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Research Report No. 41

Evaluation of Disability Living Allowance and Attendance Allowance

A survey carried out
on behalf of the
Department of Social Security
by the
Social Policy Research Unit

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A full list of other publications in this series is shown on page 243.

Contents

Page

PART ONE: **THE TARGETING STUDY**

PART TWO THE QUALITY OF SERVICE STUDY FOR NEW CLAIMANTS

PART THREE: **THE QUALITY OF SERVICE STUDIES FOR CLAIMANTS PURSUING REVIEWS AND APPEALS**

List of Tables

List of Figures

List of Abbreviations

AA	Attendance Allowance
BEL	Benefits Enquiry Line
CGHQ	Chronicity score on the General Health Questionnaire
DBC	Disability Benefits Centre
DLA	Disability Living Allowance
EMP	Examining Medical Practitioner
GHQ	General Health Questionnaire
GHQ12	12-item version of the General Health Questionnaire
GP	General practitioner
GPFR	General practitioner's factual report
ITS	Independent Tribunal Service
MAT	Medical Appeal Tribunal
MobA	Mobility Allowance
OPCS	Office of Population and Census Surveys
OR	Odds ratio
QSE	Quarterly Statistical Enquiry
RADAR	Royal Society for Disability and Rehabilitation
SPCR	Social and Community Planning Research
SSAT	Social Services Appeal Tribunal

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Key Findings and Summary

Evaluation of Disability Living Allowance and Attendance Allowance

Disability Living Allowance (DLA) was introduced and Attendance Allowance (AA) was revised in April 1992. DLA can be claimed by people who become disabled before the age of 65. Its purpose is to help meet some of the extra costs that disabled people have by bringing together and extending two earlier benefits: AA and Mobility Allowance (MobA). New lower rate awards aim to extend help with care and mobility needs to less severely disabled people who did not qualify for the former benefits. AA continues to be claimed by people who become disabled after the age of 65 and covers their care needs only.

This report presents the findings of two linked studies, commissioned by the Department of Social Security, designed to evaluate the two new benefits. The aim of the first project (the *Targeting* study) was to assess the extent to which DLA was extending help to less severely disabled people. The second project (the *Quality of Service* study) was to evaluate the quality of service provided to new DLA and AA claimants and to claimants who had requested a review of their decision or had appealed to a Disability Appeal Tribunal (DAT).

Key Findings

PART 1 - THE TARGETING STUDY

- The new lower rate criteria successfully distinguish between people with differing levels of needs for help with personal care and mobility.
- The lower rate criteria define a group of distinct everyday activities that increase the range of needs which now attract an award.
- Specific disabilities which give rise to the needs described in the conditions of entitlement distinguish lower rate recipients from both unsuccessful applicants and recipients of middle or higher rate awards.
- Lower rate recipients are more severely disabled than anticipated and, on the whole, they are as severely disabled as middle or higher rate recipients.
- Increased awards following reviews can be attributed to a reported increase in individuals' care or mobility needs rather than poor adjudication of initial claims.
- Unsuccessful applicants are often no less disabled than DLA recipients and share common problems: inability to work, limited incomes, and extra costs because of disability.
- Adjudication officers are, for the most part, successful in consistently identifying those who are eligible for lower rate awards.

PART 2 - THE QUALITY OF SERVICE STUDY FOR NEW CLAIMANTS

- The majority of claimants had no or few difficulties completing the form and found it helpful in describing their illness or disability and its effects on their everyday activities.
- A substantial minority of people experienced a lot of difficulties with the content and layout of the form. They also had problems describing how their lives were affected by disability, or in saying what their illness or disability was. Claimants with mental illnesses were particularly affected.
- Around a quarter of the DLA and AA samples said the picture they presented of themselves in the claim form was better than was actually the case.
- There were high levels of satisfaction with the help given by the Benefits Agency during the claim process and with the visit of the Examining Medical Practitioner (EMP).
- Most DLA respondents thought that the time taken to receive a decision was reasonable. However, a quarter of the AA respondents did not think their clearance times were reasonable.
- Unsuccessful claimants often found it hard to understand the decision on their claim.
- Few respondents contacted the Benefits Agency to find out more about their decision. They were less satisfied with their contact with the Benefits Agency after the decision than at earlier stages of the claiming process.

- Over 60 per cent of claimants who were unhappy with their award or whose claim was rejected said they had appealed against the decision or intended to do so.
- Claimants who were awarded a benefit tended to prefer the method of assessment that led to the award, whether it was by form or following a medical examination. Those rejected on the form only tended to state a preference for medical assessment. However, relatively few claimants rejected after a medical said they would have preferred to have been assessed on the form only.
- The analysis of claimant satisfaction revealed a correlation between the successful outcome of claims and satisfaction (the outcome effect). There are, therefore, serious questions about the validity of overall satisfaction measures applied to samples of people whose claims have been decided. Our conclusion is that a score for overall satisfaction is primarily an indication of people's satisfaction with the result of their claim rather than with the quality of service provided by the Benefits Agency. Nevertheless, the overall levels of satisfaction reported by the DLA decided claims' sample was 84 per cent, and, for the AA sample, 73 per cent.

PART 3 - THE QUALITY OF SERVICE STUDY FOR CLAIMANTS PURSUING REVIEWS AND APPEALS

- Claimants' overall satisfaction with the review process was strongly associated with the outcome of the review. Eighty-eight per cent and 87 per cent of successful DLA and AA claimants respectively said they were satisfied (compared with over 90 per cent of new DLA and AA claimants who were happy with their award). Around a half of all unsuccessful review claimants were satisfied - a comparable figure to new claimants.
- Thirty-seven per cent of claimants who were unhappy with the outcome of their review said that they would not be appealing further or were unaware that they could.
- Appellants' views about the conduct and fairness of the hearing were strongly associated with the outcome of their appeal. Over 90 per cent of successful appellants thought their hearing was fair compared with just under half of unsuccessful appellants.
- Most people did not know that a tribunal hearing would follow their appeal request.
- A sizeable minority of appellants said that the tribunal documents were not helpful to them in understanding their case.
- Most appellants who attended their tribunal hearing were satisfied with the way in which it was conducted.

Summary of Report

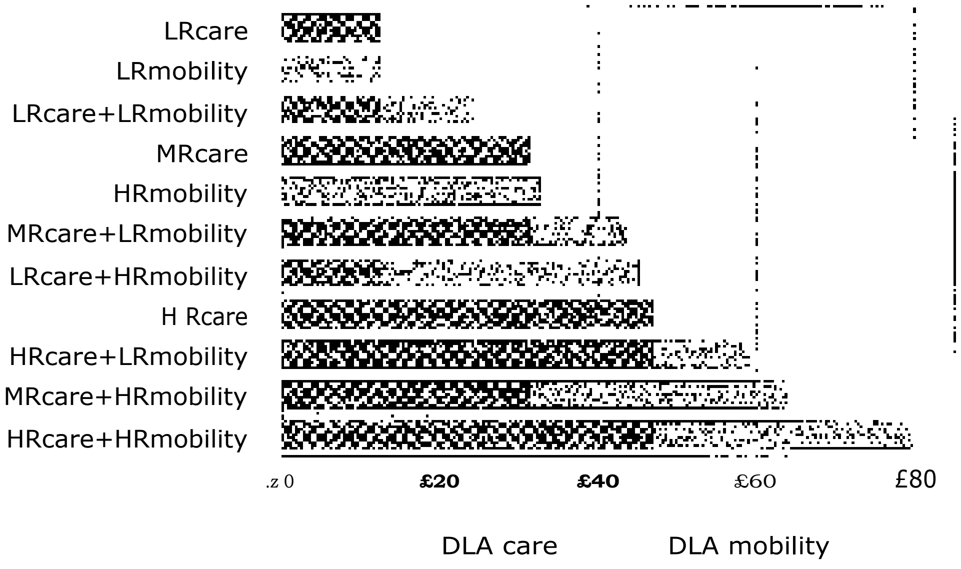
PART 1 - THE TARGETING STUDY

Structure of DLA

DLA has two components: one covering needs for help with personal care and the other for help with getting around. The care component is paid at one of three rates of benefit and the mobility component at one of two rates. Successful applicants can receive any combination of these rates in their award.

Figure S.1 Weekly rates and combinations of DLA awards (199511996)

Care component		Mobility component	
Higher rate	£46.70	Higher rate	£32.65
Middle rate	£31.20	Lower rate	£12.40
Lower rate	£12.40		



LR, MR, HR : lower, middle, higher rate

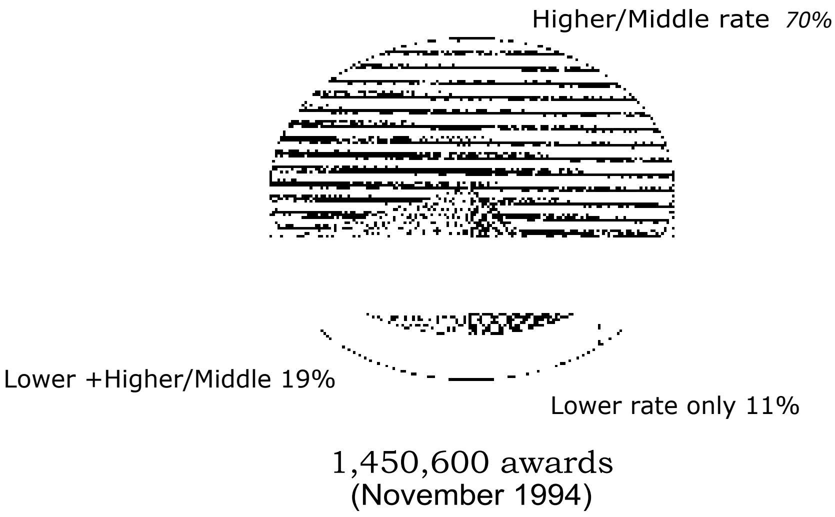
- Entitlement to the top two care rates and the higher mobility rate is based mainly on the original criteria for AA and MobA.
- Lower rate care awards are for people who need help with self-care fot part of the day or who are unable to prepare a cooked main meal.
- Lower rate mobility awards are for those who, though physically able tc walk, cannot get out and about without guidance or supervision.

Number of awards

Over 430,000 lower rate awards are paid each week - a much higher number than the original forecast (300,000). Lower rate awards are almost equally divided between the care and mobility components.

- Lower rate recipients make up less than a third of the current payload.
- Two-thirds of lower rate awards are combined with a middle or higher rate of the other component.

Figure S.2 Distribution of Awards, November 1994



Characteristics of DLA applicants

Few applicants are able to boost their incomes through paid work. Most of them say they are just managing financially but only half are satisfied with their standard of living. Illness or disability significantly curtails their ability to take part in everyday social and other activities.

A majority of households have net weekly incomes below £150. Four out of five applicants depend on social security as their main source of income. Nearly all of them have to divert part of their limited income to meet expenses that non-disabled people do not incur.

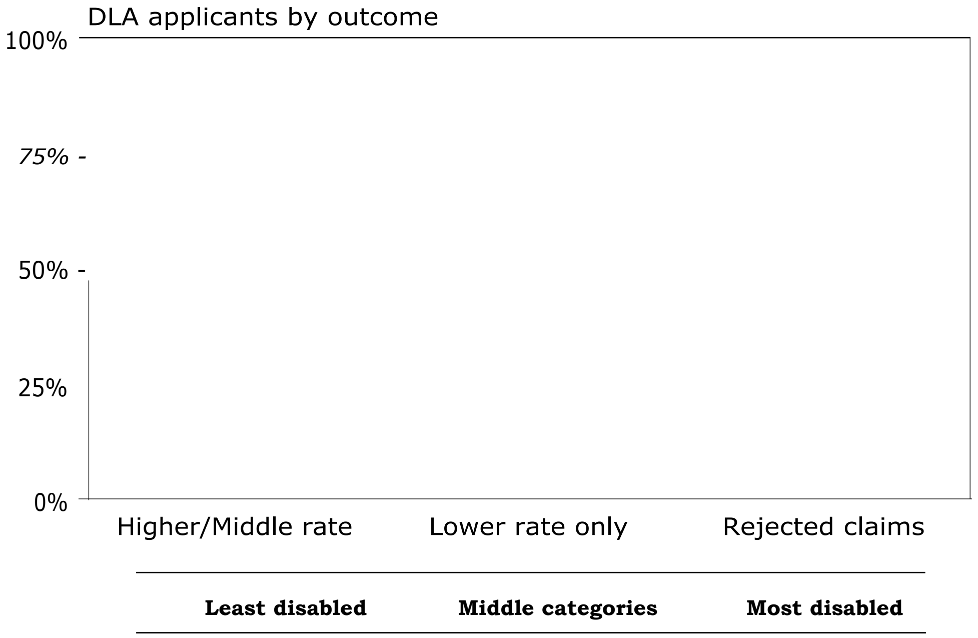
Most DLA applicants have multiple disabilities and are severely disabled. They have been disabled for around three years (median).

- Lower rate awards target applicants who become disabled earlier in life, fulfilling a policy aim of the new criteria.
- Successful applicants are more likely to report a recent improvement in their financial situation.

Severity of overall disability

The new lower rates of DLA are intended to target less severely disabled people whose care and mobility needs would fall outside the scope of the former AA and MobA. The OPCS severity scale was used to measure the severity of disability of survey respondents. The distribution of DLA awards varies little according to overall severity.

Figure S.3 DLA recipients by severity of overall diability



- Lower rate recipients are scarcely less severely disabled than higher or middle rate recipients.
- No more than one in four lower rate recipients are found in the middle of the severity range, the suggested target for lower rate awards.
- A majority of lower *rate* recipients are more severely disabled than anticipated.

Different types of disability

The new lower rate criteria identify a group of beneficiaries with particular disabilities.

Lower rate care recipients are distinguished by four types of disability:

- Personal care
- Dexterity
- Seeing
- Communication

Seeing or dexterity problems can limit or prevent the preparation of a cooked main meal. Difficulties with self-care, and communication problems arising from mental impairment or a stroke, imply needs for limited or periodic care during the day.

Four types of disability also distinguish between lower rate mobility recipients and other applicants:

- Intellectual functioning
- Behaviour
- Seeing

Intellectual and behaviour problems are associated with severe mental impairment and can imply substantial supervision needs. People with poor sight often need guidance when out and about. Fits and convulsions, or consciousness disability, also suggest a need for a companion especially when there is no warning of an attack.

- These disabilities are more prevalent and most severe among lower rate recipients than other DLA applicants.
- Lower rate recipients are less severely disabled in respect of disabilities that reflect the middle or higher rate criteria than recipients of those awards.
- Although care and supervision needs can arise from mental health problems, they may not be sufficient to attract an award, or they may not be identified in the claiming and adjudication process.

Care and mobility needs

Most lower rate recipients can be distinguished from other applicants according to the care and mobility needs they describe at interview. Their needs closely reflect the rules on entitlement to lower rate awards. The multiplicity of needs is more important than individual problems when determining eligibility for an award.

- The lower rate criteria for each component of DLA are well-defined and practical.
- They extend the scope of the former AA and MobA in line with policy aims.
- Lower rate recipients form a distinct group of beneficiaries.
- Adjudication officers are, for the most part, successful in consistently identifying those who are eligible for lower rate awards.
- There is no evidence that recipients of lower rate awards would have qualified for the old-style allowances.

The way in which individuals' needs combine shows how each component functions.

- The lower rate care criteria do not so much break new ground as bring down the level of needs that defined eligibility for the former AA.

The conditions of entitlement describe a graded, or cumulative, progression of care needs. Higher rate recipients satisfy the criteria for a middle rate award, while both higher and middle rate recipients would meet the criteria for a lower rate award.

- The guidance criteria for lower rate mobility awards define a wholly different set of needs to the walking criteria for the former MobA.

In effect, the higher and lower rate mobility awards represent two separate benefits. Failure to meet the lower rate criteria does not mean that the higher rate criteria would not be satisfied.

Nonetheless, the boundary between lower rate recipients and unsuccessful applicants is somewhat blurred. One possible reason is that the needs of some unsuccessful applicants had increased since applying for DLA. Another possibility is that the particular needs of some applicants, those with mental health problems, for example, may not be sufficient to attract an award, or they may not be identified in the claims and adjudication process. There may also be genuine difficulties adjudicating awards at the margins of eligibility.

Some applicants who claim either the care or the mobility component, but not both, are shown to have needs relevant to the component for which they do not apply. Adjudication officers may not have these needs brought to their attention in any additional evidence they use to determine such claims.

Reviews of claims and awards

Within nine months of their initial claim, 36 per cent of lower rate recipients and 50 per cent of unsuccessful claimants had their case reviewed, either because they were not happy with their initial decision or because their circumstances had changed.

Applicants who challenge the initial adjudication of claims and awards are more likely to report an increase in their care or mobility needs than those who do not.

- There is little evidence to show that increased awards arise from initially incorrect decisions.

Some applicants are frustrated by the claiming and review process.

- Around a third said that it was difficult to describe the effects of their disability on the claim form, and this could have influenced their decision to seek a review.
- One in four of those not seeking a review of their initial claim reported that their care or mobility needs had increased.

Claims and awards for children

- Most of the children for whom DLA is claimed are severely disabled.
- Children who are rejected are as severely disabled as those receiving lower rate awards.

Disabling conditions that give rise to particular needs, including medical treatments, distinguish those awarded a lower rate from other applicants. Conditions in children that attract lower rate care awards include:

- Asthma
- Eczema
- Diabetes
- Cystic fibrosis

The following conditions are more prevalent in children awarded lower rate mobility:

- Epilepsy
- Behaviour disorders
- Learning disorders
- Sensory complaints

About the targeting study

Over 1800 applicants living throughout Great Britain were interviewed during the summer of 1994. Their claims for DLA had been decided earlier that year.

The sample focused on recipients of the new lower rates, plus those who had claimed unsuccessfully. A response rate of 86 per cent was achieved.

The survey provided information chiefly on individuals' disability and their care and mobility needs. Details of their claims at the time of the initial decision and some nine months later were obtained from the DLA database.

PART 2 - THE QUALITY OF SERVICE STUDY FOR NEW CLAIMANTS

The new claiming procedure

As part of the new claiming and assessment procedures, claimants complete a two-part self-assessment form. Section 1 concerns basic biographical information about the claimant. Section 2 is optional and asks for details about their disabilities or illnesses and the effects these have on their everyday activities. Claimants are given the opportunity in the form of obtaining up to two supporting statements: one from a person who has knowledge of how their disabilities affect them, and one from a doctor or a professional with knowledge about their illness or disability. Over half of all claims are decided on the basis of the information in the claim forms. Adjudication officers can, if they deem it necessary, ask for further information, usually from the claimant's general practitioner (GP) or from a doctor contracted to the Benefits Agency (the EMP).

About the study

Two surveys were carried out between May and August 1994: the first of claimants whose claims had been decided (the `decided claims' survey), and the second of people whose claims were still with the Benefits Agency (the `claims in progress' survey). This design was chosen to allow an exploration of the effect that outcomes of claims have on expressed levels of satisfaction. Both DLA and AA claimants were included in each survey.

The `decided claims' sample comprised 1807 DLA claimants and 304 AA claimants. The `claims in progress' sample comprised 287 DLA claimants and 290 AA claimants.

Deciding to claim

- Friends and relatives were the most common source of initial information about both DLA and AA. Over a third of AA respondents said they first heard of the benefit from a health or related professional (GP, hospital, social worker or residential home) compared with just over a quarter of DLA respondents.
- Twenty-nine per cent of the DLA survey respondents and 23 per cent of the AA respondents reported that they had contacted somebody or some organisation for initial help and advice (rather than merely to request a claim pack). Nearly half of the DLA contacts and a third of the AA contacts were with the Benefits Agency. Contacts with the Agency were mainly to a local office or to one of the freephone services.
- Notwithstanding the outcome effect, both the `decided claims' and the `claims in progress' samples registered high levels of satisfaction with the service provided by the Benefits Agency at this early stage in the claiming process. This suggests that the Agency is successfully meeting the requirements of most claimants or people acting on their behalf for initial help and advice.

Completing the claim form

- The majority of claimants had no or few difficulties completing the form and found it helpful in describing their illness or disability and its effects on their everyday activities.
- However, a substantial minority of people experienced a lot of difficulties with the forms. There were problems with the content and layout of the form, such as confusing or complicated language or instructions, and lack of space for answers. People also had difficulties putting into words the ways in which their lives were affected by disability or in saying exactly what their illness or disability was.
- Claimants with certain types of disability, such as mental illnesses, experienced the most difficulty with the forms.
- Around a quarter of the DLA and AA samples said the picture they gave of themselves in the claim form was better than was actually the case.

- Most claims included at least one supporting statement. Three-quarters of statements were supplied by GPs. Adjudication officers ordered fewer reports from GPs or from EMPs when one or more supporting statements were supplied.
- Although contrary to the DSS's administrative instructions, our data suggest that awards of benefit were made on over 40 per cent of DLA claims (40 cases) that contained no supporting statements and for which no further evidence had been obtained.
- Ten per cent of the DLA sample and five per cent of the AA sample contacted the DSS for help with completing the claim form. Most contacts with the Agency were either to a local office or to one of the freephone services. The help that people obtained from the Benefits Agency in completing claim forms received very high satisfaction scores from our samples of claimants. This aspect of service therefore appeared to be working very well.

After the claim: dealings with the Benefits Agency

After a claim has been submitted and before a decision is made, the Benefits Agency might contact claimants for further information or might be contacted by them, usually for information about the progress of a claim.

- Excluding those people who did not know, 26 per cent of the DLA sample and 19 per cent of the AA sample said they had been contacted.
- Satisfaction with contacts from the Benefits Agency was comparable to the high levels associated with the earlier stages of claiming although the proportion of very satisfied respondents did not reach corresponding levels.
- Few claimants made contact with the Benefits Agency after they had submitted their claim: seven per cent of the DLA sample and five per cent of the AA sample. A local office was the most common point of contact followed by the central DLA Unit at North Fylde. Levels of reported satisfaction were lower than for earlier stages of claiming.

The EMP examination

- Around a quarter of the claimants in our samples were visited by an EMP.
- Among the DLA claimants those with chronic fatigue syndrome, spondylosis or back pain as their main disabling condition had a higher than average number of EMP examinations than other claimants. People with epilepsy or learning difficulties had the lowest rate of examinations.
- For most claimants, their personal treatment by the EMP was more important than any other aspect of the visit. As a consequence, because most respondents found the EMP polite, friendly, helpful or sympathetic they also reported generally high levels of satisfaction with the visit.

Getting the decision

All claimants are sent letters notifying them of the outcome of their claim. The letters contain standard explanations for decisions rather than detailed accounts of why a particular award was made or why a claim was rejected.

- The large majority of DLA respondents thought that the time taken to get a decision on their claim was reasonable. However, 23 per cent of the AA population said their clearance times were either `not very reasonable' or `not at all reasonable'.
- High proportions of rejected claimants said their understanding of their decision was `not good' or `none at all' (over 60 per cent for both DLA and AA samples).

- Relatively few respondents (seven per cent of the DLA sample and four per cent of the AA sample) contacted the Benefits Agency to find out more about their decision. This stage of the claiming process attracted the lowest score for satisfaction (57 per cent of the DLA sample).
- Over 60 per cent of claimants who were unhappy with their award or whose claim was rejected said they had appealed against the decision or intended to do so.

Claimants' preferences of assessment method

- Claimants who were awarded a benefit tended to prefer the method of assessment that led to the award, whether it was by form or following a medical examination. Those rejected on the form only tended to state a preference for medical assessment. However, relatively few claimants rejected after a medical said they would have preferred to have been assessed on the form only.

Analysis of overall satisfaction

- The overall levels of satisfaction reported by the DLA `decided claims' sample was 84 per cent, and for the AA sample, 73 per cent. The interpretation of these results is made difficult by the *outcome effect,* the correlation between people's responses and the outcome of their claims.
- A statistical analysis which measured the relative effects of the various aspects of claiming on overall satisfaction showed that the outcome of the claim was the only significant predictor of overall satisfaction.
- The outcome effect appears to work in two ways. First, among those claimants happy with their result there is a strong tendency to say that they were `very satisfied'. In contrast, the responses of unhappy claimants are spread along a range from `very satisfied' to `very dissatisfied'. There are claimants who will be dissatisfied with the process because they are dissatisfied with the result, but there is also a sizeable number who will give a more detached view of how the Agency dealt with their claim.
- The attempt to circumvent the problems of the outcome effect by carrying out a `claims in progress' survey has only been partially successful. The `claims in progress' sample displays what can be called a *quasi-outcome effect* which is manifested in two ways. First, the proportions of `don't know' responses are relatively high, which depresses the scores for both satisfaction and dissatisfaction. Second, relatively few respondents gave emphatic `very satisfied' or `very dissatisfied' answers to the question about overall satisfaction. This suggests that knowing the outcome of a claim polarises opinion and that until the outcome is known people tend to be more conservative in their assessments of their satisfaction.
- From the analysis of the `decided claims' data the outcome effect is less strong in the responses to questions about satisfaction with the separate aspects of claiming. Comparing satisfaction levels shows that the Agency appears to be delivering its highest quality service in giving initial advice, helping people complete the claim form and carrying out EMP visits. The contact from the Benefits Agency after the form had been submitted also gained a high satisfaction score. In contrast, responding to claimants' enquiries before and after the decision has been made had relatively high dissatisfaction scores.
- Analysis of the reasons for people's satisfaction and dissatisfaction with their contact with the Agency shows that, with the exception of the EMP visit, the substance of the contact (for example, the quality of the information, help or advice received) is cited most often. The personal treatment of people is also important but becomes the dominant concern only during an EMP visit.

- The results from this study led us to question the validity of overall satisfaction measures based on samples of people whose claims have been decided. Our conclusion is that measures of overall satisfaction are primarily an indication of people's satisfaction with the result of their claim rather than with the service provided by the Benefits Agency. As instruments of public accountability, that is, as a way of demonstrating to the public and other interested parties that the service is performing well, the use of overall satisfaction measures is probably unwarranted.

Policy ideas

A number of ideas for improving the quality of service provided to claimants were suggested by the findings. However, it was not within the remit of the research to evaluate them further.

Ideas concerning the availability of claims

- Allow GPs to hold and distribute claim packs.

