour market inclusion, both on the supply side and on the demand side. Regarding the former, assistive technologies can compensate for physical impairments and close the gap between disabled and non-disabled people in ways that would not have been possible for previous generations. (An obvious example would be the bionic hand, a much closer substitute for a ‘real’ hand than conventional prostheses.) On the demand side, the decline in the number of jobs that require physical strength, and the increase in the number of jobs that can be performed online, including from home, should also extend employment opportunities for disabled people.

In summary, it is not possible to say that x per cent of the variation in claimant counts is due to genuine increases in the prevalence of work-limiting conditions, y per cent due to economic factors, and z per cent due to changes in eligibility criteria. But the fact that economic factors and financial incentives arising elsewhere in the benefit system play a role at all is in itself telling. It shows that there must be substantial scope for bringing more disability benefit recipients back into work.

It is important to point out that the above findings do *not* mean that recipients 'feign' disabilities they do not really have. It does *not* mean that recipients take advantage of the system. The literature shows that economic variables matter, but responses to them do not have to indicate bad faith; they do not even have to be deliberate.

Firstly, policymakers have frequently instrumentalised the disability benefit system for other purposes. As MacInnes et al. (2014: 46) point out:

[S]ickness and disability benefits have over time served a variety of functions as an explicit or covert aim of government policy, including acting as a route to early retirement during the industrial dislocations of the 1980s and early 1990s and as a means for taking people with low employment prospects out of the labour market.'

Perhaps more importantly: assessing an individual's disability status and their remaining work capacity is anything but straightforward, including for the individual concerned themselves. (This is one of the main reasons why the empirical literature is often so inconclusive.) Inevitably, this is an area of ambiguity, judgement calls and educated guesses. Given this uncertainty, it would be strange if benefit advisors, medical assessors and the individuals concerned would not, if only subconsciously, take into account what the alternatives are. The decision to classify an individual as 'fit for work' will come harder when that person is deemed to have limited employment prospects. The decision to classify an individual as 'unable to work' will come easier when that person is close to retirement age anyway.

Also, disability status is, to state the obvious, not a binary variable. Jobs and the demands they place on people, meanwhile, are idiosyncratic and hard to assess in advance. Even perfectly healthy individuals can easily misjudge their ability to withstand the pressure associated with a particular job, and this must be a *fortiori* the case for people with complex long-term



illnesses. These people know to what extent their health conditions interfere with their everyday lives, but they do not automatically know to what extent those conditions will interfere with their ability to cope with the demands of any particular job. In the face of this uncertainty, a degree of risk-aversion is not the same as free-riding.

It is also plausible that the complex and time-consuming nature of the assessment process gives rise to an 'endowment effect'. Prospective recipients must pass several hurdles before they qualify for disability benefits, which may lead to an understandable reluctance to put that entitlement at risk again once those hurdles have been cleared. Re-entering the labour market and leaving the benefit rolls (the extreme case) means giving up a secure income source for an insecure one. A job offer may not work out as planned, or a disabled person may find that they had underestimated the extent to which their disability limits their work capacity. If they have already left the benefit rolls, they might have to start the whole application process all over again.

In short, we should avoid the cheap moralism of 'scroungerphobia' which is sometimes on display in the tabloid press. But we should also avoid the cheap moralism of the 'progressive' variety (which is implicit in *I, Daniel Blake* and the reactions to it). There is substantial scope for increasing employment rates among the disabled, and decreasing the cost of disability benefit programmes. This cannot be achieved without policies that seek to activate recipients, and that place demands upon them.

Every now and then, politicians declare lofty ambitions of getting disabled people into work. The current government, for example, aims to cut the gap in employment rates between disabled and non-disabled people by half. This sounds good, but Oakley (2016) spells out what this would entail in practice. Compared to current trends, it would mean moving over 1.2 million more people with disabilities into employment. However, among those who are currently in receipt of disability benefits and not in work, fewer than half a million are actively seeking work. This figure is based on self-reporting, and we know that activities which are considered 'socially desirable' are generally over-reported in surveys (Brenner 2009).