Ideas concerning the claim forms

- Reassess layout and wording of Section 1 of claim pack to assist claimants more in naming and describing their disabilities or illness.
- Reassess layout and wording of Section 2 to assist claimants more in describing the effects of their condition on their everyday lives.
- Consider how claim forms could be made more relevant to people with mental illnesses.
- Consider whether and how to reduce the small number of people disadvantaged by the two-part claim form.
- Encourage more claimants to provide supporting statements as part of their claims.

Ideas concerning decision letters

- Improve quality of information about decisions provided in decision letters.
- At least offer claimants the opportunity of receiving a full explanation if required.
- Review content of decision letters to reduce the possibility that people might be discouraged from seeking a review.

Ideas concerning administration and adjudication

- Investigate why claims are awarded on the basis of forms which contain no supporting statements and where no further evidence has been collected.
- Investigate use of telephone sections by adjudication officers.
- Reassess procedures for handling enquiries from claimants after claim has been submitted.
- Investigate adjudication officers' practices in ordering EMP reports.
- Reassess clearance targets using data on claimant experiences and expectations.

These ideas reflect the need for consolidation and incremental improvement rather than for radical change. That most people in our surveys expressed satisfaction with most aspects of service provision indicate that radical change is not required.

PART 3 - THE QUALITY OF SERVICE STUDIES FOR CLAIMANTS PURSUING REVIEWS AND APPEALS

The review and appeal arrangements

Claimants unhappy with the decision on their initial claim for DLA or AA can request, on any grounds, a review of the decision within three months. Claimants unhappy with the outcome of the review have the right of appeal to an independent DAT.

About the review and appeal studies

Two surveys were carried out in May and June 1994: the first of claimants who had requested a review, and the second of claimants who had appealed to a DAT. Both surveys covered DLA and AA claimants. Interviews were carried out with 278 DLA and 322 AA claimants whose claims had been reviewed, and 188 DLA and 174 AA tribunal appellants.

The internal review

An internal review is carried out by a different adjudication officer to the one who made the original decision, on the basis of the papers used in making that decision plus any additional information that he or she deems necessary or the claimant submits.

- There was no evidence that there was a widespread inappropriate use of the review system by people making hopeless or frivolous review requests.
- Over three-quarters of the DLA and AA samples thought that the time taken to review their claim was reasonable.
- Relatively few claimants had any contact with the Benefits Agency between submitting their request and getting a decision. Roughly a third of the DLA sample and a quarter of the AA sample had any contact at all, though a few did have more than one contact.
- The overall satisfaction of claimants with the review process was strongly associated with the outcome of the review. The proportions of successful claimants who said they were satisfied were 88 per cent for DLA and 87 per cent for AA (compared with over 90 per cent of new DLA and AA claimants who were happy with their award). Around a half of all unsuccessful review claimants said they were satisfied (a comparable figure to new claimants).
- One hundred and thirty-four claimants said they were unhappy with the outcome of their review. Thirty-seven per cent of these said they would not be appealing further or were unaware that they could.

  For some claimants the internal review will have acted as a barrier to the DAT. As a result the number of DATs which would have ensued under mainstream appeal structures is reduced.

Appealing to a DAT

Claimants unhappy with the outcome of the review have the right of appeal to an independent DAT. The tribunal comprises a legally qualified Chair, a doctor (usually a GP) and a person with experience of disability or of caring for, or working with, disabled people. Appellants have the opportunity of appearing before the tribunal in person and of being represented or accompanied by another person or of providing more information about their claim.

- There was a large degree of ignorance among appellants about what happens when an appeal is lodged. Over a half of DLA appellants and nearly two-thirds of AA appellants did not know that a tribunal hearing would follow their appeal request.
- There was a sizeable minority of appellants for whom the tribunal documents were not helpful to them in understanding their case.
- Fewer than half of the appellants thought the time they waited for their hearing to take place was reasonable.
- Seventy-two per cent of DLA appellants and 63 per cent of AA appellants either attended their hearing in person or were represented by some other

person. People attending or represented were more likely to win their appeal.

- Forty per cent of the appellants who attended their hearing said they experienced some degree of discomfort or pain travelling to the tribunal premises. One in six of travelled for an hour or more.
- One in five appellants said they had problems with access into or around the tribunal building.
- The overall picture to emerge about the conduct of tribunal hearings was positive. Responses from appellants suggest that tribunal Chairs generally performed their introductory functions well and that many people were helped by the questioning of the tribunal members. Most appellants found the atmosphere friendly even though over two-thirds were nervous to some degree during the hearing. It was important to appellants that they were treated seriously and courteously by the tribunal and that they felt they had had the opportunity of saying everything they wanted to.
- The satisfaction levels of appellants with the conduct of the hearing, and their assessments about whether they had had a fair hearing, were strongly associated with the outcome of their appeal. Ninety-three per cent of successful appellants thought their hearing was fair compared with 48 per cent of unsuccessful appellants.

Policy ideas

A number of ideas for improving the quality of service provided to DLA and AA claimants who request reviews or lodge appeals were suggested by the findings. However, it was not within the remit of the research to evaluate them further.

The following ideas for improving quality of service, and for further research emerged from the study.

Ideas concerning the internal review

- Reassess the information given in official letters and other documentation about what might happen following a claimant's review request.
- Consider ways to encourage more claimants to supply medical information with their review request.

  Consider standardising the way in which medical information is collected.
- Reassess clearance targets using data on claimant experiences and expectations.

Ideas about the appeal to a DAT

- Reassess the information given in official letters and other documentation about how appeals are dealt with.
- Improve the content and presentation of tribunal documents to make them more accessible to appellants.
- Consider ways of reducing the need for some appellants to undertake long journeys to their hearing, including a review of the number and location of tribunal premises.
- Review the access into and around tribunal premises.
- Reassess clearance targets using data on claimant experiences and expectations, taking into account the effect of sources of delay outside the control of Independent Tribunal Service.
- Consider ways to encourage more people to attend their tribunal hearing.
- Provide appropriate information to appellants about the possibility of holding a domiciliary hearing.

- Continue to emphasise to tribunal members the importance to appellants of being treated seriously and courteously by them, of being allowed to say all that they want to during the hearing and of having confidence in their expertise and competence.

Ideas about further research

- Investigate the decision-making practices of adjudication officers and tribunals to understand the reasons why decisions are overturned.
- Investigate the implementation and effectiveness of the policy of matching' tribunal members to the appellants who appear before them.

The lessons for the adjudication of initial claims from this study of reviews and appeals are unclear. Further work would be needed on appeal rates and on decision making by adjudication officers carrying out reviews and by tribunals to enable us to identify how initial adjudication could be improved.

Chapter 1 Introduction

Provision for disabled people was not included in the major review of social security policy which took place in the mid-1980s. Their needs were addressed following a wide-ranging study of the circumstances of disabled adults and children, commissioned by the then Department of Health and Social Security. The OPCS surveys were carried out in 1985 and 1986 and aimed to estimate the prevalence and severity of disability and to investigate the financial and social consequences of disability, including effects on employment and mobility. Once the OPCS data became available, the Government carried out a review of disability benefits drawing on a variety of sources including disabled people and their organisations, other research studies, and proposals put forward by interested individuals and organisations, including a report of the Social Security Advisory Committee (1988).

The Government's response was published in *The Way Ahead: Benefits for Disabled People* (Department of Social Security, 1990). Two groups of disabled people with particularly low incomes were recognised: those who were capable of some paid work but whose earnings were likely to be reduced because of disability; and people whose disability was not severe enough to qualify them for the existing disability benefits but who nevertheless did have extra costs arising from their disability. Disability Working Allowance was introduced to help the first group, and Disability Living Allowance (DLA) and Attendance Allowance (AA) the second.

In this report we present the findings of two linked studies, commissioned by the Department of Social Security (DSS), designed to evaluate DLA and AA.[i] The aim of the first study was to assess the extent to which DLA was extending help to less severely disabled people. We will refer to this as the *Targeting* study. The second project was to evaluate the quality of service provided to new DLA and AA claimants and to claimants who had requested a review of their decision or had appealed to a Disability Appeal Tribunal (DAT) (referred to as the *Quality of Service* studies).

1. DLA and AA

DLA was introduced, and AA revised, in April 1992. Among other things, it was argued that the effectiveness of existing benefits to help meet the extra costs of disability was limited by the range of disabled people actually helped. Many disabled people with costs arising from their care needs were not sufficiently disabled to qualify for cash help. Others who were not independently mobile received no help with mobility needs. The Government was also concerned about improving the delivery of benefits to disabled people. Proposals for reform, therefore, identified two broad objectives: first, to extend help with care and mobility needs to people with moderate disabilities who did not qualify for existing benefits; and second, to improve the quality of service to the public through a more straightforward and transparent claims process. DLA was designed to meet these two objectives.

Interim results from an evaluation of Disability Working Allowance have been published (Rowlingson and Berthoud, 1994). The research is continuing.

Who can get DLA?

People may be able to get DLA if they are under 66 and start to need help before their 65th birthday with personal care and/or with getting around.

People may be eligible for DLA to help with **personal care** even if no one actually gives them that help. People could need financial help with personal care because they:

- need help with, for example washing, dressing, using the toilet
- need help with preparing a cooked main meal (applies only if they are over 16)
- need someone there to keep an eye on them
- need someone there during specific periods, for example, when on dialysis.

People may be eligible for help with **mobility** if they are five years of age or over, *and* they:

- cannot walk at all
- have had both legs amputated or were born without legs or feet
- have difficulties with walking
- are both deaf and blind and need someone with them when outdoors
- are severely mentally impaired with severe behavioural problems and qualify for the higher rate care component for day and night needs
- can walk but need someone with them when outdoors.

To get DLA people must normally have needed help for three months, and must be likely to need help for a further six months or more.

However, people not expected to live longer than six months because of an illness do not have to wait three months. Moreover, they qualify for help with personal care automatically, even if no help is needed when the claim is made.

DLA brings together and extends the help for people disabled before age 65 that was formerly available through AA and Mobility Allowance (MobA). These provided help to people who needed frequent attention or continual supervision or who were unable, or virtually unable, to walk. Reflecting its origins in AA and MobA, DLA comprises two components covering personal care and mobility needs respectively (see box above).

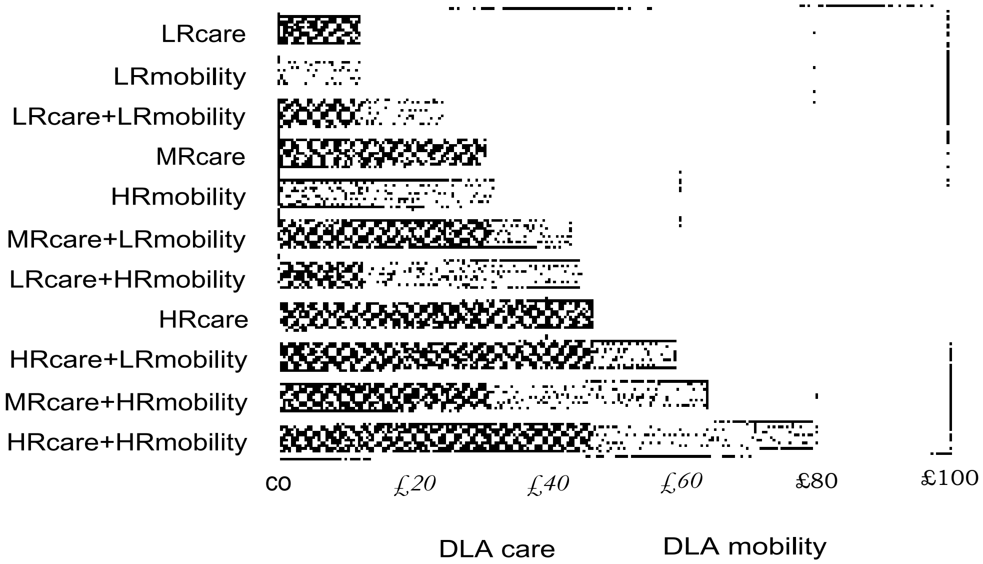
The frequency and nature of such needs are particularly important when assessing claims. Entitlement, therefore, is based on the effects of disability on a person's life, rather than the presence of a particular disabling condition. The care component is paid at three rates of benefit depending on the amount of care a person needs. The mobility component has two rates of benefit. Entitlement to the top two care rates and the higher mobility rate are based on the original criteria for AA and MobA which the OPCS surveys found to be well targeted towards the most severely disabled people (Martin and White, 1988). In addition, people who are severely mentally impaired and have severe behaviour problems are now eligible for a higher rate mobility award, providing they meet the conditions for the higher rate care component.

The lower rates of both DLA components are entirely new and were designed to provide help to an estimated 300,000 less severely disabled people whose care or mobility needs fell outside the old arrangements for AA or MobA. Lower rate care awards are for people who need help with personal care for part of the day or who are unable to prepare a cooked main meal. Lower rate mobility awards are for those who, though physically able to walk, cannot get out and about without guidance or supervision.

DLA is a non-contributory, non-means-tested, tax-free benefit. It is a weekly benefit, the amount payable being the total of the care component and mobility component awarded. Successful applicants can receive either one component only or any combination of the care (lower, middle or higher) and mobility (lower or higher) components. One of eleven combinations can be awarded, as Figure 1.1 shows.

Figure 1.1 Weekly rates and combinations of DLA awards (1995196 rates)

DLA care component		**DLA mobility component**	
Higher rate	£46.70	Higher rate	£32.65
Middle rate	£31.20	Lower rate	£12.40
Lower rate	£12.40		



LR, MR, HR : lower, middle, higher rate

AA was revised in 1992 and continues to be available for people who become disabled after age 65. The box below summarises the eligibility criteria for AA.

Who can get AA?

AA is available for people who become disabled after their 65th birthday. People may be eligible for AA if they are so severely disabled, physically and mentally, that they require (from another person):

- throughout the day, frequent attention in connection with their bodily functions, or continual supervision in order to avoid substantial danger to themselves or others *and/or*
- at night, prolonged or repeated attention in connection with their bodily functions, or, in order to avoid substantial danger to themselves or others, another person to be awake for prolonged or at frequent intervals for the purpose of watching over them.

To get AA people must normally have needed help for six months or more. However, people suffering from a terminal illness can receive an award from the date of the onset of that illness even if no help is needed when the claim is made.

AA is paid at a lower rate for people needing care during the day *or* during the night, and at a higher rate for those needing care during the day *and* during the night. In the year 1995/96 the lower rate was paid at £31.20 a week (the same as the DLA middle care rate) and the higher rate at £46.70 (the same as the DLA higher care rate)

2. The research design

All of the studies which comprised the project were based on large- or medium-scale surveys. These were carried out between June and August 1994 by Social and Community Planning Research (SCPR). Because different samples and questionnaires were used for each study (with the exception of the sample of new DLA claimants in the *Quality of Service* study which was the same as in the *Targeting* study) we have reserved detailed descriptions for each introduction to the three parts of this report.

3. Structure of the report

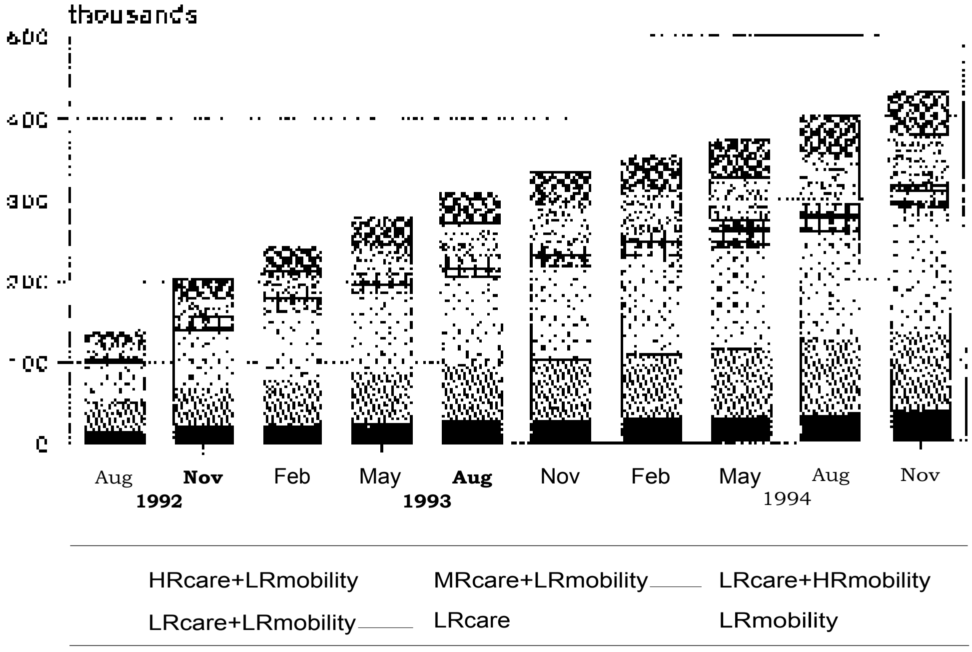
The report is divided into three parts. Part One presents the findings of the *Targeting* study which aimed to assess the extent to which DLA extends help to less severely disabled people. Parts Two and Three present the findings from the studies to evaluate the quality of service provided to new DLA and AA claimants (in Part Two), and to claimants who had requested a review of their decision or had appealed to a DAT (in Part Three). Each part contains its own introduction describing the background to each study and the methods adopted.

PART ONE
The Targeting Study

Chapter 2 Introduction to the Targeting Study

In this chapter, we describe the background to the *Targeting* study which aims to assess how well DLA is extending help to less severely disabled people. The research method is explained and implications for interpreting the findings presented later in this report are discussed. First, we describe the distribution of DLA awards focusing in particular on the new lower rate awards. We then summarise some of the key findings from the OPCS surveys that helped to shape the design of DLA. The outline of the chapters that follow in Part One of this report are described in the final section.

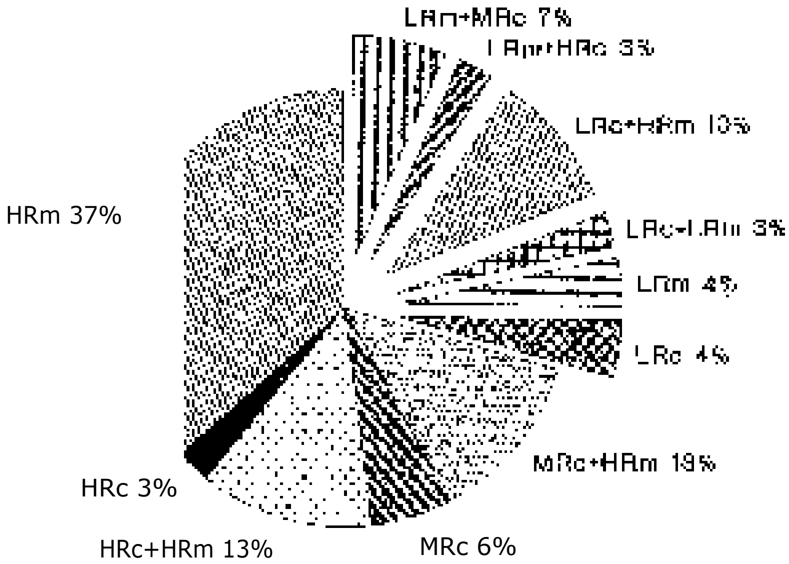
Figure 2.1 Lower rate awards in payment: 1992-94



LR, MR, HR : lower, middle, higher rate

During 1994 around 55,000 new claimants were awarded DLA each quarter. It is administered by the Benefits Agency, an executive agency of the DSS. Claims for the new lower rate awards were considered from early 1992. By August of that year, 139,000 lower rate awards were in payment. This figure increased to 430,000 in November 1994, passing the original forecast (300,000) soon after mid-1993 (Figure 2.1). Just over half of all lower rate awards (52 per cent) are for disabled people who need help with self-care.

Figure 2.2 Distribution of awards, November 1994



1,450,600 awards

LR, MR, HR : lower, middle, higher rate

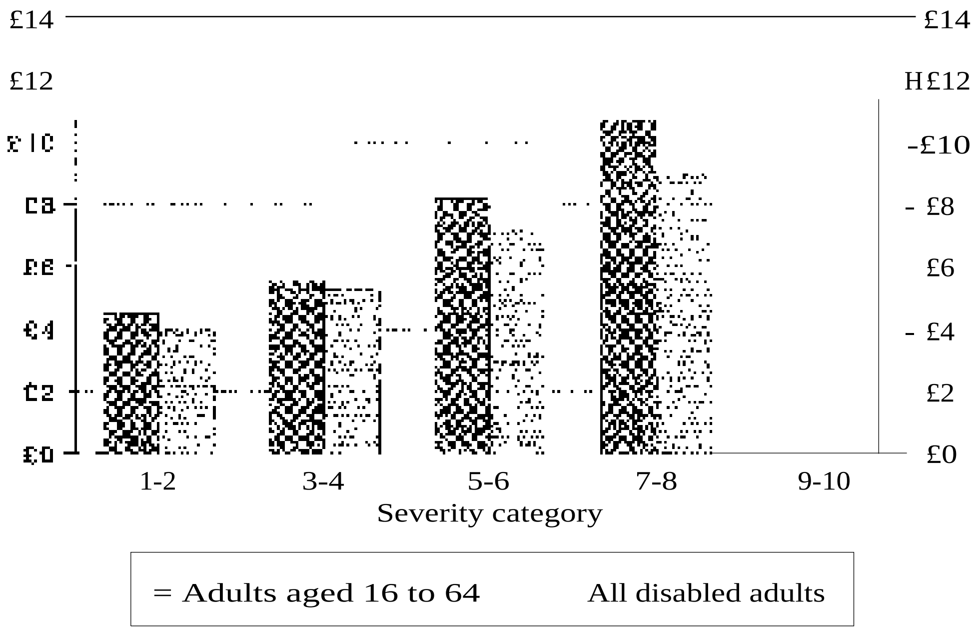
c, m : care/mobility component

Most DLA claimants receive a middle or higher rate award however. Figure 2.2 shows the total caseload towards the end of 1994. Fewer than a third of DLA recipients (430,000) receive a lower rate award. Most lower rate awards (65 per cent) are combined with a middle or higher rate award of the other component. Recipients of dual lower rate awards or single lower rate awards alone, that is individuals who formerly would not have qualified for AA or MobA, comprise around one in ten of all DLA recipients. The introduction of the new lower rates has extended additional help largely to people who received the former AA or MobA, or who now receive the equivalent rates of DLA. Details of the rules on entitlement to each rate of DLA are given in Annex 2.1 at the end of this chapter.

2.1 The OPCS disability survey

The criteria for the new lower rate awards, which aim to identify people whose disabilities are less than severe, were informed in part by the national surveys of disabled people conducted by OPCS in 1985/86. OPCS researchers developed a new scale of overall disability for these surveys (Martin *et al.,* 1988; Martin and Elliot, 1992). This scale represents the overall degree of limitation resulting from the separate effects of individual disabilities. Ten categories were defined reflecting a relative ordering of severity and multiplicity of disabilities, not clinically defined groups. Category 10 includes the most severely disabled people, category 1 the least severely disabled. (Further details of the OPCS disability measures are given in Annex 2.2.)

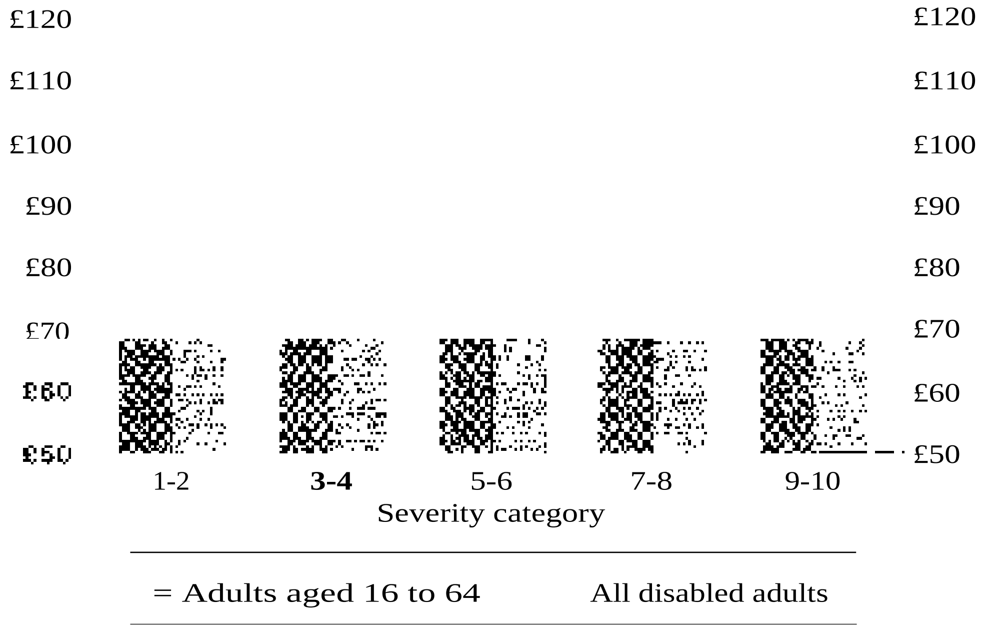
Figure 2.3 Average weekly additional disability-related expenditure by OPCS severity category



(**OPCS data, 1985** values)

In *The Way Ahead,* OPCS data on income levels and disability-related expenditure were used to show that moderately disabled people are in greatest financial need (DSS, 1990). Figure 2.3 shows, for example, that the total amount of regular additional expenditure because of disability increases with increasing severity, and the increase is more marked among non-pensioners.

Figure 2.4 Average weekly net equivalent income by OPCS severity category



(OPCS data, 1985 values)

However, there is no linear relationship between equivalent income, that is, income standardised for different families in the survey, and severity of overall disability (Figure 2.4). Average incomes are higher among the most severely disabled people, reflecting receipt of disability costs benefits, principally AA and MobA, while incomes among the least disabled are boosted by earnings. Those in severity categories 5 and 6 are worst off, although they report less additional expenditure than those in categories 7 and 8.

Further analysis of the OPCS data, relating equivalent income to benefit scales for a basic income and estimates of extra costs based on living standards, confirms that disabled people in the middle of the severity range are most disadvantaged (Berthoud *et al.,* 1993). Over half the disabled people in severity categories 5, 6 and 7 are in `poverty' according to this analysis which uses the long-term supplementary benefit scale rate for a couple as the benchmark for poverty. The new lower rates of DLA aim to target new resources on these `moderately' disabled people and to smooth the `cliff edges' in provision between severely disabled people who received AA or MobA, or both, and less severely disabled people who failed to qualify for either of these benefits (DSS, 1990; Martin and White, 1988).

2.2 Research aims

The overall aim of the research is to assess how well DLA is functioning. Part Two of this report investigates the new method of assessment and claiming introduced with DLA, and the quality of service to the public. Here the objective is to investigate the extent to which DLA is successfully extending help to less severely disabled people.

Severely disabled applicants who would have been eligible for benefit under the AA/MobA rules on entitlement should receive equivalent benefit under DLA. Although DLA extended the scope of these former benefits to people who are severely mentally impaired, policy customers wanted the *Targeting* study to focus on the new lower rates. Their primary concern was to establish whether the new criteria and assessment procedures for lower rate awards are successfully identifying moderately disabled people with care or mobility needs. The number of lower rate awards in payment soon exceeded the original forecast so a key policy question is how well such awards are targeted.

More specifically, this study addresses the following questions:

a. Do applicants awarded lower rates have disabilities that correspond to OPCS severity categories 5 and 6 as anticipated, or are they more or less severely disabled?

b. Do applicants awarded lower rates of DLA have more severe disabilities, with correspondingly greater care and mobility needs, than unsuccessful applicants?

c. Are the new lower rate criteria successfully distinguishing between people with differing levels of needs for help with personal care and mobility?

d. Are there any areas or types of disability where the lower rate criteria work less well?

The focus of the *Targeting* study, therefore, is on recipients of the new lower rate awards, plus those who have claimed unsuccessfully.

2.3 Research design and methods

A full evaluation of DLA would extend to all combinations of awards and would, in addition, investigate the association between disability, care and mobility needs, and the extra costs arising from disability. Even in respect of targeting lower rate awards, it would be useful to evaluate different measures of overall disability and to carry out experimental work on the adjudication process. The time-scale for the study was short, however, and we tailored the research design accordingly, concentrating resources on the question of how successfully lower rate awards are targeting moderately disabled people with care and mobility needs.

The policy requirement was for quantitative information broadly representative of the population of disabled people applying for DLA. To assess how well the lower rates are targeted, the care and mobility needs of successful and unsuccessful applicants must be compared. A large-scale interview survey of a sample of recent DLA applicants, stratified between lower rate awards and rejected claims, was required. The survey aimed to achieve interviews with 1000 applicants who had recently been awarded *at least* one lower rate award and a further 500 applicants rejected solely on disability grounds, that is, whose care and mobility needs were judged to be insufficient to qualify for an award.[2] Because successful applicants can receive any combination of awards, it was expected that those with a lower rate award would also include some recipients with a middle or higher rate award of the other component.

In addition, it was decided to include in the target study sample all DLA recipients who were to be interviewed as part of the separate evaluation of quality of service described in Part Two of this report. These comprised chiefly 300 recent awards at the middle or higher rate only. It was felt that boosting the number of such awards would allow wider investigation of the targeting of DLA. If overall disability and care and mobility needs increase across the boundary between unsuccessful applicants and lower rate recipients, it would be interesting to know whether the gradient continues across the lower/middle/higher rate thresholds.

A number of other considerations influenced the design for this study:

- A large sample of lower rate recipients was required because we expected that the distribution of care and mobility awards would have to be examined separately. As we have seen, DLA brings together two different benefits. Although the conditions of entitlement overlap, the care and mobility needs defined by the lower rate criteria are quite distinct. We knew from the OPCS disability surveys that these two sets of needs are unlikely to be associated (Annex 2.3). Consequently, it was necessary to ensure that sufficient numbers of both lower rate care and lower rate mobility awards were obtained so that each component could be examined separately in relation to different areas of disability and need.
- To assess how well DLA is targeted, both type and severity of disability among lower rate recipients would have to be compared with that of unsuccessful applicants. In particular, the lower rates of DLA are intended for moderately disabled people, that is those whose disabilities correspond to OPCS severity categories 5 and 6. It was necessary then, to adapt the questionnaires developed and tested by OPCS researchers in the mid-1980s. These schedules also provided the information to define 13 different types of disability, enabling us to evaluate the distribution of DLA more precisely than simply in relation to overall severity. We also included the *General Health Questionnaire,* a screening instrument for detecting psychiatric illness, because the OPCS questionnaires gave limited coverage of mental health problems (Goldberg and Williams, 1991).
- Although overall disability is a key criterion for assessing the targeting of lower rate awards, the conditions of entitlement relate specifically to care and mobility needs, not overall severity. We therefore amended some of the OPCS questions and added others to provide fuller coverage of the conditions of entitlement for DLA. This enabled us to assess the targeting of lower rate awards against a separate, survey-based assessment of individuals' care and mobility needs.
- All age groups were sampled, including children under 16 years whose disabilities were assessed differently from those of adults aged 16 and over. However, it was decided to exclude children under the age of five. Although there is no minimum age for receiving a care award, mobility

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[2] Other reasons for rejection, for example, failing to meet the prescribed qualifying periods, are not of immediate interest here.

awards are available only to applicants aged five or over. However, the main reason for excluding very young children was to simplify the survey process. OPCS researchers had, rightly, developed a separate questionnaire for assessing the disabilities of children under five years. It was felt that having two disability questionnaires, one for adults and one for children aged 5 to 15, plus a questionnaire for the *Quality of Service* studies, was quite enough for interviewers to manage.

- The research design required a sample of recent, first-time applicants because the question of targeting focused chiefly on the outcomes of new claims. It was particularly important that the information we collected about respondents' care and mobility needs reflected, as far as possible, their circumstances at the time of claiming DLA, as recorded on the application form. Sampling respondents close to the event of interest, in this case a claim for DLA, produces a `flow' sample. The main drawback is that it is not necessarily representative of previous cohorts of applicants, or the current caseload of DLA recipients.

To summarise: the design for this study focused chiefly on recent applicants whose claim for DLA resulted in a lower rate award or rejection on disability grounds. The criteria for evaluating the targeting of lower rate awards, suggested by policy makers, required replication of the methods and measures developed for the OPCS surveys of disability. In addition, information on the care and mobility needs described in the conditions of entitlement to DLA was required. Yet it is important to emphasise, as did the OPCS researchers, that the survey information we collected differs substantially from the detailed assessments of individuals' needs and circumstances typical of the adjudication of disability benefits. Our survey and the measures adopted can be used only for describing and interpreting aggregate patterns and trends across the sample as a whole, or subsamples, not for the assessment of individuals. This evaluation of the targeting of DLA awards does not test, therefore, the validity or reliability of adjudication decisions.

2.4 The sample and the survey

The sample was drawn from the computerised database of all DLA applicants. We took one week in April 1994 and, working backwards, selected all applicants who met the criteria for inclusion in the study. The sample was not clustered and covered the whole of Great Britain. Sufficient numbers were drawn to allow for any subsequent attrition. Benefit records are confidential to those administering the claim, so all potential respondents were invited to take part in the survey. In the event, 11 per cent of potential respondents for the target study opted out at this stage. The names and addresses of those not opting out were then passed to researchers at SCPR who were responsible for the fieldwork.

Following a pilot survey in late March 1994, the main fieldwork commenced towards the end of May. Almost all addresses were accounted for by the middle of July. Just over 1800 interviews were completed for the *Targeting* study, a response rate of 86 per cent. When assessed in respect of age, sex, main disabling condition and region, the achieved sample is shown to be broadly representative of the population from which it was drawn. Further details of the sample and its representativeness are given in Appendices 1 and 2 at the end of the report.

Interviews for the *Targeting* study took around {median) 45 minutes. Three out of four interviews were conducted with the adult subject on his or her own. Others were assisted by a relative or carer. In the event, six per cent of adult subjects could not take part in the interview, five per cent having a proxy and one per cent requiring an interpreter because of communication problems. In the case of DLA claims relating to children, the interviews were conducted with a parent, usually the mother.

In addition to the interview survey, valuable information was provided from two other sources. All respondents took part in the *Quality of Service* studies, and information about their experience of making a claim, the help they received, and their views on the application form and medical examination, if any, was merged with that of the *Targeting* study. Second, details of individuals' claims held by the Benefits Agency were also combined with the *Targeting* survey data. This information covers chiefly the availability of additional medical evidence to decide each claim, applicants' main disabling condition, the outcome of claims and level of awards, and reasons for the initial decisions. In November 1994, Benefits Agency staff returned to our sample on the DLA database and extracted details of the current status of respondents' claims, enabling us to chart changes over a nine-month period.

2.5 Outline of the *Targeting* study

Part One of this report presents the findings of a study which evaluates the targeting of lower rate DLA awards. An important question is how well the new lower rate criteria perform in identifying a distinct group of beneficiaries and whether applicants are consistently targeted.

The next chapter describes the demographic characteristics, socio-economic circumstances, disabling conditions and disabilities of the sample of adult claimants we interviewed. It sets these within the context of the policy considerations that led to DLA and draws comparisons with the population of disabled people in Great Britain. Chapters 4 to 7 investigate the targeting of lower rate awards on adult claimants. In Chapter 4, we look at the distribution of DLA awards in relation to severity of overall disability and investigate the extent to which lower rate recipients are assigned to the middle categories of the severity range. The distribution of lower rate awards is examined in relation to the severity of different types of disability in Chapter 5. Here the aim is to discover whether lower rate recipients are distinguished from other DLA applicants according to the prevalence and severity of disabilities which reflect the care and mobility needs described in the conditions of entitlement. In Chapter 6, the survey assessment of respondents' care and mobility needs are used to predict lower rate awards. Observed and predicted outcomes of applications for DLA are then compared to investigate the extent to which initial awards are appropriately targeted. Because disability is rarely a constant, unchanging, experience the question of changing needs and the retargeting of awards is addressed in Chapter 7. Factors associated with individuals' decisions to challenge the outcome of their claim for DLA are identified and changes in claims and awards are related to their changing circumstances. The outcome of claims made on behalf of children are examined in Chapter 8 and focuses on the distribution of DLA awards in relation to their disabling conditions and disabilities.

2.6 Note on the presentation of tables in Part One of the report

Percentages are rounded to the nearest whole number and as a result may sum to 99 or 101. Percentages less than one are shown as O. Cells with no cases are shown by ` ' . Base numbers are given in *italics* and may vary because of missing data. SD = standard deviation.

ANNEX 2.1

Summary of the qualifying conditions for DLA

Rate	**Care component**
Lower	Attention with bodily functions for a significant portion of the day, *or* Aged 16 or over and unable to prepare a cooked main meal.
Middle	Needs frequent attention with bodily functions throughout the day, or Needs continual supervision throughout the day to avoid substantial danger to themselves or others, or Needs someone to be awake during the night for a prolonged period of time, or at frequent intervals, in order to avoid substantial danger to themselves or others.
Higher	Payable if one of the middle rate day-time conditions *and* one of the night-time middle rate conditions are satisfied.

Rate	**Mobility component**
Lower	Can walk but needs someone to provide them with guidance or supervision for most of the time when outdoors in unfamiliar places.
Higher	Payable if a person: • is unable or virtually unable to walk, *or* • has to exert themself to walk to such an extent that it would constitute a danger to life or would be likely to lead to a serious deterioration in health, or • has had both legs amputated at or above the ankle, *or* • was born without legs or feet, or • is both deaf and blind and needs someone with them outdoors, or • is severely mentally impaired, displays severe behaviour problems and qualifies for the higher rate care component.

Children under 16 must need substantially more attention or supervision than a child of the same age normally needs. The mobility component is not available for children under five.

For a comprehensive, accessible account of the conditions of entitlement, see *The Disability Rights Handbook,* published annually by the Disability Alliance.

ANNEX 2.2

OPCS measures of disability

For their surveys, the OPCS researchers adopted the definition of disability recommended by the World Health Organisation (WHO), namely:

> Any restriction or lack (resulting from an impairment of the body or mind) of ability to perform an activity in the manner or within the range considered normal for a human being. (WHO, 1980)

This definition covers difficulties with ordinary activities: carrying or reaching for things, speaking to and understanding others, reading a newspaper or watching television, handling money, remembering things and so on. In other words, it focuses on what people cannot do, on individuals' functional limitations. The WHO model further suggests that impairment and disability lead to the disadvantages that disabled people experience.

Using information from their surveys, and the consensus reached by panels of judges which included health professionals, disabled people and their carers, the OPCS researchers devised scales for 13 different areas of disability. These are listed below. The higher the score, the more severe disability is judged to be. A score of zero indicates that the disability does not reach the minimum threshold of severity.

Type of disability	Severity score	Scale points
Locomotion	0, 0.5 to 11.5	14
Reaching and stretching	0, 1.0 to 9.5	11
Dexterity	0, 0.5 to 10.5	12
Personal care	0, 1.0 to 11.0	7
Continence	0, 1.0 to 11.5	12
Seeing	0, 0.5 to 12.0	10
Hearing	0, 0.5 to 11.0	9
Communication	0, 1.0 to 12.0	6
Behaviour	0, 0.5 to 10.5	9
Intellectual functioning	0, 1.0 to 13.0	12
Consciousness	0, 0.5 to 12.5	15
Eating, drinking and digestion	0, 0.5	2
Disfigurement	0, 0.5	2

Next, individuals' disability scores were weighted and combined to assign them to a ten-point scale of overall severity. To do this, the OPCS researchers first fitted a model to individuals' three highest, non-zero, severity scores from the 13 areas of disability. The three scores are combined according to the model:

highest score + 0.4 (second highest) + 0.3 (third highest) to produce a single severity score in the range 0.5 to 21.4. These severity scores were then grouped into ten categories as follows:

Severity category	**Weighted severity score**
10 (most severe)	19-21.40
9	17-18.95
8	15-16.95
7	13-14.95
6	11-12.95
5	9-10.95
4	7-8.95
3	5-6.95
2	3-4.95
1 (least severe)	0.5-2.95

Individuals without at least one non-zero score in the 13 areas of disability were excluded from the OPCS prevalence estimates because they fall below the severity threshold above which people were deemed to be disabled. Such individuals may nevertheless apply for DLA. To accommodate them we added a further category to the OPCS scale of overall severity, represented by zero. Further details of the OPCS measures of disability, including the concepts and methods used in the assessment of disability, and the use of panels of judges to scale severity levels, are given in Martin *et al.* (1988).

The WHO model underlying the OPCS scales represents a medical view of disability which focuses on individual capabilities rather than on the restrictions imposed by the social, economic and physical environments (Barnes, 1991; Oliver, 1990). Not surprisingly, the findings of the OPCS disability surveys have been criticised in relation to the measurement of disability, the ascertainment of extra costs arising from disability, and the scaling of childhood disability (Abberley, 1991; Berthoud *et al.,* 1993; Loughran *et al.,* 1992; Thompson *et al.,* 1990). Despite this, the OPCS scales have been used successfully in other large-scale surveys, research on employment and handicap, for example (Prescott-Clarke, 1990).

To evaluate the targeting of lower rate DLA awards, this study expressly required replication of the methods and measures developed for the OPCS surveys of disability. It was beyond the scope of this study to develop and test new measures of disability; nor could we contribute directly to the evaluation of the OPCS measures. However, our study highlights the limitations of a global scale of overall disability as an evaluative as opposed to a descriptive instrument. Nevertheless, it shows that some of the individual scales of different types of disability are remarkably good proxies for many of the care and mobility needs that determine the outcome of a claim for DLA. Components of the OPCS scale of overall disability prove to be good predictors of DLA entitlement.

ANNEX 2.3

Personal care and locomotion disabilities and overall severity

As part of the preparatory work for this study, we carried out secondary analysis of data from the OPCS survey of disabled adults living in private households (Martin *et al.,* 1988). We were particularly interested in the relationships between difficulties with self-care or mobility and severity of overall disability among adults under pension age. As proxy measures for care and mobility needs we used the OPCS scales of personal care disability and locomotion disability.

The findings suggest that it is unlikely that lower rate DLA awards would be shown to target less severely disabled people as measured by the OPCS scale. The reasons stem from the complex ways in which disabilities, and care or mobility needs, combine in individuals. Not surprisingly, neither the structure of DLA nor the overall severity scale adequately represents this complexity:

a. DLA comprises two distinct components with quite separate conditions of entitlement. According to the OPCS survey, personal care and locomotion disability scores are not strongly correlated and predictions from one to the other are very imprecise.[3] In other words, care and mobility needs are not necessarily found together; care needs cannot be inferred from mobility needs, or the other way round. As a consequence, applicants who are assessed as severely disabled enough to qualify for a higher rate award of one component, may be awarded the other at a lower rate, or not at all, because their disabilities, though severe, do not create the needs covered by the conditions of entitlement. While such cases can only weaken the hypothesised relationship between DLA outcomes and severity of overall disability, they do not necessarily imply that lower rate awards are poorly targeted.

b. As we have seen in Annex 2.2, the OPCS scale of overall severity is derived from the severity ratings of up to three different types of disability. These may or may not reflect the conditions of entitlement to a DLA award, so there will be no necessary relationship between overall severity and care or mobility needs. Thus, Table 2.1 shows that personal care and locomotion disabilities are not strongly associated with overall severity.[4] This suggests that, on its own, the OPCS scale of overall severity is an inadequate criterion for evaluating the targeting of DLA awards. If severity of overall disability does not distinguish the intensity or frequency of care or mobility needs, we cannot expect DLA, which is based on an assessment of those needs, to be precisely targeted in relation to the OPCS severity scale.

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[3] Including all individuals with a personal care or locomotion disability (n = 2656), the correlation between the two sets of scores is $r = 0.32$, or variance explained $r^2 = 0.10$. When predicting personal care scores from locomotion scores, the standard error of estimate is 3.8, that is a 95 per cent confidence interval of ±7.5 for a scale ranging from 0 to 11.0. The standard error is 2.8 when predicting locomotion scores from personal care scores, a 95 per cent confidence interval of ±5.5 for the scale 0 to 11.5

eta' in Table 2.1 can be interpreted as the proportion of the total variability in disability scores that can be accounted for by knowing the categories of the OPCS severity scale.

Table 2.1 Severity of personal care and locomotion disability by OPCS severity categories

Severity category	**Personal care disability mean (SD)**	**Locomotion disability mean (SD)**	**Base**
	0.1 (0.3)	0.5 (1.0)	*996*
2	0.2 (0.6)	2.5 (1.3)	*588*
3	0.3 (0.9)	1.9 (2.4)	*559*
4	0.8 (1.8)	2.3 (2.6)	*551*
5	1.5 (2.8)	3.2 (3.2)	*512*
6	2.4 (3.6)	3.7 (3.4)	*366*
7	4.5 (4.5)	4.5 (3.6)	*281*
8	6.9 (4.6)	5.7 (3.7)	*221*
9	9.6 (3.2)	7.8 (3.6)	*158*
10	10.4 (2.3)	9.2 (3.8)	*50*
Total	1.7 (3.5)	2.7 (3.1)	*4286*
eta-'	0.54	0.35	

Source: OPCS data on disabled adults aged 16-64 years living in private households.

The implications for this evaluation are twofold. First, any evaluative criteria which aim to represent the set of needs and circumstances covered by one component of DLA should not be applied to the distribution of awards of the other component. In effect, the care and mobility components should be treated as two distinct benefits when evaluating the targeting of lower rate awards against disability-related criteria. Second, the severity of different types of disability should provide a more useful criterion, than severity of overall disability, for evaluating the targeting of lower rate awards on less severely disabled people. Lack of a relationship between the distribution of lower rate awards and severity of overall disability does not necessarily mean that the new lower rate conditions are unsuccessful in fulfilling policy makers' intentions.

Chapter 3 Recent DLA Applicants: Sample Characteristics

In this chapter we describe the composition of the adult sample in terms of basic demographic characteristics and socio-economic circumstances. This includes an examination of sources and levels of income, respondents' subjective views of their financial situation, and additional expenditure arising from disability. The nature of their disabling conditions and the severity and types of disability are also described, including evidence of the degree of social handicap or disadvantage.

The chief aim is to provide a context for examining the distribution of DLA awards in later chapters. In addition, the description of the sample is set alongside some of the discussion in *The Way Ahead* which led to the introduction of DLA (DSS, 1990). Where appropriate, comparisons between the sample and the OPCS surveys are also drawn. These show whether, and in what ways, DLA applicants differ from the disabled population as a whole.

3.1 Rate and length of award

Table 3.1 Structure of the adult sample

Result of claim	(N)	(%)
Higher/middle rate only	282	17
Lower rate plus higher/middle rate	451	28
Lower rate only	439	27
Unsuccessful applicants	454	28
Total	1626	100

Source: DLA database.

The sample of adult claimants comprises 1626 respondents. These include 890 respondents with at least one lower rate award and 454 whose claim for DLA had been rejected on disability grounds. An additional 282 respondents received middle or higher rate awards only. Among the lower rate recipients, 451 (51 per cent) received a middle or higher rate of the other component, 115 (13 per cent) received a dual lower rate award, and 324 (36 per cent) received only one lower rate. Table 3.1 shows the structure of the adult sample.

Table 3.2 Sample distribution of DLA awards

	Mobility component				
Care component	**Higher rate mobility (N)**	**Lower rate mobility (N)**	**Rejected claims (N)**	**Not claimed (N)**	**Total** (N)
Higher rate care	20	38	1	1	60
Middle rate care	60	104	15	2	181
Lower rate care	309	115	194	81	699
Rejected claims	67	23	265	19	374
Not claimed	116	26	170		312
Total	572	306	645	103	1626

Source: DLA database.

Table 3.2 shows further the distribution of awards in the sample when it was drawn in March 1994. Altogether there were 1,005 lower rate awards to 890 respondents. Of these, 66 per cent (584) had been awarded lower rate care only, and 21 per cent (191) lower rate mobility only. The remaining 13 per cent (115) received dual lower rate awards.

Respondents not receiving one of the DLA components are classified in two ways: those who were `rejected' as not satisfying the disability conditions and those who had `not claimed' the particular component. The latter respondents are so classified because they had not completed the section of the claim form relating to the component in question. Where applicants complete the claim form for one component only, adjudication officers are instructed to determine the claim on the basis of both components if the evidence suggests that there is, or may be, entitlement to the other component. Where there is no evidence that entitlement exists to the other component, the officer need only consider the component for which evidence is provided.

Overall, 312 respondents had not applied for the care component and 103 had not applied for the mobility component. The disproportion between the two components in the number of non-claimants might reflect the differing prevalence of care and mobility needs in the disabled population. Whatever the reason, the group of non-claimants is problematic for the analysis because we do not know who was actually considered for the component for which they did not apply and were then rejected, and who was not considered at all. Nor do we know whether they would have been rejected on disability grounds had they completed both parts of the claim form. Non-claimants, therefore, are retained as a separate analytical category.

When an application for DLA is successful, the adjudication officer can make the award for life or for a fixed period, after which the award will be reviewed. Fixed term awards apply only if the evidence suggests that care or mobility needs will *decrease.* In fact, DLA awards are typically for life, reflected in the outcomes for two-thirds of the respondents in this survey. Fixed term awards were said to be typically for one, two or three years, the minimum period being six months. Three-quarters of awards at the lower rate only were for life, compared with 60 per cent of those containing a middle or higher rate award.

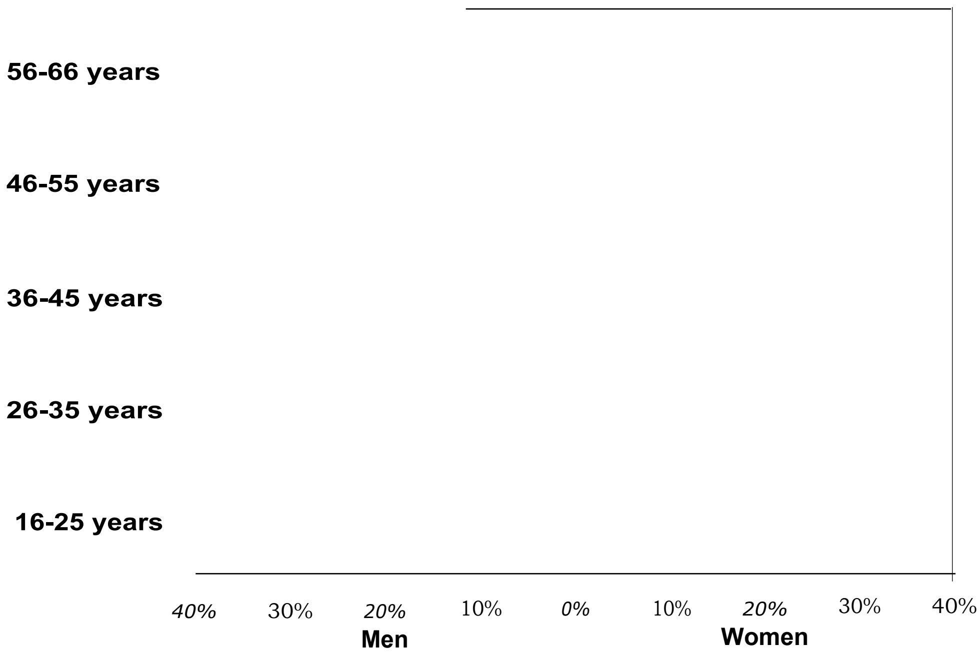
Clearly, the achieved sample reflects the study's focus on the targeting of lower rate awards and the boundary between lower rate recipients and unsuccessful applicants. It is a stratified sample of recent applicants, as described in Chapter 2. No claim can be made, therefore, that it is representative of all recent applicants for DLA. Nor can it be claimed that the sample of recipients is representative of the caseload of all DLA beneficiaries. However, the sample is broadly representative of applicants who were awarded one or both lower rate components of DLA in the first four months of 1994. Further discussion of the representativeness of the sample in relation to the age, sex, region and main disabling condition of respondents can be found in Appendix 2.

Of particular interest to this study are those who would not have qualified for the former attendance or mobility allowances, that is, those receiving only lower rate awards. In the remainder of this chapter, therefore, respondents are divided into three groups: those receiving any riddle or higher rate award (733) irrespective of whether one component is awarded at the lower rate; those receiving lower rate awards only (439); and those whose application was disallowed altogether (454). This grouping combines the first two categories of Table 3.1.

3.2 Age and sex

For social security purposes, adults are usually defined as 16 or over. Adults can claim DLA if they are under 66 and start to need help before their 65th birthday. In the event, the sample covers the full adult age range for DLA awards although a few respondents had turned 66 between applying for DLA and the time of their interview.