Just under a million recipients indicate a general willingness to work, but also say they are not actively looking for it, while another 1.75 million are not looking for it and express no desire. Of course, especially among the latter group, many will be genuinely physically unable to work, and would

want to if they could. Others will be part of a household with a partner in work, so their work status would be unrelated to their disability status. But the point remains that even if the government succeeded in placing every disabled person who is seeking work into work, it would still come nowhere near halving the disability gap. It would not have moved much more than one third of the way there.

At the moment, only about 8 per cent of non-employed disabled people move into work each year, and among those, those who are seeking work are heavily overrepresented. They are, in many ways, the low-hanging fruit. As Oakley also explains, on average they are more highly skilled than those not seeking work, they are younger, and a significant minority among them (about one third) have been in work not too long ago (less than two years). Among those not seeking work, about 70 per cent have not been in work for at least five years, and some of them have never been in work. There are plenty of low-hanging fruits left: even among those who seek work, just over one in four find work in any given year. But even if this rate could be doubled or trebled, it would not be enough to make a large difference to the overall numbers.

This is why activating policies, which come with demands and expectations, are required. But it will always be easy to attack such policies as mean-spirited. Phrases like 'You have enough money for the bankers and the tax-dodging billionaires, but you say you don't have enough money for the disabled?' will always guarantee roaring applause on *Question Time*.

## Getting disabled people into work

If the literature on the causes of the increase in disability rolls is often inconclusive, the literature on what works in getting disabled people back into employment is even more so. Vooijs et al. (2015) provide a review of literature reviews on this subject. Despite stringent quality filters, this meta-study still comes with more health warnings than conclusions. There are measures that seem to demonstrably work at the company level, but one cannot extract detailed policy conclusions from this review.

The literature review of MacInnes et al. (2014) also starts with important health warnings, namely the fact that most studies concentrate on the relatively easy cases, and only follow individuals for a period of a year or less. So this does not tell us much about complicated cases and long-term outcomes.

A finding that is potentially amenable to policy changes is that

‘those likely to end up on long-term sickness benefits for reasons of mental ill-health can be predicted three years before they start to claim such benefits [...]

This suggests that [...] the NHS [needs to] be more responsive to those who are at such risk, rather than rationing services only to those who are already very ill’ (ibid.: 42).

The next best thing to a winner, in terms of policy instruments, is supported employment schemes. These are schemes which, apart from certain adjustments to accommodate the person’s disability, are as close as possible to ‘normal’ employment. They are specifically contrasted to work or training schemes that are set up for disabled people outside the regular

labour market (ibid.: 49-50). The finding is somewhat counterintuitive, given that the latter schemes are supposed to be tailored to the needs of disabled people. And yet, this is one of the more reliable findings, because it is derived from some of the few studies which do concentrate on difficult cases and on longer-term outcomes. It also echoes findings on workfare schemes for the long-term unemployed (Crisp and Fletcher 2008).

This does not, of course, make supported employment schemes a panacea. These findings refer to specific groups of disabled people, and it is not clear to what extent they can be extrapolated to other groups. Also, 'supported employment' is a very broad term, which can mean many different things in practice.

Anti-discrimination legislation and job protection for the disabled, unsurprisingly, turn out to be a double-edged sword which benefits 'insiders' at the expense of 'outsiders'. This becomes especially clear by contrasting the Netherlands, where such protections are relatively strong, to Denmark, where they are weak (ibid.: 55-56). As a result, labour market entry rates for disabled people are higher in Denmark, while disabled people in the Netherlands have a greater chance of retaining a given job.

The restrictiveness of the disability benefit regime also turns out to be a double-edged sword: it is not generally the case that more restrictive regimes have fewer benefit recipients and/or more disabled people in work. This could be because of the aforementioned 'endowment effect': where it is difficult to qualify for disability benefits, recipients who have cleared the hurdles may be more reluctant to do anything which might put their benefit entitlement at risk again. This would, of course, include taking up work.

The authors also point out that while 'decreasing claimant counts' and 'increasing employment' are often treated as two sides of the same coin, they are, in reality, two quite different objectives that do not have to be strongly related. One reason could be that when benefits are more easily 'portable' into employment, work incentives are stronger, but there will also be more people who, despite being in work, are still entitled to disability benefits.