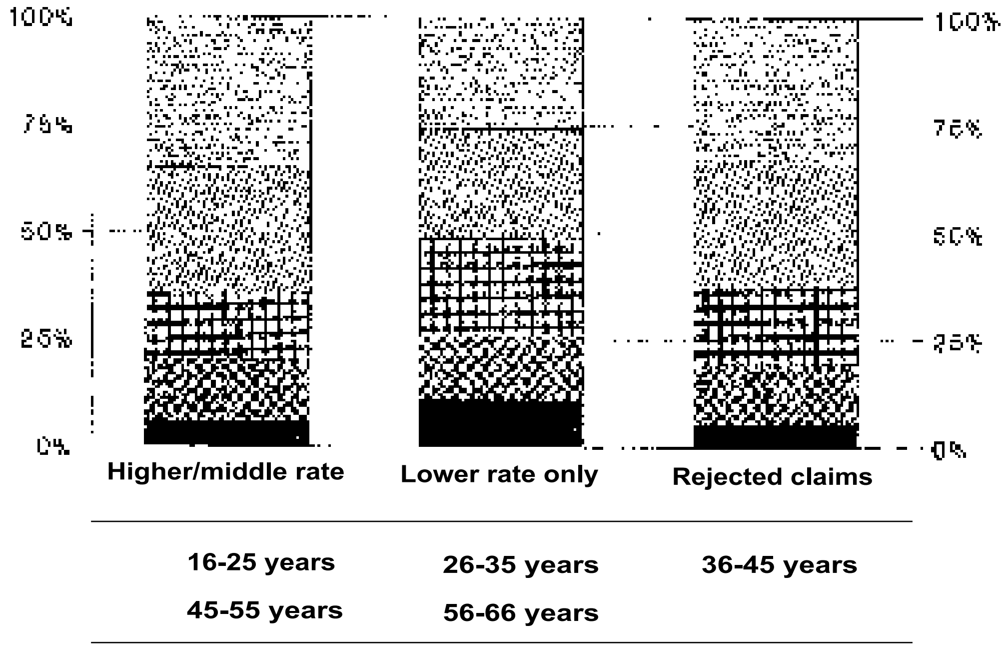
Figure 3.1 Age distribution for men and women



The average age of respondents was 47 years (SD 12.6) and there was little difference between men and women. Around 60 per cent of the sample was over 45 years and a third over 55, reflecting the association of disability with age (Figure 3.1). There were slightly more women than men, 53 and 47 per cent respectively. However, there were more men than women in the oldest age group: 36 per cent of men compared with 29 per cent of women were over 55. Compared with disabled adults under pension age in the British population, these DLA applicants were slightly younger on the whole, with over 10 per cent fewer in the 56-66 year age group (Martin and White, 1988).

Figure 3.2 shows further that lower rate recipients tend to be younger on the whole than other applicants: almost half were aged 45 or under. By comparison, 64 per cent of higher or middle rate recipients, and 62 per cent of unsuccessful applicants, were over 45 years. Men predominated among unsuccessful applicants: 54 per cent were men compared with 44 per cent of higher or middle rate recipients, and 45 per cent of lower rate recipients.

Figure 3.2 DLA *awards* by *age*

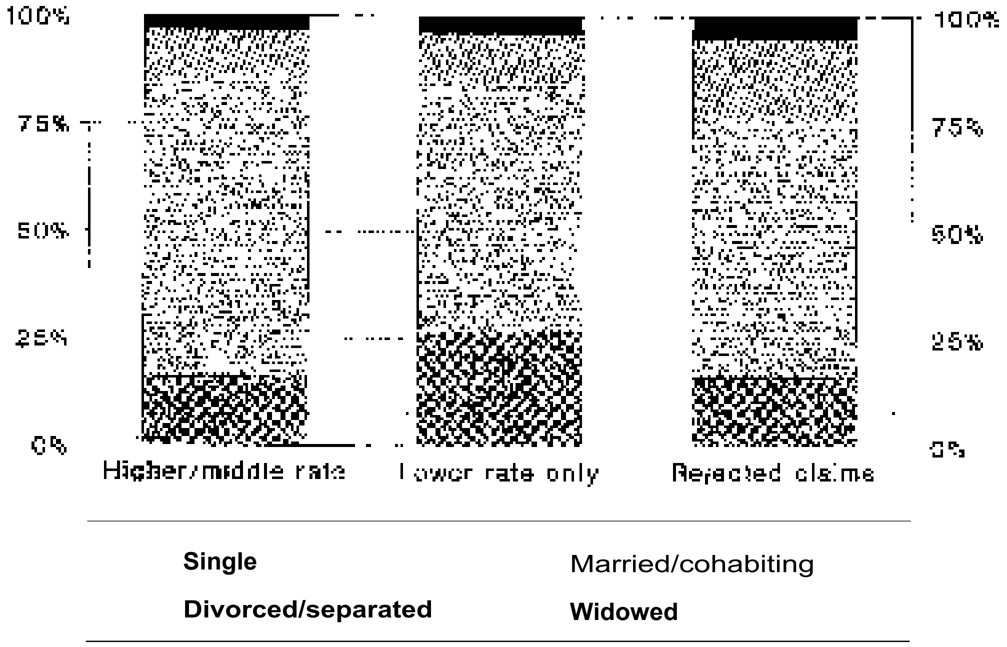


3.3 Marital status

Two-thirds of respondents said they were married or living as married, 19 per cent were single, 13 per cent divorced or separated, and four per cent widowed. These proportions are broadly similar to those for all disabled adults under pension age (Martin and White, 1988).

Figure 3.3 shows that there were more married respondents among those with a middle or higher rate award and more single respondents among those awarded DLA at the lower rate only. By comparison, there were more divorced and separated respondents among those whose claims had been unsuccessful.

Figure 3.3 Marital status



3.4 Residence, tenure and household composition

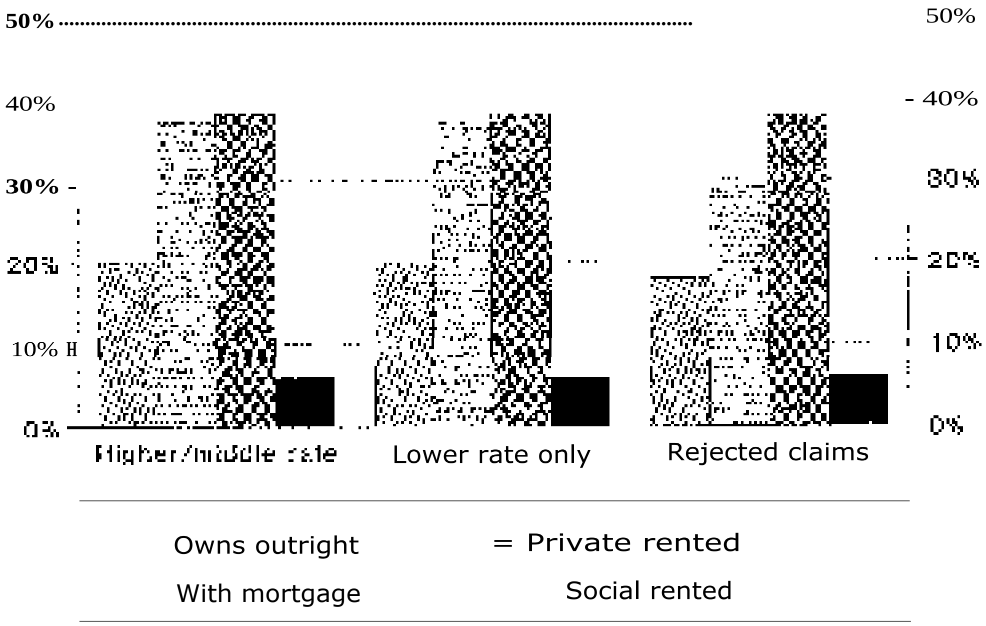
Nearly all respondents, 97 per cent, were living in private households. The remaining 56 individuals lived in a variety of communal establishments, chiefly residential homes, hostels and group homes, or were temporarily in hospital. Just over half of those in private households were living in owner-occupied housing, one-third in local authority housing and six per cent each in housing association or privately rented property. Differences between DLA outcomes were small. However, unsuccessful applicants were less likely to be living in owner-occupied housing and more likely to be renting from a local authority or housing association (Figure 3.4). The overall proportions of those living in owner-occupied dwellings or rented accommodation, 53 and 47 per cent respectively, are similar to all disabled adults under pension age (Martin and White, 1988).

Table 3.3 Household composition (adults living in private households)

Living arrangement	**Higher/middle rate recipients** (%)	**Lower rate recipients** (%)	**Unsuccessful applicants** (%)	All (%)
Lives alone	13	14	21	15
Lives with partner only	35	27	26	30
Lives with partner and others	37	34	36	36
Lives with other relatives	13	22	17	16
Lives with non-relatives	2	3	2	3
Base (= 100%)	707	*416*	*440*	*1563*

Table 3.3 shows that a small minority of respondents lived alone. Most lived with a partner, either on their own or with other family or household members. Fewer DLA recipients than unsuccessful applicants lived alone, as might be expected among those with appreciable care or mobility needs.

Figure 3.4 Housing tenure (adults living private households)



3.5 Ethnicity

Ninety-three per cent of respondents described themselves as white. Two per cent each were Indian (38), black Caribbean (30) and from other Asian cultures (28). These proportions did not vary across DLA outcomes.

3.6 Social disadvantage

The exclusion of disabled people from mainstream society is well documented (Barnes, 1991) and in *The Way Ahead* it was recognised that the social security system has a role to play in promoting their social integration and personal autonomy (DSS, 1990). It was decided to investigate the extent to which respondents felt unable to participate in, and maintain, social relationships and everyday activities because of illness or disability. To do this we used a well-known scale, the SF 36, of health outcomes (Jenkinson *et al.*, 1993). This covers eight dimensions. We focused on those which describe the individual's normal role and usual social activities, exploring the extent to which physical health or emotional problems interfered with work or other daily activities. Each scale ranges from 0 (worst possible health state measured by the questionnaire) to 100 (best possible health state). The results are summarised in Table 3.4.

Table 3.4 Social disadvantage

SP 36 Concepts	**Higher/middle rate recipients mean (SD)**	**Lower rate recipients mean (SD)**	**Unsuccessful applicants mean (SD)**	**All mean (SD)**
Physical role limitations	11.8	22.1	9.3	13.8
	(26.5)	(36.7)	(23.2)	(29.2)
Emotional role limitations	47.0	52.2	38.7	46.1
	(46.4)	(46.4)	(44.9)	(46.3)
Social functioning	30.9	41.9	31.7	34.1
	(26.4)	(32.0)	(25.7)	(28.2)
Base	724	433	449	1606

The findings show considerable variation in the ability of respondents to fulfil their usual role and participate in normal social activities. On the whole, lower rate recipients are somewhat less disadvantaged than other applicants for DLA. When standardised for age and sex, however, all DLA applicants, irrespective of outcome, are much more disadvantaged than adults in the general population. Normative scores for the three dimensions considered here range from 80 to 90 on average for adults of working age in the British population (Jenkinson *et al.*, 1993). One interpretation is that DLA is targeting people who are severely disadvantaged because of their care and mobility needs.

3.7 Economic activity

One of the arguments for introducing the new lower rates of DLA, discussed in *The Way Ahead,* is that people in the middle severity categories were less likely to be able to increase their incomes by earnings from employment. Less severely disabled people of working age were most likely to be in paid work while the most severely disabled people were more likely to be receiving AA or MobA (DSS 1990). According to the OPCS disability surveys, almost one in three disabled adults under pension age and one in four of those in severity categories 5 and 6 had a paid job in 1985 (Martin and White, 1988). Employment levels among the DLA applicants we interviewed were even lower.

Table 3.5 Economic activity

Employment status	**Higherlmiddle rate recipients** (%)	**Lower rate recipients** (%)	**Unsuccessful applicants** CYO	**All** (%)
In work	8	13	7	9
Seeking work	3	6	8	5
Receiving benefit as sick or incapable of work	71	61	68	68
Retired	13	11	10	11
Housewife	4	6	7	5
Full time education or training	1	3	1	2
Base (=100%)	700	413	433	1546

Table 3.5 shows the economic activity of respondents, distinguishing between people who were in paid work and those who were or were not seeking employment. One in seven respondents was economically active according to usual definitions, that is, in paid work (nine per cent) or actively seeking work (five per cent). Perhaps the chief reason for the difference in working status between DLA applicants and the population of disabled people under pension age is that the former are more severely disabled (see below). Occupational handicap generally increases with overall severity.

The majority of respondents, more than two-thirds overall, said they were receiving benefit because of long-term illness or incapacity for work. A further 11 per cent were retired and five per cent were housewives. Slightly more lower rate recipients were working and, as a consequence, they were somewhat less likely than other respondents to be receiving sickness or incapacity benefits. The proportion of retired individuals is highest for middle or higher rate recipients and lowest for unsuccessful applicants.

3.8 Sources and levels of income

It was not possible to collect more than summary information about income levels without increasing interview times unduly. Respondents were first asked to specify the main source of their personal income: whether state benefits, earnings, occupational pension or other. They were then invited to indicate the band within which their usual net weekly income falls. As we shall see, this approach does not necessarily produce accurate estimates.

Figure 3.5 Main source of DLA applicants' income (living in private households)

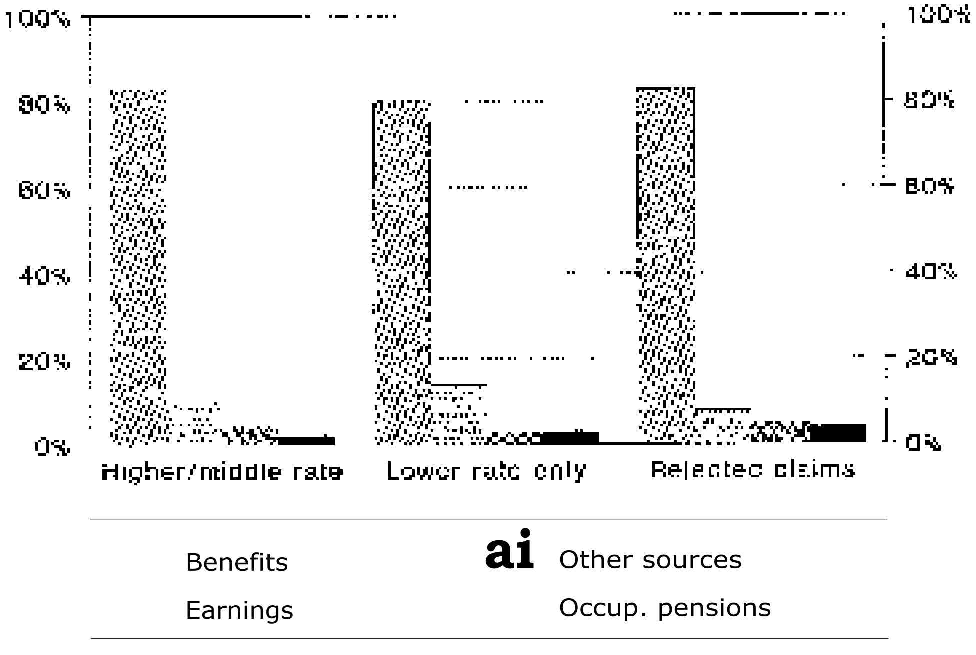


Figure 3.5 shows that over 80 per cent of respondents said that state benefits were their main source of income. Eleven per cent had income mainly from earnings, four per cent from occupational pensions and three per cent from other sources. Differences between DLA outcomes are small, though slightly more lower rate recipients had incomes mainly from earnings, reflecting a higher proportion in paid work. Largely because the vast majority of respondents had income mainly from state benefits, overall income levels are relatively low. Around one in five each had less than £50 per week, £50 to £74 per week, £75 to £99 per week, or between £100 and £149 per week (Table 3.6). More middle and higher rate recipients had

personal incomes in the higher bands, partly reflecting the rate of their DLA award. However, unless respondents were not receiving all the benefits to which they were entitled, it is possible that some of them underestimated their incomes, possibly not regarding DLA as `income'. For example, 19 per cent of higher or middle rate recipients said they received less than £50 a week yet receipt of any other benefits (see below), particularly Income Support in addition to DLA, should bring their incomes above this level.

Table 3.6 Income levels of DLA applicants (living in private households)

Income band	**Higher/middle rate recipients** (%)	**Lower rate recipients** (%)	**Unsuccessful applicants** (%)	All (%)
Less than £50	19	26	18	21
£50 to £74	16	23	31	22
£75 to £99	16	18	22	18
£100 to £149	27	23	18	24
£150 to £199	14	6	7	10
£200 to £249	5	2	2	3
£250 and over	3	2	3	3
Base (= lOt?	*660*	*398*	*408*	*1466*

Figure 3.6 Main source of an come (private households only)

When personal income is combined with that of a partner, more respondents said that earnings were the main source of `family' income (Figure 3.6). Nonetheless this was the case for only a quarter of the sample. Overall, two-thirds relied on benefits as the main source of `family' income, more so among unsuccessful applicants.

Table 3.7 Level of `family' income (private households only)

Income band	Higher/middle rate recipients (%)	Lower rate recipients (%)	Unsuccessful applicants (%)	All (%)
Less than £50	6	7	10	8
£50 to £74	8	19	23	15
£75 to £99	12	17	22	16
£10O to E149	29	23	22	25
£150 to E199	20	16	11	17
£200 to £249	10	11	6	9
£250 and over	14	8	6	10
Base (= 100%)	*636*	*385*	*405*	*1426*

Table 3.7 shows that 64 per cent of estimated `family' incomes fell below EIS() per week. Unsuccessful applicants were less likely to have weekly `family' incomes in the higher bands.

Table 3.8 Proportion of respondents receiving each state benefit

State benefit	Higher/middle rate recipients (%)	Lower rate recipients (%)	Unsuccessful applicants (%)	All (%)
Income Support	33	36	38	35
Invalidity Benefit	33	23	41	33
Council Tax Benefit	27	27	32	28
Housing Benefit	25	25	32	27
Child Benefit	18	19	21	19
Retirement Pension	9	8	7	8
Severe Disablement Allowance	8	6	3	6
Sickness Benefit	4	5	3	4
Industrial Injuries Benefit	4	3	3	4
Invalid Care Allowance	4	3	1	3
Other	5	5	7	6
None of the above	17	21	10	16
Base (= 100%)	*714*	*423*	*446*	*1583*

Percentages sum to more than 100 because some people receive more than one benefit.

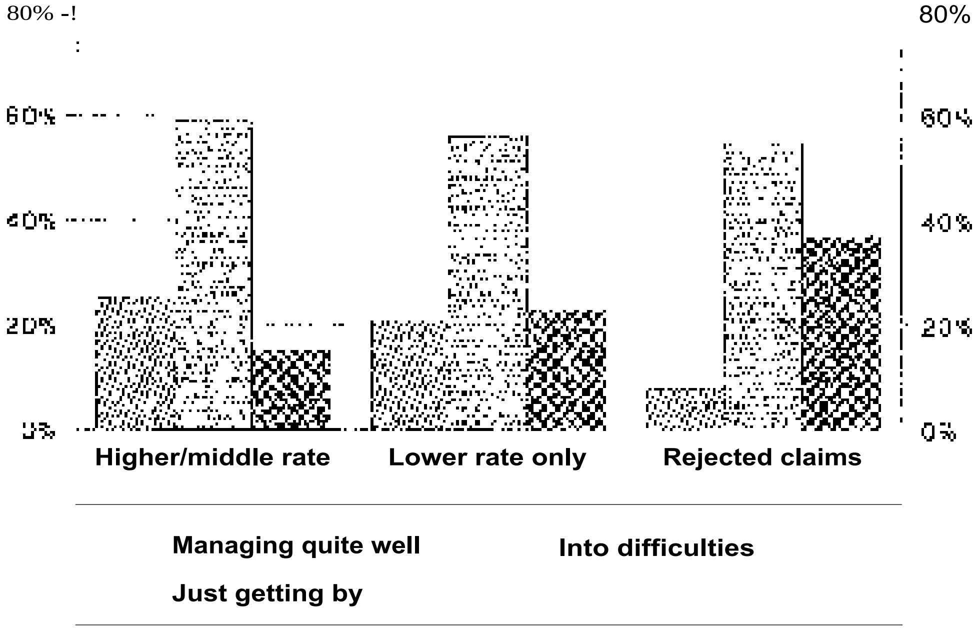
Respondents were also asked to identify which state benefits they were receiving other than DLA (Table 3.8). Overall 16 per cent were not in receipt of any other benefits. The findings suggest that no more half these DLA applicants had been able to build up an adequate insurance contributions record through paid work.[5] The findings further reflect the relatively low incomes of some DLA applicants in that a sizeable minority received means-tested benefits. Thus, 35 per cent were receiving Income Support, 28 per cent Council Tax Benefit, and 27 per cent Housing Benefit. A third also received Invalidity Benefit suggesting that they had been forced to give up paid work because of illness or disability. Unsuccessful applicants were more likely than other respondents to be receiving these benefits. They were also more likely than DLA recipients to be receiving at least one of the benefits listed.

3.9 Financial problems and standard of living

So far the findings show that many DLA applicants have low levels of financial resources and most rely on state benefits as their main source of income. To explore this further, we asked for respondents' opinions of their current financial situation. Two subjective measures were used to allow comparisons with the OPCS disability survey (Martin and White, 1988). Respondents were invited to say how they were managing on their money at the moment and how satisfied they felt with their `standard of living', that is, their housing, furniture, food and leisure activities, for example. The findings are summarised in Figures 3.7 and 3.8.

Contributory benefits include invalidity benefit retirement pension, sickness benefit and industrial injuries benefit.

Figure 3.7 Subjective perceptions of financial situation



Altogether, one-fifth said they were `managing quite well', 57 per cent were reportedly `just getting by', and 23 per cent felt they were `getting into difficulties'. More of these respondents said they were getting into difficulties than was the case among disabled adults in the OPCS survey, where the figure for disabled people as a whole is seven per cent overall (Martin and White, 1988). Middle or higher rate recipients were more likely to be managing or getting by than other respondents. By comparison, only eight per cent of unsuccessful applicants said they were managing quite well while 37 per cent said they were getting into difficulties (Figure 3.7).

Respondents were also invited to reflect on how they were managing on their money one year previously. The majority (55 per cent) reported that their financial situation had not changed. Overall, 27 per cent said they had managed better in the past year; 18 per cent were managing better in the current year. Those who had been awarded DLA were more likely to report an improvement in their financial situation.

Figure 3.8 Subjective perceptions of standard of living

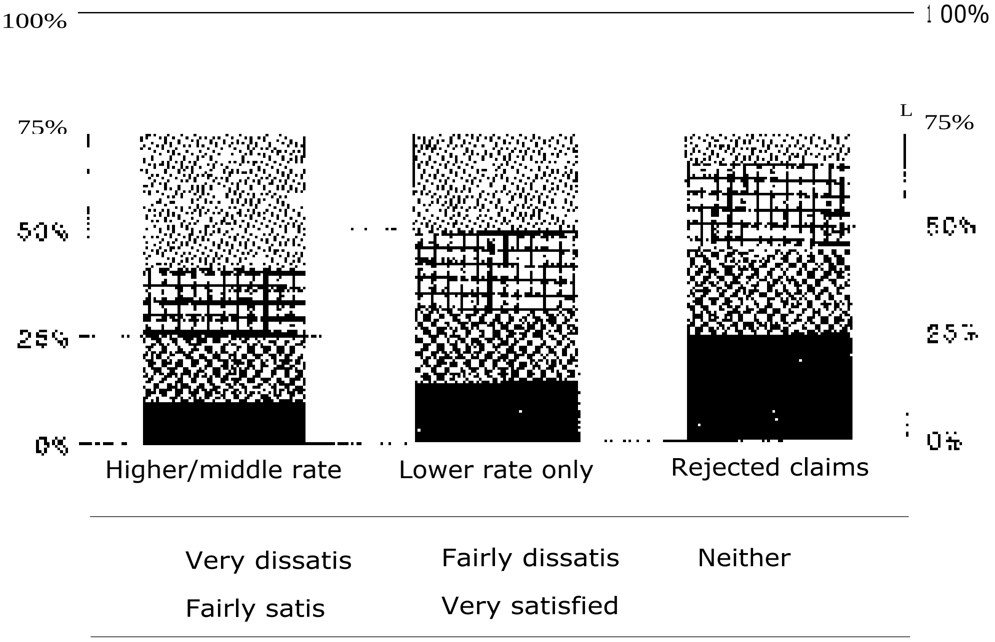


Figure 3.8 summarises respondents' views about their standard of living. Altogether, half the respondents said they were fairly or very satisfied with their standard of living while a third said they were fairly or very dissatisfied. They were much less satisfied than disabled adults generally. Figures for disabled people as a whole show that around 70 per cent were satisfied with their standard of living and 15 per cent dissatisfied (Martin and White, 1988).

Differences in relation to perceived standard of living are similar to respondents' views about their financial situation. Middle or higher rate recipients were more satisfied than lower rate recipients who, in turn, were more satisfied than unsuccessful applicants.

3.10 Disability-related expenditure

DLA is intended to help meet some of the extra costs of disability incurred by people with care or mobility needs. The lower rates were introduced to extend help to people who are less severely disabled than those eligible for the old-style AA and MobA. Ideally, we would have evaluated the distribution of DLA awards in relation to expenditure patterns but that was beyond the resources available for this study. Indeed, it is notoriously difficult to quantify the extra expenditure incurred as a result of disability. Available estimates vary by a factor of three or more and reflect variations in definitions and measurement techniques (Berthoud *et al.,* 1993).

For comparative purposes, we decided to replicate questions from the OPCS disability survey on the *incidence* of extra expenditure. Respondents were asked directly whether they had spent any money during the previous 12 months because of disability. Two topics were covered: regular expenditure on items or services due solely to disability, and additional expenditure on `normal' household or personal items because of disability. This information, therefore, describes the frequency and range of different types of expenditure.

Table 3.9 Regular disability-related expenditure (living in private households only)

Itemlservice	**Higher/middle rate recipients** (%)	**Lower rate recipients** (%)	**Unsuccessful applicants** (%)	All (%)
, „ *required solely of disability*				
Tra‘ ci to hospital	65	57	57	61
Chemist items	51	45	46	48
Other hospital costs	36	31	35	34
Prescriptions	31	26	26	28
Hospital treatment	4	6	4	4
Home services	5	5	2	4
Incontinence aids	4	5	4	4
Home treatment	1	1	2	1
1dd:1mm' r/nv t· on normal items				
Fuel	71	60	68	67
Travel	63	51	57	57
Telephone calls	59	52	52	55
Maintenance to home	39	33	36	37
Clothing/bedding	34	27	31	31
Cleaning, window cleaning	32	27	35	31
Food	30	28	29	29
Car repairs maintenance	29	17	25	24
Laundry	21	17	21	20
Paying or buying presents for people who sit with them	22	16	19	20
Repairing/replacing furniture	15	13	13	14
Other item	8	9	10	9
Any of the above	98	93	95	96
Base (= 100%)	*708*	*427*	*444*	*1579*

The results summarised in Table 3.9 show that DLA attracts applications from disabled people who incur a wide range of extra expenses on account of disability. All but four per cent of respondents reported some disability-related expenditure. Some items were mentioned by more than half the sample: fuel, travel to hospital, everyday travel, and telephone calls. On the whole, those receiving middle or higher rate awards were more likely to report extra expenditure while lower rate recipients were less likely to incur disability costs. Differences are small however, and we cannot estimate the additional weekly amounts which may be substantially higher than the current rates of DLA (Berthoud *et al.,* 1993).

Comparisons with the disabled population under pension age are revealing (Martin and White, 1988). The incidence of expenditure on items required solely because of disability are broadly similar, though DLA applicants are more likely to report hospital travel and other hospital costs than disabled people in the general population. However, the incidence of additional expenditure on normal items is often much higher among DLA applicants than disabled people generally. These include: travel, telephone calls, maintenance to home, clothing/bedding, cleaning, car repairs, paying or buying presents for people who sit with the respondent, and repairing or replacing furniture. Such additional expenses clearly reflect some of the extra costs incurred by disabled people with care or mobility needs.

3.11 Conditions causing disability

At the beginning of the interview, respondents were asked to describe up to three health problems or medical conditions which gave rise to their disabilities. We acknowledge that such information does not provide an accurate picture of the complaints causing disability. Some people were unable to give a specific diagnostic label and had only a vague idea of their condition. Nonetheless, responses were coded into 16 groups according to a modified version of the *International Classification of Diseases* developed by OPCS researchers (Martin *et al.,* 1988). The initial classification used in the survey comprises 129 categories and is too extensive to report in full.

Table 3.10 Frequency of complaints causing disability

Classification of complaints	**Higher/middle rate recipients** (°Yo)	**Lower rate recipients** (°A)	**Unsuccessful applicants** (%)	All (%)
Musculo-skeletal system	54	47	57	53
Nervous system	24	24	10	20
Circulatory system	19	12	27	20
Mental disorders	13	23	13	16
Respiratory system	17	8	18	15
Endocrine and metabolic	8	7	6	7
Digestive system	7	6	8	7
Eye complaints	3	14		6
Skin disease or disorders	3	4	3	3
Neoplasms	3	3	3	3
Ear complaints	2	3	3	2
Genito-urinary system	2	2	2	2
Other congenital	1		1	1
Infectious and parasitic	1	1	1	
Blood and blood forming organs	1	0	0	1
Other complaints	9	6	7	8
Base (= 100%)	*733*	*439*	*454*	*1626*

Percentages sum to more than 100 because some people reported two or three conditions.

Just under half the sample (45 per cent) described one condition only and 29 per cent described two conditions; the remaining 26 per cent described three. Not surprisingly, complaints likely to be associated with care and mobility needs predominate. Table 3.10 shows that musculo-skeletal disorders are most prevalent with more than half the sample reporting such complaints. This group includes rheumatism, arthritis and back problems. Musculo-skeletal disorders are also the most prevalent complaints causing disability in the population at large though somewhat less so than in this sample of DLA applicants (Martin *et al.,* 1988). Lower rate recipients were less likely to report such complaints. Lower rate recipients were also less likely to report disorders of the circulatory system such as coronary disease, or disorders of the respiratory system such as bronchitis or asthma. However, they were more likely to report mental disorders or eye complaints. Here mental disorders include psychological and psychiatric complaints, as well as brain damage and retardation.

Information is also available from the DLA database on the main disabling condition used in the assessment of claims. In most cases, this would be reported by a doctor or other health professional who knows most about the applicant's illness or disability. The two classifications are not entirely compatible and there are a number of inconsistencies between the database codes and the disabling conditions reported by respondents. To explore this further, we asked an adjudication officer to link the two classifications. In 69 per cent of cases, at least one of the conditions reported by respondents was consistent with the DLA database codes on their claim. Using the reduced classification shown in Table 3.10, less than an eighth of the database codes are in a different group from those reported by respondents. These findings suggest that most applicants had a reasonably accurate account of their disabling condition.

After describing their disabling condition, respondents were asked at what age it started and for how long it had been as bad as at present. In *The Way Ahead,* it was recognised that people disabled early in life are particularly disadvantaged because they have less opportunity to make financial provision to enable them to meet extra disability-related expenses (DSS, 1990). Table 3.11 shows that there is considerable variability in the age of onset of disability among DLA applicants. Overall, disability started around age 35 on average (median 37 years; inter-quartile range 23-48 years). Although all respondents were recent claimants, they said they had been disabled for around six years on average (median 3 years; inter-quartile range 1-8 years).

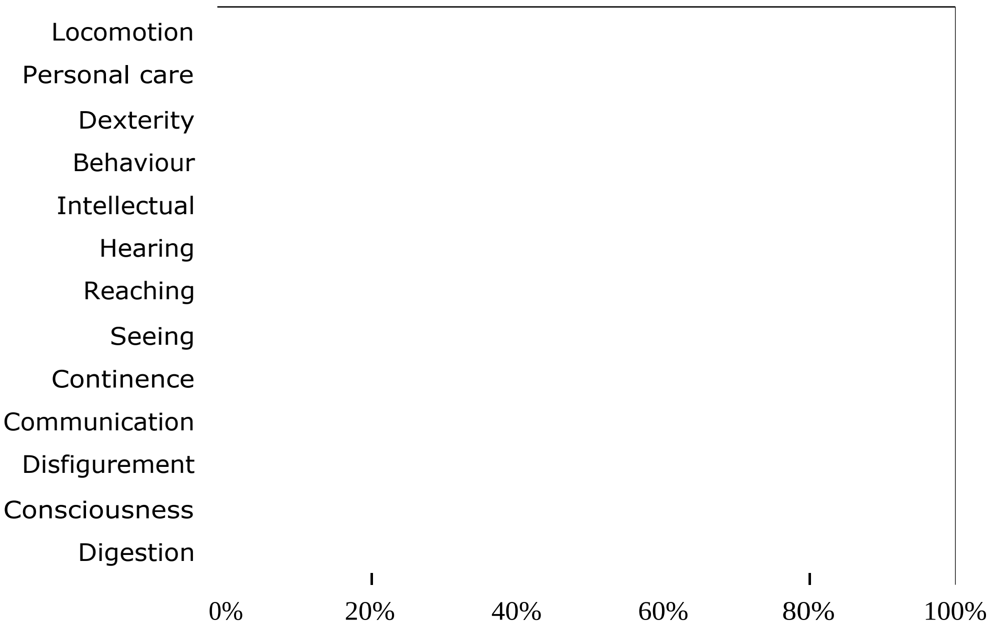
Table 3.11 Number of years disabled

Disabling condition	Highertmiddle rate recipients mean (SD)	Lower rate recipients mean (SD)	Unsuccessful applicants mean (SD)	All mean (SD)
Age at onset	36.5 (16.0)	30.5 (18.8)	36.5 (15.2)	34.9 (16.8)
Age as bad as at present	42.6 (14.6)	37.0 (17.5)	42.2 (14.0)	41.0 (15.4)
Years as bad as at present	5.5 (7.0)	7.9 (10.3)	5.7 (6.9)	6.2 (8.1)
Base	*729*	*435*	*450*	*1614*

Fulfilling a policy aim of the new lower rate criteria, lower rate awards target applicants who became disabled somewhat earlier in life than other applicants. One reason is that mental disorders and eye complaints, which are most prevalent among lower rate recipients (Table 3.10), are reported to have started at a much earlier age than other disabling conditions. The onset of these two conditions is around age 27 on average or between eight and eleven years earlier than other disabling conditions.

3.12 Different types of disability and overall severity

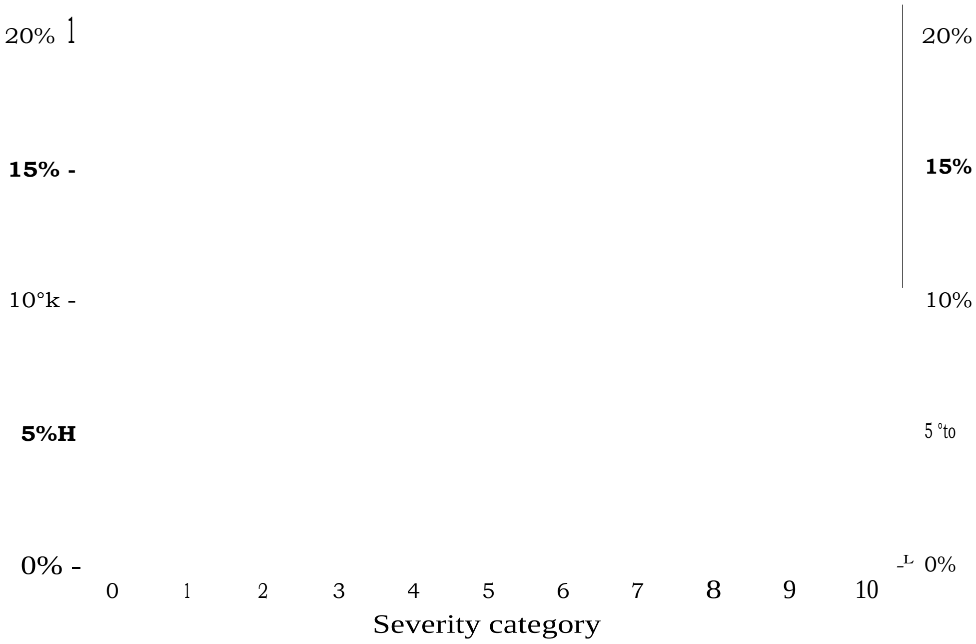
Figure 3.9 Prevalence of different ypes of disability



As described in Chapter 2, a requirement for this study was the measurement of 13 types of disability to form the composite scale of overall disability developed by OPCS researchers (see Annex 2.2). Figure 3.9 shows the prevalence of each of the disabilities. It is clear that most respondents are multiply disabled: overall 91 per cent have two or more disabilities, 56 per cent four or more. Not surprisingly, locomotion and personal care are the two most prevalent disabilities, reflecting some of the mobility and care needs in this claimant sample. Dexterity, behaviour and intellectual disabilities follow in overall prevalence and, as we shall see in Chapter 5, these are also closely related to the conditions of entitlement to DLA.

We did not ask respondents which disabling conditions were considered to give rise to particular disabilities but some connections can be loosely inferred from the findings of the OPCS disability survey (Martin et *al.,* 1989). The predominance of musculo-skeletal complaints would largely account for locomotion, reaching and dexterity disabilities, for instance. Mental complaints are associated with intellectual and behaviour disabilities. However there are some discrepancies. For example, 23 per cent of respondents have seeing disabilities, yet eye complaints are reported by no more than six per cent. Comparable figures for hearing disability and ear complaints are 30 and two per cent respectively. One explanation for the apparent under-reporting of these disabling conditions is that respondents were asked to name no more than three conditions which `most limit everyday activities'.

Figure 3.10 Severity of overall disability



As described in Annex 2.2, these different types of disability can be combined into a scale of overall severity. Figure 3.10 shows the proportion of respondents in each of the ten severity categories derived by OPCS researchers. Fewer than two per cent are judged not to have an appreciable disability according to the OPCS criteria; these individuals are assigned to category 0. It can be seen that the number of respondents increases with severity until category 7 and declines sharply in categories 9 and 10, reflecting in part the sample design which under-represents middle and higher rate recipients who are likely to be very severely disabled. The focus on recipients of at least one lower rate has boosted the number of people in the moderate to severe categories. This contrasts markedly with the population of disabled people where there are fewer people in the higher severity categories than in the lower (Martin *et al.,* 1988).

Table 3.12 Frequency of different types of disability by OPCS severity category

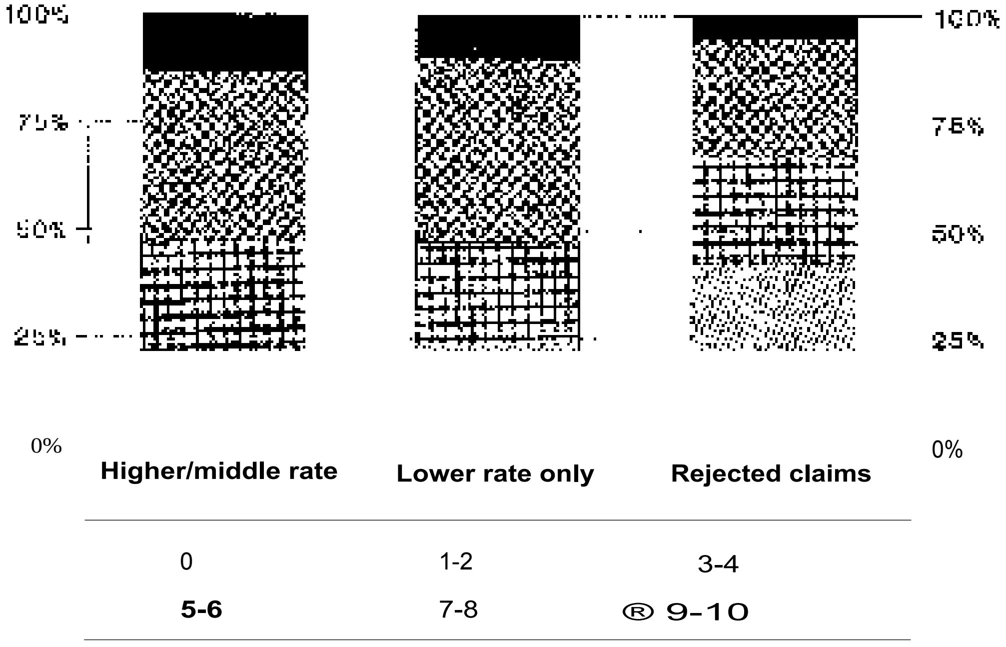
Type of **disability**	0 (%)	**1-2** (%)	**3-4** (%)	**5-6** (%)	7-8 (%)	**9-10** (%)	All (%)
	Severity category						
Locomotion		75	77	80	88	94	82
Personal care		29	41	62	86	92	66
[illegible]		1	21	35	64	74	44
Behaviour		10	22	36	42	66	36
Intellectual functioning		12	21	31	40	63	34
Hearing		17	22	28	36	42	30
Reaching and stretching		6	12	19	43	52	29
Seeing	–	15	21	21	23	44	23
Continence		4	10	21	27	44	22
Communication		6	12	16	27	37	20
Disfigurement		4	9	9	9	12	9
Consciousness		1	2	6	9	23	8
Eating, drinking, digesting	–	2	2	4	5	10	4
None of the above	100			–			
Base (= 100%)	*24*	*162*	*243*	*432*	*596*	*163*	*1620*

Percentages sum to more than 100 because some people have more than one disability.

Table 3.12 shows the frequency of different types of disability by severity category. The prevalence of all 13 disabilities increases with severity, reflecting in part the way in which overall severity is defined. With increasing severity, multiple disabilities become more likely, irrespective of whether they are one of the three most severe disabilities that actually determine sseverity of overall disability.

Figure 3.11 shows the distribution of respondents by overall severity. Unsuccessful applicants are generally the least severely disabled of all DLA recipients. Lower rate recipients are somewhat less severely disabled than middle or higher rate recipients. In the next chapter we consider further evidence for the existence of a severity gradient across DLA outcomes for the care and mobility components.

Figure 3.11 DLA recipients by severity of overall disability



3.13 Conclusions

DLA is intended to contribute to some of the extra costs of disability. Policy makers acknowledged that some people disabled early in life have limited financial resources and are often unable to boost their incomes through paid employment. It was recognised that they are particularly disadvantaged not only in relation to the workforce but also in terms of their standard of living and social participation. Most have to divert part of their limited income to meet expenses that non-disabled people do not incur. The majority depend on the social security system for most of their income (DSS, 1990).

The evidence presented in this chapter shows that few DLA applicants would fall outside the scope of these concerns. DLA, therefore, is largely fulfilling policy makers' intentions. However, eligibility for DLA is not based on such considerations but according to the nature and frequency of applicants' care or mobility needs. The economic problems of disabled people who are considered not to have such needs, arguably, are covered by other social security provision. Nonetheless, our findings suggest that unsuccessful applicants are often as disadvantaged as recipients of DLA, some more so. They have lower incomes and are more likely to be in receipt of means-tested benefits, or to have left the workforce on account of disability. Although somewhat less severely disabled than successful applicants, rejected claimants are not, on the whole, recently disabled and are as likely to report extra disability-related costs.

DLA has extended additional resources to many thousands of disabled people. Those beyond its reach represent a continuing challenge to the scope of social security provision in general and disability benefits in particular.

Chapter 4 Severity of Overall Disability

4.1 Measuring disability

The rules on entitlement to DLA do not define people as either disabled or not disabled. The benefit is for people with care and mobility needs who are `severely disabled physically or mentally', while the new lower rates aim to extend help to *less severely* disabled people. Implicit here is the idea of a continuum of disability ranging from more to less severe. Hence an important aim of this research was to investigate the extent to which DLA awards correspond to severity of overall disability.

The planning and development of DLA took place in the wake of the OPCS disability survey for which new measures of type and severity of disability were developed and tested (Martin *et al.,* 1988). These informed the criteria for, and the targeting of, the new lower rates. Use of the OPCS scales of disability was expressly required for this evaluation. Although we did not limit ourselves to collecting information relevant only to them.

In this chapter we investigate DLA awards by severity of overall disability using the ten-point scale developed by OPCS researchers (see Annex 2.2). There are two evaluative criteria:

a. Recipients of lower rate awards are expected to be *less severely* disabled than those receiving middle or higher rate awards. As noted in Chapter 2, the new, lower rates of DLA are intended for people who would have failed to qualify for the former attendance or mobility allowances. In the case of the DLA care component, we might also expect a *gradient* of increasing severity from lower, through middle, to higher rate recipients though this is not strictly implied by the conditions of entitlement which relate specifically to care and mobility needs, not overall severity. Likewise unsuccessful applicants are not necessarily expected to be less severely disabled than lower rate recipients. Nonetheless we shall examine the evidence for a gradient of severity across the outcomes of applications for DLA.

b. The lower rate conditions of entitlement are intended to target people in OPCS severity categories 5 and 6 who have relevant care and mobility needs. This criterion can be interpreted in various ways. It could mean that most, or a majority of, lower rate recipients are expected to be in the target categories. Alternatively, it could mean that the target categories should contain the largest proportion of lower rate recipients. Either way the more lower rate in al ds fall into severity categories 5-6, the better targeted they are considered to be. However we otdd not expect all people assigned to categories 5-6 to be eligible for a lower rate award: some might be awarded a nl Id d le or higher rate, while others might have their claim rejected if their care and mobility needs fall outside the rules on entitlement.[6] In other words, the extent to which people in categories 5-6 do or do not receive a lower rate award is not relevant to assessing the

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[6] Claimants can be rejected for other reasons, for example, not fulfilling the conditions of service and presence in Great Britain, or the prescribed qualifying periods. The sample was designed to exclude unsuccessful applicants rejected on other than disability grounds.

targeting of lower rate awards. Rather this criterion focuses on the extent to which lower rate recipients are assigned to the target severity categories.

Although these evaluative criteria may be related, they are clearly independent: one might be fully met while the other will be completely absent. As an example, all lower rate recipients might be less severely disabled than middle or higher rate recipients but this does not mean that lower rate awards will be targeted on severity categories 5 and 6. Thus both criteria are important to evaluating the targeting of lower rate awards. We shall see that neither is adequately met. Lower rate recipients are scarcely less severely disabled than other recipients while around half of lower rate awards go to people more severely disabled than expected.

In the next section we shall examine the distribution of care awards in relation to severity of overall disability and then move on to consider mobility awards. Severity levels among recipients are also compared with those of unsuccessful applicants and those not applying for one or other component. The findings show that lower rate awards are poorly targeted in relation to overall severity. Lower rate recipients are only slightly less disabled than middle or higher rate recipients, no more than a quarter are assigned to the target severity categories 5-6, and a majority are more severely disabled. Further investigation indicates that the disabling condition of some lower rate recipients had worsened since applying for DLA. To what extent we do not know, but it is possible that they might have been received a higher rate of award if they had claimed DLA at the time of the survey. If they were less severely disabled at the time their claim was considered, our findings would underestimate the proportion of lower rate awards that actually go to people in severity categories 5 and 6. We also recognise that a different sample, representative of the caseload of all beneficiaries, might show greater correspondence between overall severity and outcomes.

4.2 DLA care awards and overall severity

Most of those classified as severely disabled on the OPCS scale have multiple disabilities and, as Table 3.12 shows, these often include difficulties with self-care. As a consequence, they might be expected to satisfy the attendance criteria for a middle or higher rate care award. Some severely multiply-disabled people may also satisfy the supervision criteria for such awards. The OPCS disability survey shows, however, that very few people at lower severity levels meet the criteria for the old-style AA (Martin and White, 1988). The expectation was that they would be brought into entitlement by the new lower rate conditions for DLA.

Table 4.1 DLA care awards by OPCS severity category

Severity **category**	**Higher rate care** (%)	**Middle rate care** (%)	**Lower rate care** (%)	**Rejected claims** (%)	**Not claimed** (%)
9-10	25	18	11	7	4
7-8	47	42	45	32	20
5-6	22	24	26	29	29
3-4	7	10	11	18	24
1-2		6	6	12	21
0	–	1	1	2	2
Base (= 100%)	*60*	*179*	*696*	*374*	*311*

Table 4.1 shows that most recipients of middle or higher rate awards are severely disabled but, contrary to expectation, so too are many lower rate recipients. Among higher rate recipients, 72 per cent are in severity categories 7 and above, compared with 60 per cent of middle rate recipients, 56 per cent of lower rate recipients and 39 per cent of unsuccessful claimants. Conversely, seven per cent of higher rate recipients are in categories 4 and below, compared with 17, 18 and 32 per cent respectively.

These figures provide evidence of a severity gradient across DLA care outcomes, illustrated in Figure 4.1. As severity of overall disability increases or decreases, so does the rate of an award. Further, unsuccessful claimants are generally less severely disabled than lower rate recipients while those who did not apply for a care award are, on the whole, least severely disabled. However, there is considerable overlap in severity levels and the correlation between outcomes and severity is statistically weak.[7] If overall severity is a good indicator of care needs, this is not reflected in the distribution of care awards. Differences in severity levels between middle and lower rate recipients are especially small. Moreover, it is somewhat surprising that 39 per cent of rejected claims and 24 per cent of those not applying for a care award are classified as severely disabled (category 7 and above) because most have multiple disabilities, which often implies needs for care.

Fiore 4.1 DLA care awards by OPCS severity category

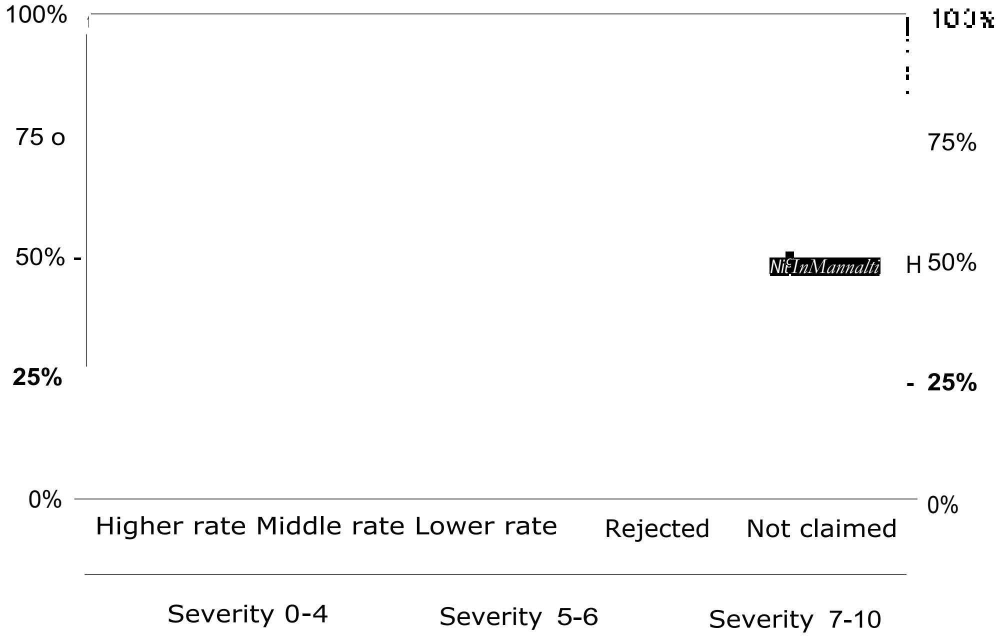

Figure 4.1 also shows that the targeting of lower rate care awards is less than precise, at least in terms of overall severity. All severity levels are represented among lower rate recipients: around one in four fell in the target categories 5-6. A majority are more severely disabled than anticipated. Unsuccessful applicants are also widely distributed across all severity levels and, on the whole, are only slightly less severely disabled than lower rate recipients.

4.3 DLA mobility awards and overall severity

We expected the distribution of mobility awards by overall severity to be more complex than that of care awards. People classified on the higher severity levels of the OPCS scale are not necessarily entitled to a mobility award because their disabilities, though severe, often do not affect walking ability or imply a need for guidance outdoors. Those who `cannot walk at all' should be eligible for a higher rate award, but on its own this disability would classify them as no more severely disabled than category 6 on the OPCS scale. If destructiveness implies a need for

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A loglinear model for ordinal data fits the data in Table 3.1 well (p = 0.79) and shows a positive correlation between severity and the rate of a care award. This correlation was measured by the tau-c and Somers' d coefficients of association which can both range from +1 to -1, with 0 representing no association. Though statistically significant, the correlation is weak (both coefficients = 0.17). Those not applying for the care component were excluded from these analyses.

supervision when out and about - one of the criteria for a lower rate award - this risk alone would place a person no higher than severity category 4.