## Implications for the broad direction of policy

The fact that we know so little about 'what works' in getting disabled people into work represents a strong case for a polycentric approach, which allows policy experimentation, trial-and-error, incremental learning and benchmarking. This is almost the exact opposite of how disability policy currently works in the UK. Like most areas of welfare policy, disability policy is extremely centralised. All the major disability benefits are national benefits, and all the major disability programmes are national programmes. There may be some unintentional variation in practice, but there is no meaningful way in which we could talk about, for example, the 'Liverpool model of disability policy', and how it differs from the 'Birmingham model'.

This is true even when specific functions have been outsourced to independent sector providers. In 2008, the government outsourced responsibility for work capability assessments (WCAs). This would have been sensible if had meant splitting the caseload among a range of competing providers, with each provider handling a small or medium-sized caseload. Had the government chosen that path, it would have created a quasi-market setting (albeit with the government as a monopoly commissioner), with some scope for trial-and-error, learning from best practice and self-correction. But instead, the task was assigned to one single company, Atos Healthcare, and later transferred to a rival company, Maximus. This is not a trial-and-error process. It is a succession of temporary monopolies, which misses the whole point of involving the private sector in the first place.

### ***Localisation***

The UK is one of the most centralised countries in the world, and a greater degree of decentralisation and local autonomy would be desirable in a variety of policy areas (see Booth 2015) – but disability policy in particular practically screams out for it. The administration of most disability benefits and programmes could be delegated to the local level, and financed through a combination of local tax revenue and central government block grants. Economically weaker areas, which have a smaller tax base, also tend to have larger numbers of disability benefit recipients, which is why block grants would level the playing field a bit. But they would be awarded on the basis of some standardised economic and demographic variables, not ‘need’, because otherwise, local authorities would have an incentive to inflate the disability rolls in order to qualify for more central government funding. They would be able to retain surpluses, but as a flipside, they would also be responsible for financial shortfalls. An additional local revenue source would give local authorities – and, indeed, local electorates – some ‘skin in the game’.

Among other things, the decision to outsource particular functions to private contractors would then also become a local decision. There would be no DWP block contracts with a single provider, such as Atos or Maximus, anymore. The current single-payer/single-provider model would be replaced with one of multiple commissioners and multiple service providers. There would be variation in the extent to which private providers are involved at all, and insofar as they would be involved, there would be variation in contracting techniques and payment formulas. For example, if one local authority found a new proxy measure for ‘output’ or ‘performance’ (concepts which are, of course, difficult to measure in this area), and wanted to pay providers on the basis of that measure, they would be free to do so.

### ***Privatisation***

Decentralisation can create a more polycentric system, in the sense that different places would adopt different disability policies. But there is also scope for greater plurality on the ‘horizontal’ as well as the ‘vertical’ dimension, in the sense of having different approaches to disability policy in any given place. The main income replacement benefit for disabled people in the UK, Employment and Support Allowance (ESA), comes in two versions, a contributory and a means-tested one. The former is linked

to recipients' prior record of National Insurance contributions. Contributory ESA could, in principle, be replaced by private disability insurance.

Disabilities that people are born with, or that they develop before they reach working age, are not insurable (unless parents take out private disability insurance for an unborn child). But disabilities that people develop later in life are mainly insurable risks. People could be given the freedom to opt out of contributory ESA, receive a refund in National Insurance contributions, and use those refunds to take out private disability insurance instead. This is the principle of 'contracting-out', which has worked for decades in the pension system (Booth and Niemi 2015). There used to be a flat-rate minimum pension and an earnings-related pension. While the former had a strong safety net character, the latter was essentially like a financial product that could as well be provided privately. Hence, people were allowed to replace the earnings-related state pension with a private alternative. The same principle could be applied to the disability benefit system. It has safety net components and it has insurance components. The former are not easy amenable to private provision, but the latter could be privatised.

Contracting-out would, however, be a bit more complicated in the disability benefit system than it was in the pension system. People who opt out would have to receive actuarial National Insurance rebates, the amount of money it would cost to buy a private insurance product roughly equivalent to what they would otherwise receive from the government. Unlike in the case of pensions, this will depend on individual risk factors, which would require additional data gathering. This could, however, also have its advantages, in generating more information.