Table 4.2 DLA mobility awards by OPCS severity category

Severity category	Higher rate mobility (%)	Lower rate mobility (%)	Rejected claims (%)	Not claimed (%)
9-10	12	14	7	9
7-8	39	35	35	41
5-6	30	25	24	27
3-4	12	16	17	17
1-2		9	15	3
0		2	2	3
Base (= 100	*570*	*303*	644	*103*

Table 4.2 shows that recipients of a lower rate mobility award are not invariably less severely disabled than higher rate recipients. The proportion of successful and unsuccessful claimants who are severely disabled, that is in categories 7 and above, varies by only nine percentage points (42-51 per cent). Indeed the distribution of lower rate mobility recipients by overall severity closely mirrors that of higher rate recipients, and neither differs markedly from that of unsuccessful claimants. There is a good deal of overlap; overall, severity cannot be used to predict with any confidence the result of an application for a mobility award.

Figure 4.2 DLA mobility awards by OPCS severity category

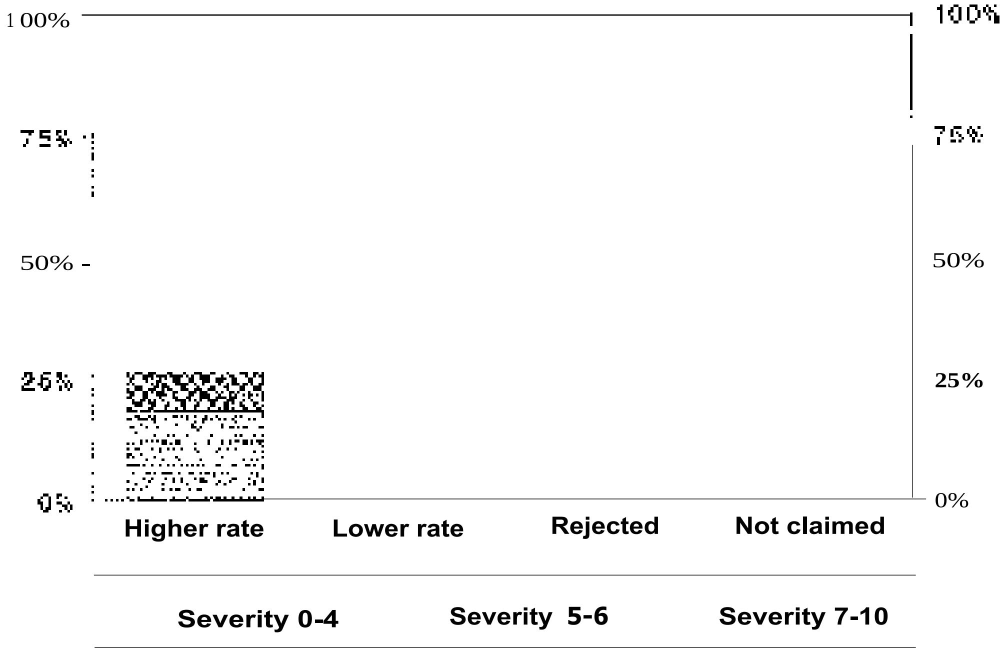

Figure 4.2 shows that any tendency for severity levels to increase from unsuccessful claimants, through lower, to higher rate recipients is slight. It also shows that lower rate recipients are no more severely disabled than applicants who did not apply for a mobility award. The correlation between DLA mobility outcomes and severity of overall disability is weak and not statistically significant.[1]

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[1] A loglinear model for ordinal data does not fit the data in Table 3.2 (p = 0.009). For these data, tau-c = 0.13 and Somers d = 0.11. Those not applying for the mobility component were excluded from these analyses.

Figure 4.2 also shows that lower rate mobility awards are widely distributed around the intended target: only 25 per cent of recipients are assigned to categories 5 and 6, while almost half are more severely disabled. There is also considerable variation in severity levels among unsuccessful claimants for a mobility award.

4.4 Lower rate recipients and overall severity

Table 4.3 DLA awards by OPCS severity category

Severity **category**	**Higher/middle rate recipients** (%)	**Lower rate recipients** (%)	**Unsuccessful applicants** (%)
9-10	13	10	5
7-8	39	42	28
5-6	30	24	25
3-4	11	15	20
1-2	7	6	19
0	0	2	3
Base (= 100%)	*730*	*436*	*454*

The weak correlation between DLA awards and severity of overall disability is not altogether unexpected because it could arise from the way the benefit itself is structured. As noted in Chapter 2 (and see Annex 2.3), the disability conditions for each component (care and mobility) are quite distinct. It is possible that an applicant who is severely disabled enough to receive a higher rate award for one component might nonetheless be rejected on disability grounds, or receive a lower rate award, for the other. A lack of association between care and mobility needs would confound the relationship between overall severity and the rate of an award on each component. To investigate this further, we compared those receiving any middle or higher award, that is those who formerly would have received AA or MobA, with those who received a dual lower rate award or one award only at the lower rate. The expectation was that this would emphasise any severity gradient between outcomes. Table 4.3 summarises the results.

It can be seen that recasting the analysis in this way makes little difference to the findings already presented. Recipients of lower rate awards are, on the whole, slightly less severely disabled than higher or middle rate recipients, while unsuccessful applicants are generally the least severely disabled. But the severity gradient is weakly defined.[9] Lower rate awards are dispersed across the severity levels and less than one in four are in the target categories 5 and 6. Most lower rate awards are to people more severely disabled than anticipated.

4.5 Has severity of disability worsened?

Table 4.4 Changes in disabling condition since applying for DLA

	Lower rate care awards Severity category			**Lower rate mobility awards Severity category**		
Disabling condition	**0-4** (%)	**5-6** (%)	**7-10** (%)	**0-4** (%)	**5-6** ("A)	**7-10** (%)
Much better	2		1	4	3	1
Somewhat better	13	7	4	5	7	7
About the same	65	60	49	77	66	58
Somewhat worse	14	25	30	10	18	24
Much worse	6	8	16	4	6	10
Base (= 100%)	*126*	*178*	*391*	*80*	*77*	*146*

The survey findings show that almost half of lower rate mobility awards and a majority of lower rate care awards went to applicants who are more severely disabled than anticipated. It would be too simple to expect all lower rate awards to fall neatly into severity categories 5 and 6, but the proportion of applicants who are more severely disabled than this invites further enquiry. One explanation might

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[9] *Tau-c* = 0.19 and Somers' d = 0.17.

be that their condition had worsened since applying for DLA, pushing them into a higher severity category by the time they were interviewed for this study. As a proxy measure of potential changes in overall severity, we asked respondents whether their disabling condition was better or worse than when they completed their application form around four months earlier.[10] A five-point scale was used as a prompt and the responses of lower rate recipients are summarised in Table 4.4.

Most people said their disability was neither better nor worse than it was at the time of applying for DLA. A small minority thought their condition had improved. However the proportion reporting that their disability had deteriorated increased with overall severity. Between a third and a half of lower rate recipients who are above target, that is in categories 7-10, said their disability had worsened. Substantial minorities of middle and higher rate recipients and unsuccessful claimants also reported that their condition had deteriorated.

We cannot say how many of those reporting a worsening condition would have been assigned to lower severity levels if our assessment of disability had been conducted at the time of their DLA application. Nor is it possible to say that these reports of a deteriorating condition necessarily imply greater care or mobility needs. But taken at face value, the findings suggest that some lower rate recipients might have received a higher rate of award if they had claimed DLA at the time of the survey.

4.6 Summary and conclusions

In this chapter we have examined the distribution of DLA awards according to severity of overall disability. The findings show considerable variation in overall severity among recent applicants and suggest that initial decisions on claims for DLA do not necessarily reflect severity levels among applicants. However, we recognise that there could be greater correspondence between overall severity and outcomes in the caseload of all beneficiaries. The main conclusions are:

a. The new lower rate of care is currently awarded to people who, on the whole, are slightly less disabled than recipients of the higher rate; but there is a good deal of overlap and little difference in severity levels between recipients of middle and lower rate care awards.

b. Recipients of the new lower rate mobility awards are no less severely disabled overall than higher rate recipients.

c. No more than a quarter of lower rate recipients, whether of care or mobility, are classified in the intended target severity categories 5 and 6.

d. Around half of lower rate recipients are more severely disabled than anticipated, although some of them might have been assigned to the target severity categories at the time of their DLA application.

e. Lower rate recipients of one component of DLA are severely disabled, irrespective of whether or not they satisfy the higher or middle rate criteria for the other component.

f. Unsuccessful claimants, and those not applying for one component or the other, are often as disabled as recipients of any award, some more so.

These findings suggest that the new lower rates of DLA are not directing resources to people who are less severely disabled than recipients of the old-style AA and MobA, nor are they targeting moderately disabled people. If so, the new lower rate awards are unlikely to have smoothed the so-called 'cliff-edges' in provision between severely disabled people and less severely disabled people who would have failed to qualify for either of these former benefits.

The OPCS severity scale was suggested by policy makers as one way of identifying the target population for lower rate DLA awards. One advantage of this scale is that it provides an independent criterion unrelated to the assessment and adjudication process. It also provides an overall, generic scale to assess the

[10] Self-reported changes in care and mobility needs are examined in Chapters 5 and 6.

objective of targeting people with moderate disabilities. The findings presented in this chapter suggest that DLA lower rate awards are poorly targeted in relation to overall severity as measured by the OPCS scale, or that the OPCS scale is an inadequate construct for assessing the outcome of claims for DLA. It is possible for both conclusions to be valid because severity of overall disability, however measured, is a poor representation of the rules on entitlement to DLA.

It cannot be concluded, therefore, that lower rate awards are wrongly targeted nor that the eligibility criteria are inappropriate. The OPCS severity scale was not intended to represent the pattern of needs in a disabled population; as a proxy measure it covers much more than difficulties with self-care and mobility. Arguably, DLA outcomes are more likely to reflect the pattern of disabilities among claimants than overall severity. Measures of different types of disability, particularly locomotion and personal care disabilities, should represent more accurately the needs for which DLA is intended to provide cash help. These relationships are explored in the next chapter. We shall see that those disabilities which most closely reflect the lower rate criteria are more prevalent and most severe among lower rate recipients. We shall see further in Chapter 6 that, irrespective of overall severity, most lower rate recipients have care or mobility needs that correspond to the lower rate rules on entitlement.

Chapter 5 Different Types of Disability

5.1 Introduction

The conditions of entitlement to DLA address some of the consequences or handicaps arising from disability, chiefly those relating to dependency on the assistance of others to meet care and mobility needs. Such needs are shaped by various factors, including the presence or absence of a carer, housing circumstances and individuals' determination to be independent. Insofar as these needs result from particular types of disability, we might expect the outcomes of applications for an award to reflect the pattern of disabilities in a claimant population. Indeed, some of the criteria for each rate and component imply clear links with the effects of different types of disability (see Annex 2.1). It might be expected, for example, that lower rate mobility awards would be associated with learning difficulties or behaviour disorders because these often imply a need for supervision out of doors. Severe walking disability should distinguish higher rate mobility awards, while care awards could be expected to reflect the nature and frequency of self-care needs arising from various physical disabilities. Lower rate care awards might also be associated with seeing or dexterity problems which could prevent the preparation of a cooked main meal. However, we recognise that these relationships would be diluted where information unrelated to type and severity of disability, such as the level of supervision needed, informs the adjudication process.

The match between disabilities and outcomes of DLA applications, therefore, is unlikely to be clear-cut but any relationships should be consistent with the rules on entitlement, or at least not contradict them. Thus, in relation to each component of DLA, we would expect that:

a. disabilities associated with the conditions of entitlement to middle or higher rate awards should be less prevalent and less severe among lower rate recipients than middle or higher rate recipients

b. disabilities associated with the criteria for lower rate awards should be more prevalent and more severe among lower rate recipients than unsuccessful claimants.

The stronger these relationships, the better targeted are lower rate awards. Unlike the criterion of overall severity discussed in Chapter 4, however, there is no predetermined target defined by any disability, or combination of disabilities, for lower rate awards.

To investigate these relationships, we replicated the 13 disability scales defined by (RCS researchers (Annex 2.2), including a widely used scale of psychiatric disturbance to ensure adequate coverage of difficulties arising from mental health problems. These scales describe the prevalence and severity of different types of disability. In this chapter each scale of disability is used on its own to examine first the distribution of care awards and then mobility awards. We also consider all disabilities together to take account of the way they combine in individuals. The aim is to identify that set of disabilities which best distinguishes lower rate recipients. This is achieved according to standard statistical criteria of `goodness of fit' but equally important is whether or not the subset of disabilities so defined is consistent with the rules on entitlement. If so, we are in a position to judge whether the lower rate criteria extend help with extra costs to a new group of beneficiaries distinguished from other claimants according to type and severity of disability.

As expected, patterns of disability are extremely complex, and there is considerable overlap in type and severity between DLA outcomes. Disabilities reflecting the lower rate criteria are often as severe, though less prevalent, among middle and higher rate recipients as lower rate recipients. Patterns of disability in relation to mobility outcomes reveal a marked disjunction between walking difficulties and guidance needs. In some areas, unsuccessful applicants are as severely disabled as those who receive an award.

Nonetheless the findings show that, on each DLA component, lower rate recipients are differentiated from other applicants according to the prevalence and severity of a specific subset of disabilities which reflects the criteria for lower rate awards. Moreover, lower rate recipients are less severely disabled in respect of those disabilities most closely associated with the middle or higher rate criteria. The implication is that the lower rate criteria of both components identify new, well-defined groups of beneficiaries who, in relation to middle or higher rate recipients, are less severely disabled.

5.2 DLA care awards and different types of disability

Lower rate care is mostly awarded to people who are unable to perform the skills for the cooked `main meal test'. Fortunately, the OPCS researchers defined a dexterity disability, that is, difficulties holding things, mainly in terms of kitchen-based activities, so this disability should provide a good measure of targeting. Similarly, problems reaching and stretching for things might be expected to limit an individual's ability to operate effectively in a poorly designed kitchen. However, the DLA test is more than an assessment of cooking ability and includes the capacity to plan for and prepare a cooked main meal. Such skills may be limited or absent because of learning or seeing disabilities.

Lower rate care is also awarded to disabled people who need personal attention for part of the day, including help with getting in and out of a bed or chair, dressing and undressing, and getting to or using the toilet. Such activities are largely covered by the OPCS scale of personal care disability, although other problems, learning and behaviour disabilities, for example, might also indicate a need for help with self-care.

It was expected, then, that dexterity, reaching and stretching, seeing, and personal care disabilities in particular would be associated with lower rate care awards. Any correspondence between lower rate awards and learning or behaviour disabilities seemed less certain, however. Although individuals with these disabilities may require limited care or help with meal preparation, severe learning and behaviour disorders are often associated with needs for continual supervision to prevent self-harm or danger to others. If so, they are more likely to be awarded middle or higher rate care. Severe difficulties with self-care would also be reported by some middle or higher rate recipients reflecting their needs for frequent help with bodily functions.

5.2.1 Prevalence of disabilities - care awards

Table 5.1 shows that, compared with other DLA outcomes, lower rate care recipients are much more likely to have a personal care disability. They are also more likely to have disabilities which commonly have a physical origin and directly affect bodily movement: locomotion, reaching and stretching, and dexterity disabilities. While difficulties with personal care are treated here as a disability in their own right, they can also be viewed as consequences of these `physical' disabilities.

Table 5.1 Prevalence of different types of disability by DLA care awards

Type of disability	Higher rate care (%)	Middle rate care (%)	Lower rate care	Rejected claims (%)	Not claimed (%)
Locomotion	78	74	81	82	90
Personal care	53	61	76	62	56
Dexterity	33	35	59	36	26
Behaviour	69	57	34	37	26
Intellectual functioning	67	55	32	34	23
Hearing	38	28	27	31	34
Reaching and stretching	19	23	38	26	18
Seeing	30	22	25	21	20
Continence	35	25	21	23	
Communication	53	26	20	19	14
Disfigurement	12	6	9	10	9
Consciousness	32	24	4	6	2
Eating, drinking, digesting	8	7	4	4	4
Base (= 100%)	*60*	*181*	*699*	*374*	*312*

Percentages sum to more than 100 because some people have more than one disability.

Dexterity and personal care disabilities, in particular, are associated with lower rate care awards. As suggested above, it was thought that these disabilities would reflect the meals test and the limited care criteria respectively. However they did not distinguish clearly between the adjudication officers' reasons for a lower rate award as recorded on the DLA database. While 84 per cent of those who were considered to need limited care have a personal care disability, so do 74 per cent of those who were thought to need help to prepare a cooked main meal. The prevalence of dexterity disability provides a mirror image (47 and 60 per cent respectively) but again there is considerable overlap.

Physical and personal care disabilities are somewhat less prevalent among recipients of a middle or higher rate award than lower rate recipients. This is chiefly because middle and higher rates are not awarded solely on the grounds of a frequent need for assistance with personal care. Recipients of the higher rate, however, are more likely than other respondents to have a continence disability, which is often associated with the `heavy' end of caring and needs for attention during both the day and night. By comparison, rejected applicants are less likely to be physically disabled or to have a personal care disability than respondents with a lower rate award. Nonetheless, over half of unsuccessful claimants and non-applicants report personal care needs, raising a question about their eligibility for at least a lower rate award although adjudication officers must also take into account the amount of care required.

Communication, behaviour and intellectual disabilities are most prevalent among middle and higher rate recipients, reflecting the conditions of entitlement relating to continual supervision. These disabilities, particularly when they are found together, often indicate mental impairment or `mental handicap' and can imply substantial supervision needs. Consciousness disability, describing problems arising from fits or convulsions, also implies a need for watching over by another person and is most prevalent among recipients of higher and middle rate care.

These findings show that patterns of disabilities broadly mirror the conditions of entitlement for different levels of an award, but overall no clear-cut relationships are suggested. Apart from susceptibility to loss of consciousness, no disability is even moderately associated with the result of applications for a care award." This was not unexpected. The rules on entitlement require a judgement about the frequency and intensity of care and supervision needs rather than simply the

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" With one exception, the prevalence of each disability is weekly correlated with the outcomes of applications for a care award, this is *tau-c* Somers' d < 0.15. In the case of a consciousness disability the degree of association could be described as moderate (Somers' d = 0.35).

presence of a disability. So severity of each disability should distinguish between outcomes more clearly than crude prevalence rates.

5.2.2 *Severity of disabilities - care awards*

Evidence relating lower rate care awards to the severity of different types of disability is limited however. Table 5.2 shows that differences between scores according to DLA outcomes are quite small on average and often not statistically significant.'[2] Although the raised severity levels of behaviour and intellectual disabilities among middle or higher rate recipients are consistent with needing supervision, severity of personal care, dexterity, and reaching and stretching disabilities fail to distinguish between recipients of any rate of award. Despite a raised prevalence among higher rate recipients, the severity of continence and consciousness disabilities do not vary significantly according to outcome. However, lower rate recipients have more severe seeing difficulties than rejected claimants, confirming that these are closely associated with the ‘meals test'.

Table 5.2 Severity of different types of disability by DLA care awards

Type of **disability**	**Higher rate care mean (SD)**	**Middle rate care mean (SD)**	**Lower rate care mean** (SD)	**Rejected claims mean (SD)**	**Not claimed mean (SD)**
Locomotion	5.7	*6.5*	5.9	5.5	5.5
	(3.2)	(2.7)	(2.6)	(2.5)	(2.5)
Personal care	8.9	7.8	7.9	6.4	4.5
	(3.2)	(3.8)	(3.5)	(3.9)	(4.0)
Dexterity	8.0	7.6	7.5	7.2	6.7
	(1.8)	(1.8)	(1.8)	(1.9)	(2.0)
Behaviour	8.0	7.2	6.3	6.7	6.4
	(2.9)	(3.1)	(2.9)	(2.9)	(3.4)
Intellectual functioning	6.5	5.8	4.7	5.0	5.1
	(3.2)	(2.9)	(2.9)	(3.0)	(2.9)
Hearing	2.2	1.5	1.9	2.1	1.6
	(2.5)	(1.9)	(2.3)	(2.4)	(2.1)
Reaching and stretching	3.6	4.4	4.1	4.3	4.3
	(2.4)	(2.3)	(2.5)	(2.4)	(2.2)
Seeing	1.7	2.0	3.0	1.7	1.8
	(2.0)	(2.8)	(3.4)	(2.3)	(2.4)
Continence	6.0	5.5	5.1	5.4	5.0
	(3.0)	(3.0)	(2.8)	(3.0)	(2.8)
Communication	4.8	4.5	4.5	4.0	4.0
	(3.0)	(2.3)	(2.5)	(2.4)	(2.6)
Consciousness	8.5	8.9	7.9	8.0	5.6
	(2.9)	(2.7)	(3.0)	(2.3)	(2.8)

* Excludes people below the minimum threshold for each disability. Severity levels for disfigurement and digestion disabilities were not defined.

Interestingly, personal care and dexterity disabilities fail to distinguish between lower rate recipients who were considered to need limited care by adjudication officers, and those who were considered to need help preparing a cooked main meal. The average personal care disability score is 8.0 (SD = 3.5) and 7.9 (SD = 3.5) respectively, while the average dexterity score is 7.3 (SD = 1.7) and 7.5 (SD = 1.8) respectively.

Respondents not applying for a care award are less severely disabled on the whole than other applicants. As for rejected claimants, their profile of disabilities is more often than not like that of successful applicants. However, both unsuccessful applicants and non-claimants have less severe personal care disabilities on average than recipients of an award.

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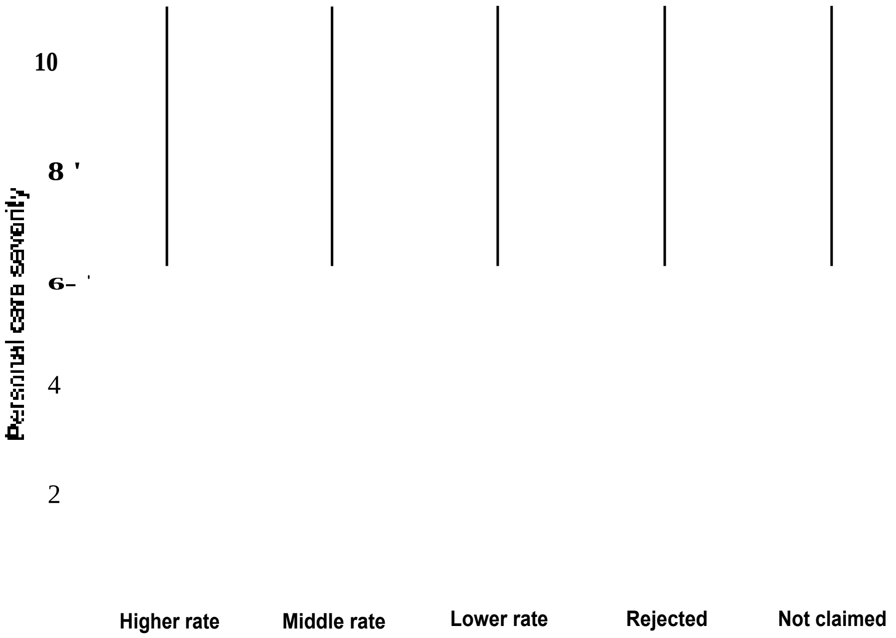
[2] Throughout this chapter differences between means were tested using multiple comparison procedures and a conventional significant level ($p < 0.05$).

Figure 5.1 Severity of personal care disability by DLA care outcomes



There is then considerable variation in severity levels across outcomes. To illustrate the extent of overlap, Figure 5.1 plots the distribution of individuals' personal care scores. Within each outcome, the vertical line connects the minimum and maximum scores while the shaded bar encompasses the central 50 per cent, or inter-quartile range, of respondents' scores. It can be seen that each outcome includes individuals with scores ranging over the full severity scale, from 1.0 to 11.0 (see Annex 2.2). Although most higher rate recipients are well-defined within a narrow band of the most severe self-care difficulties, the inter-quartile range is much broader for other outcomes indicating greater variability. Indeed, severity levels do not distinguish between middle and lower rate recipients. Rejected claimants and non-applicants are somewhat less severely disabled on the whole but clearly many have the same self-care difficulties as successful applicants. Such overlap is typical of other disabilities, dexterity for instance, which mirror some of the rules on entitlement.

Furthermore, a personal care disability score of 4.5 and above indicates an explicit need for help from another person with self-care and, possibly, entitlement to an award on attendance grounds. Clearly, if this were the only information available on which to assess a claim, there would be a very different set of outcomes. The implication is that the outcomes of applications for a care award do not adequately distinguish between different types of disability when these are considered one at a time.

5.2.3 Combinations of disabilities - care awards

So far we have examined each disability in turn but it seems likely that this approach misrepresents both the experience of disablement and the scope of DLA. In this section, we investigate the possibility that combinations of disabilities better distinguish DLA outcomes. The OPCS severity scale of overall disability represents one way of combining disabilities but, as we discovered in Chapter 4, the scope of this scale is rather wider than the DLA conditions of entitlement. To find the `best' combination of disabilities we used logistic regression analysis. This statistical technique identifies the smallest subset of disabilities which discriminates most clearly between DLA outcomes.[°] Two analyses were carried out, one which separated those awarded a middle or higher rate from lower rate recipients, and

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[n] The full disability scales, including zero, were entered as covariates using forward stepwise selection. The overall fit of a model was assessed by testing that all disabilities entered had a significant effect on outcome. Odds ratios represent the strength of association between disabilities and outcomes. See Appendix 4 for further details.

another which separated lower rate recipients from unsuccessful applicants. This was done because it seemed likely that disabilities would combine in different ways depending on which outcomes are compared; both boundaries are relevant to the adjudication of lower rate awards.

Table 5.3 Lower rate care awards and different types of disability

	Association with lower rate care awards versus:			
	Rejected claims		**Higher/Middle rate awards**	
Type of disability	**OR**	**OR***	**OR**	**OR***
Locomotion	*ns*	*ns*	*ns*	0.94
Personal care	1.10	1.08	1.06	*ns*
Dexterity	1.13	1.11	1.12	1.11
Behaviour	*ns*	*ns*	0.86	0.93
Intellectual functioning	*ns*	*ns*	0.84	0.89
Hearing	*ns*	0.89	*ns*	*ns*
Reaching and stretching	1.09	*ns*	1.14	*ns*
Seeing	1.15	1.18	*ns*	1.17
Continence	*ns*	0.94	0.94	*ns*
Communication	*ns*	1.11	0.90	*ns*
Disfigurement	*ns*	ns	ns	ns
Consciousness	ns	ns	0.80	0.82
Eating, drinking, digesting	ns	*ns*	0.21	*ns*
Outcomes correctly predicted	68%		79%	

* Odds ratio (OR) adjusted for the effects of one disability upon another.
ns = not significant.

The association of each type of disability with lower rate awards is shown in Table 5.3 by odds ratios (ORs). These ratios represent the multiplier effect of a disability on the chances of a lower rate award as the severity score increases by one unit. If a disability increases the likelihood of a lower rate award, the OR is greater than one; if the ratio is less than one the chances of a lower rate award are decreased. A ratio of one, or close to one, means no significant effect. As an example, it will recalled from Annex 2.2 that the OPCS seeing disability scale ranges from 0 to 12. According to Table 5.3, assignment to the top of that scale, which includes people who 'cannot tell by the light where the windows are', increases the chances of receiving lower rate care, as opposed to the chances of rejection, 13.8 times (1.15 x 12). When other disabilities are taken into account, being so visually disabled increases the chances 14.2 times (1.18 x 12). One way of interpreting this is that blind applicants are 14 times as likely to be awarded the lower rate as be rejected. Or, lower rate care recipients are 14 times as likely to be blind as unsuccessful applicants.

Table 5.3 shows that, four types of disability taken together are associated with lower rate awards:

Seeing
Dexterity
Personal care
Communication

Dexterity and seeing disabilities are the most important and distinguish both adjudication boundaries. As suggested above, difficulties arising from dexterity, seeing and personal care disabilities are not far removed from the lower rate criteria. Communication disability is also associated with lower rate awards. In this sample, severe communication problems arise chiefly from a stroke or mental impairment, and these, too, often limit the ability to prepare a cooked meal. Interestingly, reaching and stretching difficulties do not discriminate between care outcomes when all disabilities are considered, presumably because such difficulties are often associated with, and therefore subsumed under, dexterity problems.

As expected, disabilities associated with middle or higher rate as opposed to lower rate awards largely reflect needs for supervision. The most important are: behaviour disorders, intellectual functioning and consciousness disabilities. In addition, middle or higher rate awards are associated with locomotion disabilities reflecting the often greater needs for attendance of people with reduced mobility.

Each model can be used to predict care outcomes. Such predictions indicate the extent to which application of the rules on entitlement to a care award differentiate applicants according to type and severity of disability. It can seen that both models correctly predict over two-thirds of outcomes, indicating a good fit with the subset of disabilities. In other words, adjudication according to the nature and frequency of care needs differentiates a majority of applicants according to distinct patterns of disability. The findings further suggest that the distinction between lower and middle or higher rate recipients is somewhat better defined than are differences between lower rate recipients and unsuccessful applicants. One interpretation is that the lower rate care criteria have identified a new group of beneficiaries in the disabled population.

5.3 DLA mobility awards and different types of disability

The OPCS scale of locomotion disability largely covers difficulties associated with walking and climbing and should distinguish between higher rate recipients and other applicants. Up to three disabilities - seeing, behaviour and intellectual functioning - could imply a need for guidance or supervision when out of doors and the expectation was that these disabilities in particular would be associated with lower rate mobility awards.

Table 5.4 Prevalence of different types of disability by DLA mobility awards

Type of disability	**Higher rate mobility** (%)	**Lower rate mobility** (%)	**Rejected claims** (%)	**Not claimed** (%)
Locomotion	99	58	85	45
Personal care	85	38	64	64
Dexterity	50	22	44	69
Behaviour	26	62	34	35
Intellectual functioning	23	64	31	33
Hearing	30	25	32	30
Reaching and stretching	36	10	29	46
Seeing	19	38	21	17
Continence	22	23	22	18
Communication	14	39	17	24
Disfigurement	10	6	8	16
Consciousness	3	23	5	3
Eating, drinking, digestion	4	5	4	3
Base (= 100%)	*572*	*306*	*645*	*103*

Percentages sum to more than 100 because some people have more than one disability.

5.3.1 Prevalence of disabilities - mobility awards

Table 5.4 shows that almost everyone with a higher rate mobility award has a locomotion disability (that one per cent apparently do not is probably due to errors in the survey process or the DLA database). The raised prevalence of reaching and stretching, dexterity, and personal care disabilities among higher rate recipients also suggests that they are more likely to be physically disabled than other applicants.

As expected, the findings show that seeing difficulties and disabilities associated with mental impairment - behaviour, intellectual functioning and communication - are most prevalent among recipients of lower rate mobility awards. Lower rate recipients are also more likely to report fits or convulsions. The lower rate criteria note that people who tend to fall may need watching over when walking, and this would apply to those with a consciousness disability, especially if they have no warning of an attack.

Nonetheless, there is considerable overlap in the prevalence of different types of disability between mobility outcomes. Rejected claimants often have the same disabilities as successful applicants: the vast majority have a locomotion disability and around a third are mentally impaired, for instance. Substantial minorities of claimants not applying for a mobility award also have these disabilities. Such apparent inconsistencies could be explained if the disabilities associated with mobility needs are less severe among rejected claimants and non-applicants.

5.3.2 Severity of disabilities - mobility awards

The severity of each disability is summarised in Table 5.5 according to the outcome of an application for a mobility award. Compared with other applicants, it can be seen that locomotion disability is more severe among higher rate recipients and the difference is statistically significant. Although other respondents report walking difficulties, it would appear that these are not severe enough on average to qualify for the higher rate.

Table 5.5 Severity of different types of disability by DLA mobility awards

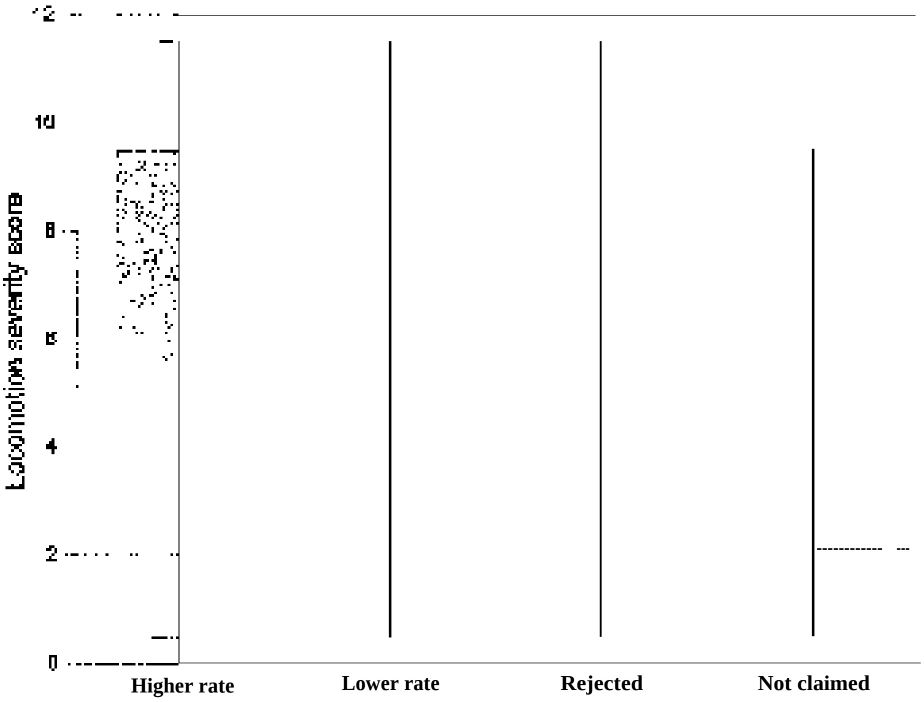
Type of disability	**Higher rate mobility mean (SD)**	**Lower rate mobility mean (SD)**	**Rejected claims mean (SD)**	**Not claimed mean (SD)**
Locomotion	6.5	5.3	5.3	4.2
	(2.5)	(2.7)	(2.5)	(2.2)
Personal care	7.3	7.2	6.6	8.7
	(3.8)	(4.0)	(4.0)	(3.2)
Dexterity	7.4	7.3	7.4	7.1
	(1.8)	(2.0)	(1.9)	(1.7)
Behaviour	6.1	7.2	6.6	6.9
	(2.9)	(3.1)	(3.1)	(2.8)
Intellectual functioning	4.8	5.9	4.8	4.6
	(3.0)	(3.0)	(3.0)	(2.4)
Hearing	1.8	1.9	1.9	2.0
	(2.2)	(2.2)	(2.4)	(2.1)
Reaching and stretching	4.4	4.2	4.3	2.9
	(2.4)	(1.9)	(2.4)	(2.4)
Seeing	2.0	3.8	1.4	1.8
	(2.9)	(3.6)	(1.9)	(2.2)
Continence	5.4	5.3	5.3	4.0
	(2.9)	(2.7)	(2.9)	(3.6)
Communication	4.4	4.5	4.0	4.8
	(2.6)	(2.6)	(2.5)	(2.3)
Consciousness	*6.7*	*8.9*	7.7	6.7
	(3.0)	(2.5)	(2.9)	(3.7)

* Excludes people below the minimum threshold for each disability. Severity levels for disfigurement and digestion disabilities were not defined.

Other significant differences are consistent with the need for guided mobility covered by a lower rate award. Thus lower rate recipients have a more severe seeing or intellectual disability than either higher rate recipients, unsuccessful claimants or non-applicants. Behaviour and consciousness disabilities are also more severe on average among lower rate recipients than other outcomes.

In spite of these associations there is a good deal of overlap. To illustrate this, Figure 5.2 plots the distribution of individuals' scores on severity of walking difficulties by mobility outcomes. It can be seen that, apart from those not applying for an award, all outcomes include individuals across the full severity range of the locomotion disability scale (0.5 to 11.5). Higher rate recipients report the most severe walking difficulties on the whole but many lower rate recipients and unsuccessful applicants have similar problems getting around. As might be expected, severity of walking difficulties does not distinguish lower rate recipients and unsuccessful applicants.

Figure 5.2 Severity of locomotion disability by DLA mobility outcomes



5.3.3 *Combinations of disabilities - mobility awards*

To discover which subset of disabilities best distinguishes lower rate mobility awards, we carried out two analyses, one comparing higher and lower rate awards and another comparing lower rate awards and rejected claims.

Table 5.6 Lower rate mobility awards and different types of disability

	Association with lower rate care awards versus:			
	Rejected claims		**Higher/Middle rate awards**	
Type of disability	**OR**	**OR***	**OR**	**OR***
Locomotion	0.86	0.89	0.68	0.73
Personal care	0.92	*ns*	0.84	0.88
Dexterity	0.87	0.92	0.85	0.91
Behaviour	1.14	*ns*	1.22	1.10
Intellectual functioning	1.22	1.22	1.30	1.22
Hearing	*ns*	*ns*	*ns*	0.81
Reaching and stretching	0.78	0.85	0.73	*ns*
Seeing	1.40	1.44	1.27	1.32
Continence	*ns*	*ns*	*ns*	*ns*
Communication	1.23	*ns*	1.25	*ns*
Disfigurement	*ns*	*ns*	0.29	*ns*
Consciousness	1.21	1.21	1.34	1.37
Eating, drinking, digesting	*ns*	*ns*	*ns*	*ns*
Outcomes correctly predicted	80%		86%	

* OR adjusted for the effects of one disability upon another.
ns = not significant.

The findings, summarised in Table 5.6, show that together four types of disability are significantly associated with lower rate mobility awards:

Seeing
Consciousness
Intellectual functioning
Behaviour

As suggested above, these four disability areas closely mirror the lower rate criteria on the need for guidance and supervision out of doors. Communication difficulties are also associated with lower rate awards but not when the effects of other disabilities are taken into account. This is because communication difficulties are associated with severe mental impairment which, with severe behaviour disorders, often implies supervision needs. So communication difficulties are covered by intellectual disability when all disabilities are considered together. The implication is that people with communication difficulties but who are not severely mentally impaired would not necessarily be eligible for a lower rate mobility award.

Higher rate recipients are also clearly distinguished according to patterns of disability. In addition to severe walking difficulties, these findings confirm that many people who are unable or virtually unable to walk often have other physical disabilities, affecting dexterity and self-care, for example.

Both models correctly predict four out of five mobility outcomes. Adjudication of mobility needs, therefore, distinguishes most applicants according to distinct patterns of disability. This was not unexpected. Walking difficulties and guidance needs, which define the higher and lower rate criteria respectively, arise from quite unrelated impairments.'[4] Higher rate recipients, for example, do not necessarily meet the conditions of entitlement to a lower rate mobility award. Indeed, the higher rate and lower rate mobility criteria could be said to define two different benefits. As a consequence, we would expect the determination of mobility awards to discriminate clearly between applicants according to different subsets of disability.

One implication is that unsuccessful applicants form a rather diverse group, some with walking difficulties, others with supervision needs, some with both, but in neither case sufficient to qualify for an award at either level. However, our findings suggest that unsuccessful applicants are more likely to have disabilities which give rise to walking difficulties than to needs for guidance outdoors. Most would be better characterised as unsuccessful applicants for a higher rate than a lower rate award.

Thus Table 5.6 shows that many of the disabilities associated with higher rate awards are also associated with unsuccessful applicants more or less to the same extent. Both have more severe locomotion disabilities and less severe `guidance disabilities' than lower rate recipients, suggesting, on the face of it, that unsuccessful applicants are very similar to higher rate recipients. To investigate this further, we compared the disabilities of higher rate recipients and unsuccessful applicants by logistic regression analysis. Not surprisingly, higher rate recipients were differentiated by more severe locomotion disabilities (OR = 1.24); they also have more severe personal care disabilities than unsuccessful applicants (OR = 1.06), suggesting generally higher levels of physical disability. But only one `guidance disability', behaviour disorders, separates the two groups (OR = 0.93), being more severe among unsuccessful applicants than higher rate recipients. Both groups are equally likely to present the guidance needs arising from seeing, intellectual and consciousness disabilities. As a consequence, the distinction between higher rate recipients and unsuccessful applicants is somewhat less clear-cut than that between other mobility outcomes. Altogether, the model predicts 64 per cent of higher rate awards and rejected claims.

5.4 Mental health problems

Mental health problems *can* be both a cause and a consequence of severe disability, greatly complicating any association between psychiatric disturbance and DLA outcomes. It may be that, on their own, mental health problems rarely determine the result of an application for DLA. With appropriate medication and support, including day care, most mental health sufferers cope with daily living and would not be sufficiently disabled to qualify for DLA. However, almost everyone in this

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[14] Nor is there any positive association, statistically speaking, between walking difficulties and guidance needs. The correlation between locomotion disability and 'guidance disabilities' are: seeing (r = -01), behaviour (-0.20), intellectual functioning (-0.19) and consciousness disability (-0.10).

study has other disabilities and how these combine with psychiatric disorders would be taken into consideration when assessing their claim for DLA. Psychiatric problems can themselves imply care needs especially in the form of supervision or watching over; mobility needs may also occur.

Although the OPCS disability scales provide a comprehensive account of the experience of disablement, they do not cover many of the consequences arising from psychological impairments. To remedy this we asked respondents to complete the 12-item version of the *General Health Questionnaire,* a widely used screening instrument for detecting psychiatric disorder (Goldberg and Williams, 1991). Findings on the prevalence of psychiatric or chronic cases and measures of severity of psychiatric disturbance are summarised in Annex 5.1.

Our findings suggest that the distribution of DLA awards largely reflect variations in supervision needs arising from mental health problems. Psychiatric symptoms are most prevalent among recipients of middle or higher rate care, and lower rate mobility. Despite this, some of the most severely disturbed respondents had their claim for DLA disallowed.[15] As suggested above, such people may not qualify for DLA because eligibility is not based on the nature or degree of mental health problems. However, it may be that applicants with mental health problems, or their carers, fail to give a full account of their needs or that these are not fully addressed in the claiming and adjudication process. To investigate this further we compared the pattern of disabilities among people with and without mental health problems across DLA outcomes.

Our examination found no evidence to suggest that people with mental health problems are more likely to be rejected for a DLA award than other applicants. Where they have disabilities implying care or mobility needs, they are as likely to get the same award as similarly disabled people who do not have psychiatric symptoms. In other words, the findings suggest that people with mental health problems are not treated differently from other DLA applicants solely on account of those problems. If people with severe mental health problems do have care or mobility needs, they may not be sufficient to attract an award or are not identified in the claiming and adjudication process.

5.5 Summary and conclusions

Eligibility for DLA is based on the effects of disability rather than the severity or nature of disability. Measures of different types of disabilities, therefore, can never be more than proxies for the conditions of entitlement to DLA. They are conceptually one step removed from the handicaps that DLA aims to address. Our examination of DLA outcomes according to patterns of disability does not pretend, therefore, to evaluate the extent to which the conditions of entitlement are consistently applied. That is the subject of the next chapter. Rather, in this chapter we aimed to take a broader look at the targeting of lower rate awards, to assess their scope, describe the disabilities of people brought into benefit by the conditions of entitlement, and locate the boundaries of entitlement. If DLA is functioning as intended, the new lower rate criteria should identify a group of beneficiaries with distinct patterns of disability. Additionally, disabilities reflecting the middle or higher rate conditions of entitlement should be less severe among lower rate recipients. This was largely confirmed.

The findings show that:

a. Lower rate recipients of each component of DLA are mostly defined by distinct subsets of disabilities which reflect the criteria for lower rate care and lower rate mobility awards respectively. As might be expected, there is considerable variation in the types of disability considered here, both within and between DLA outcomes. There are no watertight categories

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[15] This was the case even after excluding respondents who may not be eligible for a care award because they are living in a communal establishment.

because different types of disability, especially when considered one at a time, represent imperfectly the frequency or severity of care and mobility needs in a disabled population. Certain well-defined combinations of disabilities are consistent with the conditions of entitlement, however. Where a link with entitlement can be inferred, variations in the prevalence and severity of disabilities correlate with outcomes. Disabilities reflecting the lower rate criteria are more prevalent and most severe among lower rate recipients. Moreover, lower rate recipients are less severely disabled in respect of disabilities reflecting the middle or higher rate criteria than recipients of these awards.

b. As a result, lower rate recipients of each component are readily distinguished from other beneficiaries. Lower rate mobility awards in particular identify a new constituency of recipients because guidance needs, represented here mainly by intellectual and behaviour disabilities, are quite distinct from, and often unrelated to, walking difficulties. The three rates of care award represent a more graded sequence, at least in terms of attendance needs, and it is not clear that the so-called `meals test' breaks new ground. Many of those with dexterity disabilities - who need help to prepare a cooked main meal - have personal care disabilities, and vice versa. It seems that in practice the lower rate care criteria reduce the threshold of care needs rather than establish a different or additional dimension of entitlement. They nevertheless bring into benefit people with distinct patterns of disabilities which are quite different from that of those who qualify for a middle or higher rate award.

c. The similar patterns of disability among people applying or not applying for one or other component is potentially worrying. Those claiming both a care and a mobility award have had their claims considered, at least in part, on the basis of the evidence submitted by claimants. However, many respondents who did not apply for a component have patterns of disability similar to that of their counterparts whose claim was successful and, on the face of it, they also have similar care or mobility needs. Adjudication officers may not have had these needs brought to their attention in any additional evidence they considered to determine such claims. Whether the needs of these claimants are sufficiently frequent or severe to satisfy the criteria for an award is a separate matter but the findings raise a question about their potential entitlement. It seems that they would have been best advised to apply for both components.

d. Some respondents with severe psychiatric disorders, as measured here, often do not qualify for any award. Comparing their disabilities with those of other applicants provided no firm evidence to suggest that unsuccessful claimants with mental health problems would satisfy the criteria for an award. We recognise, however, that the presentation of such conditions, particularly their fluctuating nature, can make it difficult to determine the level of care or mobility needs and their likely duration. It may also be that the care or mobility needs of such applicants are insufficient to attract an award or that their needs are not identified in the claiming and adjudication process. Further investigation of these issues is required.

It is now clear why so many lower rate recipients fall above the target severity categories 5 and 6 on the OPCS scale, discussed in Chapter 4. Not only are most people multiply, and therefore severely, disabled (Table 3.12). Many of the disabilities they have, and which can contribute to their overall severity scores, are unrelated to the entitlement criteria for DLA. Disabilities related to lower rate awards are most prevalent at the higher overall severity levels. It is not surprising, therefore, that there is little association between severity of overall disability and the distribution of lower rate awards. Considering different types of disability, however, shows that lower rate recipients are *less severely disabled* in respect of those disabilities that give rise to the care or mobility needs covered by the middle or higher rate criteria. In this sense, the new lower rate awards are meeting one of the chief objectives of DLA: to extend help with care and mobility needs to people with moderate disabilities who did not qualify for the former attendance or mobility allowances.

The analysis presented here can provide no more than a broad assessment of the targeting of DLA for reasons discussed above. In the next chapter, we move on to examine DLA outcomes according to explicit measures of the care and mobility needs that correspond more closely to the conditions of entitlement.

ANNEX 5.1

Mental health problems

To measure the psychological health or ill-health of individuals and estimate the prevalence of psychiatric disturbance, we included in our survey of adults the 12-item version of the *General Health Questionnaire,* or GHQ-12. This is a widely used screening questionnaire for detecting psychiatric illness and has been shown to be valid and reliable in community surveys (Goldberg and Williams, 1991). It is designed to identify difficulties in carrying out one's normal `healthy' functions, and elements of distress such as depression and anxiety.

We developed three measures of prevalence. Two are derived from questions which Goldberg and Williams recommend as a simple way of detecting psychiatric or chronic cases:

a. Are you taking any medicines or tablets for your nerves?

b. Do you think that you have a nervous illness?

As a third measure of prevalence, any four positive answers on the GHQ-12 was chosen as the threshold for the identification of probable psychiatric cases: a `GHQ case'.

To measure severity and place individuals on an overall dimension of psychiatric disturbance, the GHQ-12 can be scored in various ways. Three scoring methods, described by Goldberg and Williams are used here: the GHQ score, the simple Likert score and the chronicity score or CGHQ scoring method. For each method, the higher the score the greater the degree of disturbance measured by the questionnaire. The findings are summarised in Tables 5.7 to 5.10.

Table 5.7 Prevalence of psychiatric disorder by DLA care awards

Psychiatric case	**Higher rate care** (%)	**Middle rate care** (%)	**Lower rate care** (%)	**Rejected claims** (%)	**Not claimed** (%)
Takes medication for nerves	33	28	17	21	11
Thinks has a nervous illness	38	31	15	22	14
GHQ case	80	59	59	69	56
Base (= 100%)	*60*	*181*	*699*	*374*	*312*

Percentages sum to more than 100 because of multiple response.

Table 5.8 Severity of psychiatric disorder by DLA care awards

GHQ scale	**Higher rate care mean (SD)**	**Middle rate care mean (SD)**	**Lower rate care mean (SD)**	**Rejected claims mean(SD)**	**Not claimed mean (SD)**
GHQ score	6.7	5.3	5.3	6.3	4.9
	(4.0)	(4.0)	(4.0)	(4.1)	(4.0)
GHQ Likert score	20.5	18.0	17.6	19.5	17.3
	(8.0)	(7.5)	(7.2)	(7.7)	(7.1)
GHQ Chronicity score	8.2	7.5	7.5	8.1	7.5
	(3.1)	(3.0)	(3.2)	(3.2)	(2.9)

Table 5.9 Prevalence of psychiatric disorder by DLA mobility awards

Psychiatric case	**Higher rate mobility** (%)	**Lower rate mobility** (%)	**Rejected claims** (%)	**Not claimed** (%)
Takes medication for nerves	13	29	18	23
Thinks has a nervous illness	10	33	20	22
GHQ case	61	51	66	60
Base (= 100%)	*572*	*306*	*645*	*103*

Percentages sum to more than 100 because of multiple response.

Table 5.10 Severity of psychiatric disorder by DLA mobility awards

GHQ scale	**Higher rate mobility mean (SD)**	**Lower rate' mobility mean (SD)**	**Rejected claims mean (SD)**	**Not claimed mean (SD)**
GHQ score	5.4	4.6	5.9	5.8
	(3.8)	(4.2)	(4.1)	(4.3)
GHQ Likert score	17.8	16.5	18.9	18.7
	(6.8)	(8.1)	(7.5)	(7.8)
GHQ chronicity score	7.7	6.7	8.0	7.7
	(2.9)	(3.5)	(3.1)	(3.2)

Chapter 6 Care and Mobility Needs

6.1 Introduction

The DLA application form consists of two sections. The first section asks for personal details about the applicant and for basic factual information to register a claim. Section 2 goes on to ask how illness or disability affects the claimant's life and covers a range of mobility and care needs described in the conditions of entitlement. There is also space for two 'supporting' statements about the applicant's illness or disabling condition: one from someone who looks after the applicant or knows them well like a relative or friend, and one from a GP or other health professional who knows most about the applicant's illness or disability.[16] In addition, adjudication officers may request a full medical report from the applicant's GP, a hospital or an EMP appointed by the DSS. The EMP usually visits the claimant in their own home. Adjudication officers may also seek further information from the claimant by telephone, letter or a visit from a Benefits Agency visiting officer. It was beyond the scope of this study to investigate how such information is used to determine claims and awards. Clearly a full account of the volume, pattern and timing of the help needed by each applicant is required to make an informed decision on his or her claim. Such an account provides, therefore, an important yardstick against which to evaluate the targeting of awards.

We did not repeat the questions from the claim form, nor was it practical to talk to applicants' families or professional carers. As noted in Chapter 2, the research design for this study required us to use the disability questionnaire developed for the OPCS survey. With some adaptation, however, this questionnaire covers much the same ground as the assessment of needs in Section 2 of the application form. The information generated by our survey is used here to investigate:

a. the extent to which respondents, classified according to the outcome of their application for DLA, can be distinguished according to patterns of need, and

b. whether variations in patterns of need according to DLA outcomes reflect the conditions of entitlement.

Our principal focus is the distribution of lower rate awards. The first aim addresses the question of who is being reached by these awards, while the second examines the question of whether lower rate recipients reflect the intended scope of the lower rate criteria. Both aims embrace the principle of consistency, that is, the extent to which those with similar patterns of care or mobility needs are treated the same in accordance with the eligibility criteria. Consistency is measured here by the accuracy of statistical predictions.