Private insurers could then offer or commission rehabilitation services and reintegration into the labour market where this is possible, and income replacement where it is not. While the latter is relatively straightforward, the former offers scope for competing strategies, which is what a system of multiple insurers would provide.

### ***Simplification***

Finally, there is also a strong case to be made for consolidating and simplifying the system. There are a number of benefits which are exclusively available to disabled people (or their carers), the main ones being Employment and Support Allowance (received by about 2.4 million people), the Personal Independence Payment (2.5 million) and Attendance Allowance (1.8 million) (DWP 2016). But apart from that, plenty of the conventional benefits which are mainly received by able-bodied people also come with special disability-related components. There is a disability premium for income support, VAT relief for selected goods and services, exemptions from vehicle tax, and so on. This means that there is a multitude of instruments which ultimately serve the same or very similar goals. This complexity has developed in a haphazard way, with successive governments piling layer upon layer. There has to be scope for some major consolidation, which could be fiscally neutral, and provide the same level of support in a much simpler way.

### ***General points***

The tax and benefit system contains adverse incentives, penalising both entry into the workforce and progression within it. In particular, effective marginal tax rates – the sum of income tax, national insurance and benefit withdrawal rates – are highest for those with the weakest levels of labour market attachment (Niemietz 2012: 217-222). The British labour market is like a ladder on which the bottom rungs are furthest apart, and this explains a major share of long-term economic inactivity and underemployment. This is a problem which affects all groups with weak labour market attachment, rather than one which specifically affects the disabled. And yet, they must be disproportionately affected.

The tax and benefit systems also discriminates against family formation by leaving couples, or joint households generally, relatively worse off. This is, again, not a problem which specifically affects the disabled, but they are probably among the most affected, given that care is probably best provided within the family.

A solution would be to move to a negative income tax system, whilst also replacing personal tax allowances with household tax allowances. Under such a system, each household would be assigned a tax-free allowance



based on the number of adults and children, in such a way that in 'equivalised' terms, the allowance would be the same for all household types (ibid.). This allowance would be freely transferrable between household members. The system would thus be neutral with regard to household size and composition, as well as with regard to how many breadwinners there are.

In the current system, millions of households are both taxpayers and transfer recipients at the same time, and this fiscal churning produces very high effective marginal tax rates. A negative income tax would eliminate most fiscal churning. Households would be either taxpayers or transfer recipients, not both at the same time.

Finally, as mentioned above, the disability benefit system is sometimes used as an early retirement vehicle. This is counterproductive in more than one way. Sahlgren (2013) finds evidence that working longer and retiring later is generally beneficial for the health of older workers. Incentives for early retirement, whether they are provided by the pension system itself or in the disability benefit system, are thus likely to give rise to a 'lose-lose-situation' of worse health outcomes *and* worse fiscal outcomes. This dynamic needs to be reversed, and replaced with a virtuous circle of longer working lives, better health, more years spent paying taxes and fewer years spent receiving transfers.

## Conclusion

Despite huge improvements in population health, more and more people qualify for disability-related benefits, and the cost of the system has shown a steady upward trend since its inception. Fewer than half of those classified as disabled are in work (and among those who are, fewer than three out of four are in full-time work). While the problem is widely recognised, and successive governments have tried to counter these trends, the problem is not well understood. We know little about the relative importance of different drivers, and we know even less about what would work in reversing the trend.

In the face of this uncertainty, one cannot confidently draw strong policy conclusions, except for making the case for a much greater degree of policy experimentation. This could be achieved through greater decentralisation, as well as greater involvement of independent sector insurers. The system is currently lacking a trial-and-error process, in which different solutions can be tried and tested.

There may not be any short-term savings to be made in this way, but one of the few reliable conclusions in the literature is that disabled people generally benefit from being in work, not just financially but also in terms of their mental and physical health. Ideally, a work-focused approach would give rise to a virtuous circle, in which higher work levels led to better health outcomes, leading to yet higher work levels. Getting more disabled people into sustained employment could also provide scope for more intensive support of those who need it most, rather than spreading resources thinly across a huge caseload.

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## Acknowledgement

This publication was made possible through the support of a grant from the John Templeton Foundation. The opinions expressed in this publication are those of the author and do not necessarily reflect the views of the John Templeton Foundation.





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