In this chapter we identify various measures of care and mobility needs from our survey assessment. The choice and definition of these indicators were informed by the conditions of entitlement. They are then used to evaluate the targeting of lower rate care awards and lower rate mobility awards in turn. Observed and predicted

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[16] Section 2 of the application form is optional so adjudication officers may rely on other sources of information instead of, or in addition to, that supplied by the applicant to decide a claim. The applicant can also choose to fill in the first part of Section 2 which covers mobility needs, or the second part covering care needs, or both. The primary function of the two 'supporting' statements is to verify the applicant's identity, as required by the Secretary of State, but they often contain valuable information about applicant's illness or disability and how it affects them.

outcomes are compared and incorrect predictions are examined further to shed light on the degree of consistency in the initial distribution of awards.

Although we did not fully assess levels of need, the findings show that the vast majority of lower rate awards (96 per cent of care and 70 per cent of mobility awards) can be predicted from our survey assessment. The relative lack of success in predicting lower rate mobility awards can be attributed chiefly to the difficulties of ascertaining guidance needs and to the structure of the mobility component which, as noted in Chapter 5, comprises essentially two distinct benefits. Sizeable minorities of unsuccessful applicants are predicted to receive lower rate awards, but there is no firm evidence to suggest that they might have expected a more favourable outcome on their initial claim. Some applicants are also predicted to receive a lower rate award for that component of DLA for which they did not apply, raising a question about their potential entitlement. Overall, however, the evidence supports the view that the lower rate criteria of each component identify new and distinct constituencies of beneficiaries. It further shows that adjudication officers are successful in consistently identifying those who are eligible for an award.

Table 6.1 Care needs: lower rate awards and rejected claims

Care needs	**Lower rate care** (%)	**Rejected claims** (%)	**OR**	**OR***
Needs help preparing a hot meal	72	40	3.9	3.2
Needs 20 hours or more help a week	66	52	1.8	ns
Needs to be accompanied outdoors	54	42	1.6	ns
Needs help washing up and drying dishes	52	29	2.7	*ns*
Needs help dressing and undressing	42	29	1.8	*ns*
Needs help washing all over	39	24	2.0	*ns*
Needs help preparing a snack	35	16	2.9	ns
Needs help making a hot drink	30	14	2.6	ns
Needs help getting in and out of bed	30	22	1.6	*ns*
Needs help feeding including cutting up food	23	6	5.0	3.1
Needs help every few hours during day/most nights	22	11	2.3	*ns*
Cannot pick up and pour from a full kettle	17	6	2.9	*ns*
Cannot unscrew the lid of a coffee jar	15	4	4.2	3.1
Cannot serve food from a pan using a spoon or ladle	11	4	2.8	*ns*
Cannot pick up and hold a mug of tea or coffee	9	4	2.3	*ns*
Needs a lot of help/attention throughout day or night	9	5	1.7	ns
Needs help washing hands and face	6	3	2.0	ns
Needs help drinking from a cup or mug	3	1	5.5	*ns*
Needs less than 20 hours help a week	33	47	0.6	*ns*
Gets so upset that runs away	13	20	0.6	0.5
Cannot turn a tap on and off	9	6	*ns*	*0.5*
Base (= 100%)	*699*	*374*		

* OR adjusted for the effects of one indicator upon another. ns = not significant.
Percentages sum to more than 100 because some people have more than one need for help.

6.2 DLA care awards and care needs

We defined 40 indicators of care needs from the survey information. These are shown in Annex 6.1 grouped according to needs for attention (19 indicators), supervision (11) and help preparing a cooked main meal (10), the three main dimensions of needs covered by the care component. They include self-care activities with which individuals might need help, washing and dressing for example, behaviours which can imply a need for watching over, and some of the skills required to plan and prepare a meal. Some indicators represent the amount and frequency of needs that applicants may have during the day or night. To investigate the distribution of care awards according to these indicators, we look first at the boundary between lower rate awards and rejected claims, and then compare lower rate recipients and recipients of middle or higher rate awards.

6.2.1 *Lower rate care recipients and unsuccessful applicants*

Twenty of these needs distinguish between lower rate recipients and unsuccessful applicants. Their prevalence and associations with outcome, as measured by ORs, are shown in Table 6.1. As an example, 72 per cent of lower rate recipients said they need help preparing a hot meal compared with 40 per cent of unsuccessful applicants. Lower rate recipients are nearly four times as likely (OR = 3.9) to need help preparing a hot meal as unsuccessful applicants. Another way of expressing this is that needing help to prepare a hot meal increases the chances of a lower rate award, as against rejection, nearly four times.[17]

It can be seen that 18 of these needs, so defined, are associated with lower rate awards although some are reported by very few respondents. Each of them describes a need for personal attention with bodily functions, or for someone to cook a hot meal or perform related activities requiring similar skills. Further, many of the attendance indicators associated with lower rate awards imply limited or periodic needs for care, perhaps three or four times a day: first thing in the morning, at meal times, and again in the evening. Preparing a cooked meal or limited care are precisely the areas covered by the lower rate criteria, although not all such needs, as defined here, would necessarily have informed the adjudication process.[18] Other attendance needs listed in Annex 6.1, which do not distinguish, statistically, between lower rate recipients and unsuccessful applicants are also more prevalent among the former group, confirming that they have a greater overall need for help with personal care.

Two indicators are associated with an unsuccessful claim: needing less than 20 hours of help a week and a risk of running away. This last indicator represents a need for supervision. Most of the indicators shown in Annex 6.1 that do not distinguish between lower rate recipients and unsuccessful applicants reflect supervision needs. This is as expected: such needs should only distinguish between higher or middle rate recipients and other applicants. Lower rate recipients may have supervision needs, more or less in the same proportions as unsuccessful applicants, but presumably in neither case were these considered to give rise to substantial danger. As a result, they did not qualify for a middle or higher rate award.

No single need as defined here is reported by everyone, but most respondents clearly have more than one: people who need help getting in and out of bed will often need help dressing, for example. This suggests that patterns of needs rather than their crude prevalence would distinguish more sharply between outcomes. To find the best combination to predict lower rate awards we evaluated all 40 indicators using logistic regression analysis.

When considered together, only the five indicators shown in the last column of Table 6.1 distinguish between lower rate awards and rejections.[19] The three most important predictors, all associated with lower rate awards, indicate a need for help with preparing and eating a main meal. Needing help preparing a cooked meal, a key test for lower rate awards, is also the most inclusive indicator, mentioned by more than seven out of ten recipients. Feeding difficulties imply limited or periodic care as well as dexterity problems. Two of the five predictors are associated with unsuccessful applicants, including the one shown at the bottom of Table 6.1 which, on its own, does not have a significant effect on outcome. One of these, running away, implies supervision needs. The other, an inability to turn taps on and off, relates to dexterity and arguably should be associated with lower rate awards: this

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[17] ORs greater than one show that a need is associated with, or more prevalent among, lower rate recipients; those less than one the reverse. ORs are assessed as signifcantly different from 1.0, that is, no association, according to 95 per cent confidence intervals. Appendix 4 provides further details on the interpretation of ORs.

[18] The conditions of entitlement are summarised in Annex 2.1. A need to be accompanied outdoors was ruled as attention in connection with bodily functions in April 1994 after the initial claims of respondents in this survey had been determined.

[19] The best predictors are identifed by statistical criteria. They do not necessarily identify individuals' most important needs or those that actually determine the outcome of their claims.

is the case when considered on its own (OR = 1.6), though insufficiently so be statistically significant.

Table 6.2 Needs for help with care: lower rate and higher or middle rate awards

Care needs	**Lower rate care** (%)	**Higher/ middle rate care** (%)	**OR**	**OR***
Needs help preparing a hot meal	72	63	1.6	1.9
Needs help washing up and drying dishes	52	41	1.5	*ns*
Needs help dressing and undressing	42	29	1.8	ns
Needs less than 20 hours help a week	33	24	1.6	*ns*
Occasionally needs help during the day or night	27	10	3.3	1.9
Needs 20 hours or more help a week	66	74	0.7	*ns*
Needs to be accompanied outdoors	54	67	0.6	*ns*
Needs help with medical treatment	29	41	0.6	*ns*
Needs someone to keep a watchful eye day and night	22	46	0.3	0.6
Feels the need to have someone present all the time	18	38	0.4	*ns*
Often gets confused	17	38	0.3	0.5
Gets so upset that runs away	13	27	0.4	*ns*
Needs help with oral communication	12	21	0.5	*ns*
Needs a lot of help/attention throughout day or night	9	15	0.5	*ns*
Needs help getting to the toilet	9	16	0.5	0.3
Gets so upset that breaks or rips up things	9	21	0.4	*ns*
Needs help washing hands and face	6	12	0.5	*ns*
Gets so upset that hits other people	5	12	0.4	*ns*
Needs help using the toilet	4	7	0.5	*ns*
Often forgets to turn off fire, cooker or taps	4	8	0.5	*ns*
Wanders off without realising	3	13	0.2	0.4
Gets so upset that injures him/herself	3	17	0.2	0.3
Usually gets no warning of a fit/convulsion	2	16	0.1	0.1
Needs help feeding including cutting up food	23	17	*ns*	*2.3*
Cannot serve food from a pan using a spoon or ladle	11	14	*ns*	0.5
Base (= 100%)	*699*	*241*		

* OR adjusted for the effects of one indicator upon another. *ns* = not significant.
Percentages sum to more than 100 because some people have more than one need for help.

6.2.2 *Lower rate and middle rate care recipients*

Our indicators of care needs also distinguish between different levels of an award in ways that are consistent with the conditions of entitlement. Twenty-three indicators distinguish between lower rate recipients and higher or middle rate recipients, as shown in Table 6.2. The first five are associated with lower rate awards. These relate to needs for help with preparing a cooked main meal or for limited attention from someone for personal care - help with getting dressed or occasional help during the day or night for instance.

The remaining 18 indicators are associated with middle or higher rate recipients and, as might be expected, they divide almost equally between supervision and attendance needs. They imply a need for continual supervision arising from aggressive behaviours, self-harm, potential dangers out of doors, unforeseen epileptic fits or impaired memory. Fewer specific attendance needs are significantly associated with higher or middle rate recipients, probably because our indicators do not adequately capture the frequency or intensity of need that would distinguish them from lower rate recipients. Nonetheless, those attendance needs that are associated with higher or middle rate awards imply heavy or important care needs, help with toileting or medication for example, and for lengthy periods of attention during the day or the night, or both.

Although lower rate recipients are more likely to need help preparing a cooked meal, a majority of recipients reported such a need irrespective of the level of award. Moreover, many of the needs associated with preparing a meal (those arising from poor dexterity skills, for example) do not distinguish between different levels of a care award. This is not surprising. Although most lower rate recipients qualify for an award solely on account of the meals test, people who qualify for a middle or higher rate award are also often unable to prepare a cooked meal because of dexterity or learning difficulties. Some middle and higher rate recipients also report the limited or periodic care needs associated with lower rate awards, for example, help with dressing and undressing. Clearly, such needs may be present regardless of whether the more demanding attendance or supervision criteria are met.

When considered together ten indicators, shown in the last column of Table 6.2, are sufficient to predict lower rate and other awards. It can be seen that these predictors cover attendance and supervision needs, and help with preparing a main meal. They include help with feeding and difficulties serving food which, on their own, do not distinguish between lower rate and other recipients.

6.2.3 Predicting lower rate care awards

The model separating lower rate recipients from unsuccessful claimants, and the model separating those receiving the lower rate from middle or higher rate recipients, can be used to assign each case to a predicted outcome. That is, using the information at its disposal, each model predicts the probability of an individual belonging to one group or another. Estimated probabilities greater than one-half identify the predicted outcomes for individuals. Comparing the observed and predicted outcomes provides an indication of consistency in the distribution of awards, at least according to the model.

Figure 6.1 Observed and predicted outcomes: DLA care awards

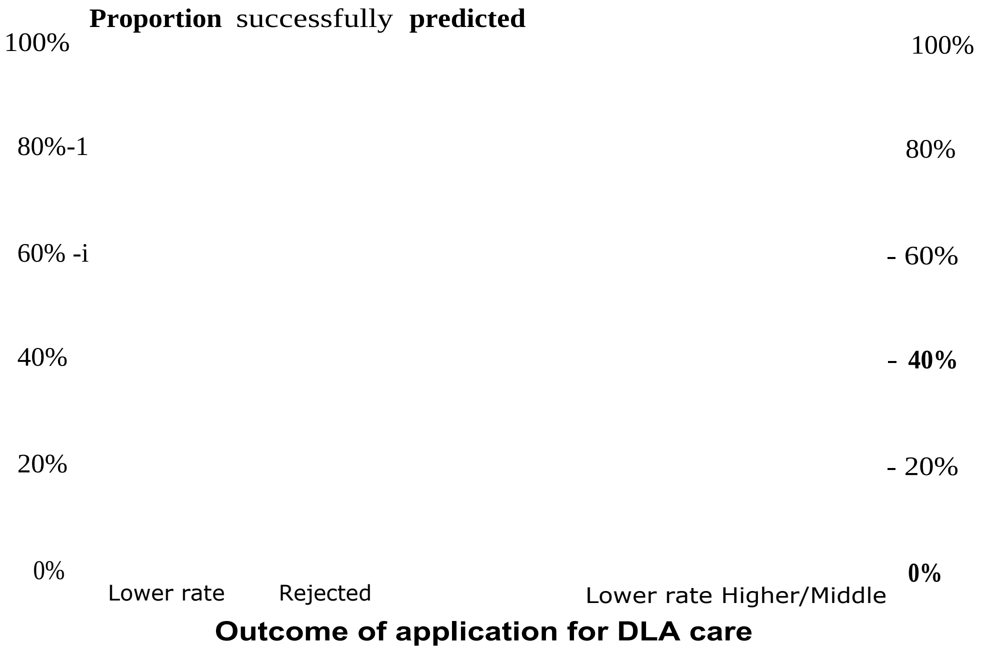

Figure 6.1 shows the predicted outcomes with a probability of 0.5 or more. Most lower rate recipients are correctly predicted, as are a majority of unsuccessful applicants. However, comparatively few higher or middle rate recipients are correctly assigned because, as noted above, our indicators reflect poorly the frequency and intensity of needs in this group. As a consequence, they are not so clearly distinguished from lower rate recipients.

Table 6.3 compares predicted outcomes for lower rate recipients from both models. The rows of the table show the predictions from the model separating lower rate recipients and unsuccessful applicants. The columns summarise the predictions from the model separating lower rate from middle or higher rate recipients. Individuals have been grouped according to the probability of a lower rate award.

Instead of two outcomes predicted by probabilities greater or less than one-half, a middle category is introduced. This defines outcomes which are uncertain according to the model, that is with estimated probabilities close to 0.5.

Table 6.3 Lower rate care awards: prediction results

Predicted probabilities of a lower rate award	**Lower rate care** (5 **0.6)** **(N)**	**Uncertain (? 0.4< 0.6)** **(N)**	**Higher/middle rate care** (<0.4) **(N)**	**Missing cases** **(N)**	**Total** (N)
Lower rate care (≥ 0.6)			II		439
Uncertain (? 0.4 < 0.6)	I-	13	*6*	*2*	192
Rejection (< 0.4)	21	3	3	1	28
Missing cases				*	I
Total	589	41	20	10	660

* 39 cases excluded from both analyses because of missing data.

It can be seen that 60 per cent *(396)* of lower rate care recipients are confidently predicted to receive lower rate care awards by both models, and a further 36 per cent (236) by one model or the other. These predictions are shaded in the table. Only four per cent of lower rate recipients (28) are incorrectly predicted by both models, or the outcome of their claim is uncertain.

Almost all lower rate care recipients, therefore, can be distinguished by one or both models from unsuccessful applicants and other recipients according to their pattern of needs. Further, these findings settle the concern about the poor targeting of lower rate care awards in relation to severity of overall disability, discussed in Chapter 4. The vast majority of lower rate recipients, whether on, above or below the target severity categories, are predicted to receive a lower rate award. Although three out of four lower rate recipients miss the intended severity categories 5-6, usually because they are more severely disabled, there is no evidence that this reflects variations in care needs. Of the 28 lower rate recipients who are incorrectly predicted by both models (the unshaded area of the table), most (20) are above the target categories, and only six are predicted to receive a middle or higher rate award.

These findings show that lower rate care recipients are consistently identified according to a distinct set of needs. If the indicators are good measures of the care needs for which DLA is intended to cover, the results further suggest that the adjudication process consistently identifies claimants who are eligible for a lower rate award.

Rejected claims are not so easily distinguished. According to one model (see Figure 6.1) 41 per cent of unsuccessful applicants (147) are predicted to receive a lower rate award (probability >_ 0.5). Apart from six individuals who failed to satisfy the prescribed qualifying periods,[20] all were rejected on disability grounds, that is failure to meet the conditions of entitlement relating to attendance, supervision or the preparation of a cooked main meal. We felt that the proportion of unsuccessful applicants predicted to receive lower rate care was sufficiently large to justify further investigation. In addition, 25 per cent of applicants (75) who did not apply for a care award, are predicted to receive a lower rate award. Although it is not clear what evidence of their care needs, if any, was considered when determining their claim for DLA, we decided that they too required further examination.

6.2.4 Incorrectly predicted unsuccessful applicants for a care award

In one sense it is not surprising that some unsuccessful applicants are predicted to receive a lower rate award. Rejection arises from a failure to meet prescribed conditions rather than satisfying criteria which positively identify an unfavourable

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[2] To qualify, the conditions of entitlement must be satisfied three months before and six months following the date on which the award would begin.

outcome. Unsuccessful applicants may have similar patterns of need, defined by our indicators, to those of lower rate recipients yet their care needs may be insufficiently frequent or severe to qualify for an award. Moreover, our assessment of needs post-dates the initial claim for DLA. Compared to other unsuccessful applicants, those predicted to receive lower rate care are three times as likely to report that their attendance and supervision needs had increased since they filled in their application form (OR = 3.0). Some applicants, therefore, may have satisfied the disability conditions for a lower rate award *at the time of our survey*, though this possibility is indicated for less than one in five of those predicted to receive such an award.

As described in Chapter 5, unsuccessful applicants generally report more severe psychiatric symptoms than lower rate recipients (Table 5.8). Further investigation showed that the prevalence of psychiatric disturbance did not vary between unsuccessful applicants predicted to receive lower rate care and other claimants who were rejected for an award. However, the former group are more severely disturbed.[21] So one possible explanation for the predicted awards is that the particular care needs of some people with mental health problems may not be sufficient to attract an award, or they may not be identified in the claiming and adjudication process.

Another possibility is that unsuccessful applicants predicted to receive lower rate care may not have been able to present a full or accurate picture of their needs for care. To test this hypothesis we compared their accounts of submitting a claim for DLA with those of other unsuccessful applicants and lower rate recipients. Three questions are of greatest concern:

a. Did claimants have any help filling in the claim form, including a `supporting' statement from a carer, doctor or other health professional?

b. Did the claim form, or medical examination if any, enable applicants to describe the effects of their illness or disability and provide an accurate picture?

c. Were applicants happy with the decision on their claim?

These issues are addressed in the *Quality of Service* study described in Part Two of this report. We drew on information from that study to investigate further incorrectly predicted outcomes.

A narrow majority of unsuccessful claimants who were predicted to receive a lower rate care award reported that they were unable to present an adequate picture of their needs but these difficulties do not reflect lack of help with or investigation of their claim. On the whole, however, they reported a less satisfactory experience of claiming DLA than lower rate recipients. Although these unsuccessful applicants are no less likely than recipients to have been helped when filling in the claim form, to have obtained a `supporting' statement, or to have been examined by a visiting doctor in connection with the claim, they are more often dissatisfied with the process. They are significantly less likely than lower rate recipients to say that the claim form was helpful in describing their illness or disability (51 and 62 per cent, respectively), in describing its effects on their lives (46 and 63 per cent), and in providing an accurate picture of their needs (43 and 57 per cent). Where a medical examination had been conducted, they were also less likely to feel that this presented an accurate picture of their condition (57 and 80 per cent). Not surprisingly, therefore, fewer unsuccessful applicants predicted to receive a lower rate award said they were happy with the decision on their claim (22 per cent as opposed to 80 per cent of lower rate recipients) and most intended to ask for a review or had already done so (78 per cent).

However, it is difficult to conclude that the dissatisfaction expressed by these unsuccessful applicants indicates that their needs received less than adequate

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[27] The GHQ score, the Likert score and the Chronicity score, defined in Annex 4.1, are significantly higher among unsuccessful applicants predicted to receive a lower rate award than other unsuccessful applicants. The average scores in turn are: 7.3 and 5.6, 21.2 and 18.2, 8.7 and 7.6, respectively.

consideration in the adjudication process. It may arise largely from the negative experience of rejection - an outcome effect - because their experience of claiming is reportedly no less satisfactory than that of other unsuccessful claimants. Overall, the experience of unsuccessful applicants making a claim for DLA is remarkably similar, irrespective of whether or not our model predicts that they should receive lower rate care. The only significant difference is that those who are predicted to receive lower rate care are more likely to challenge the outcome. As already noted, when interviewed for this study, 78 per cent said they had already asked for a review, or intended to do so, compared with 52 per cent of other unsuccessful applicants. In other words, our model has identified those unsuccessful applicants who are more likely to feel the decision on their initial claim was unfair, sufficiently so to want to challenge it.

6.2.5 Incorrectly predicted cases not applying for a care award

Seventy-five people who applied for a mobility award alone, and did not fill in the claim form in respect of care needs, are predicted to receive a lower rate care award. They are more than twice as likely as other applicants who did not apply for a care award to report an increase in their needs for attention or supervision between applying for DLA and our survey. If the level of need is now sufficient in such cases to qualify for an award, it would account for no more than one in five of those predicted to receive a lower rate award.

When we asked these applicants what component of DLA they had claimed, a third (26) reported: `for help with looking after you'. This is puzzling if no such claim was made but some may have forgotten which parts of the application form were originally completed. Some may not know, because in 11 cases someone other than the claimant had filled in the form. In addition, some may have been wrongly coded on the DLA database. Whatever the reason, the question arises as to whether or not there were *any* indications in the claim which might have alerted adjudication officers to the care needs reported in our survey.

This question can be satisfactorily answered only by returning to the original claim form and any supporting documents. According to the DLA database, there is evidence additional to that in the claim form on almost half of these applicants so they had extra opportunities to report any needs for care. One applicant was asked to provide further information on his or her claim, nine claims were supported by a EMP's report, and in 26 cases there was a factual report from the claimant's own doctor. However, any additional evidence may have been sought only in respect of their application for a mobility award.

Table 6.4 Disabling conditions of applicants predicted to receive lower rate care but not applying for an award

Code	**Disabling condition**	**n**
DOl	Arthritis including rheumatoid and osteoarthritis	26
D02	Spondylosis including disc disease and cervical/lumbar	4
D03	Back pain not specified	2
D05	Disease of the muscles, bones or joints	7
D06	Trauma to limbs: loss of fingers/toes/amputation	5
D08	Blindness	1
D09	Deafness	1
Dl l	Heart disease including coronary, ischaemic, myocardial or heart attack	5
D12	Chest disease including bronchitis, emphysema and bronchiectasis	2
D13	Asthma	1
D16	Cerebrovascular disease or accident, including stroke and hemiplegia	2
D17	Peripheral vascular disease including thrombosis and claudication	2
D28	Chronic fatigue syndromes including ME/post-viral	1
D30	Diabetes mellitus	4
D40	Mental subnormality	4
D44	Psychosis including schizophrenia and manic depression	3
D45	Psychoneurosis including anxiety, depression, phobia and hysteria	2
D55	Renal disorders including dialysis	1
D60	Inflammatory bowel disease - including Crohn's, ulcerative and colitis	1
	Total	74*

Source: DLA database.
* Excludes one case with missing data.

Almost half of these applicants (37) were awarded the mobility component, mostly at the higher rate (29). So a substantial minority was thought to be severely disabled and, potentially, to have attendance needs. Their disabling conditions, listed in Table 6.4, also imply care needs according to *The Disability Handbook* which adjudication officers use to help inform their decisions (Aylward *et al.*, 1992). Whether these needs are sufficiently frequent or severe to qualify for a care award is not known. Adjudication officers may have considered their care needs, but we do not know, and therefore cannot say, that they were actually rejected on disability grounds. However, the evidence available at the time of the claim raises a question about their potential entitlement.

6.3 DLA mobility awards and mobility needs

We defined 40 indicators of mobility needs from our survey information, covering the ability to walk and the need for guidance out of doors, which distinguish higher rate and lower rate awards respectively. They are shown in Annex 6.2 where they are grouped into the broad criteria identified in the conditions of entitlement: walking difficulties (seven indicators), guidance needs (5), mental impairment (12), behaviour problems (8), and other mobility-related needs such as pain and breathlessness (8). The findings show that variations in patterns of needs according to the outcomes of applying for the mobility component of DLA are broadly consistent with the criteria for an award, whether higher or lower, and that unsuccessful claimants are unlikely to satisfy either set of criteria. We look first at the mobility needs of lower rate recipients and unsuccessful applicants, and then go on to compare lower and higher rate recipients.

6.3.1 *Lower rate mobility recipients and unsuccessful applicants*

Table 6.5 shows the prevalence and association of each mobility need, so defined, among lower rate recipients and unsuccessful applicants. As an example, 63 per cent of lower rate recipients said they always needed to be accompanied out of doors, compared with 39 per cent of unsuccessful applicants. Applicants reporting this particular need are two and half times as likely to be awarded lower rate mobility as to be rejected (OR = 2.6). All but two of the 40 indicators distinguish between lower rate recipients and unsuccessful applicants.

As expected, needs for guidance and supervision are associated with a lower rate award (Table 6.5a). This is the case where a need for assistance is explicitly indicated or where it is merely implied because of memory impairment, visual problems, learning difficulty, behaviour problems or the risk of falling.' Lower rate recipients are generally more than twice as likely to report such needs and difficulties as unsuccessful applicants. The most inclusive need, reported by six out of ten lower rate recipients, is always needing help out of doors or in unfamiliar places, a key condition for a lower rate award.

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[22] As far as we could ascertain, only one person in our sample could be regarded as deaf and blind so no indicator was defined for this condition.

Table 6.5a Mobility needs: lower rate awards and rejected claims

Type of mobility impairment	**Lower rate mobility** (%)	**Rejected** claims (%)	**OR**	**OR***
Always needs to be accompanied outdoors	63	39	2.6	2.7
Impossible to use a train on own	52	37	1.8	*ns*
Needs someone to keep a watchful eye during the day	50	27	2.7	*ns*
Thoughts tend to be muddled or slow	49	20	3.8	*ns*
Often loses track in the middle of a conversation	45	22	2.9	*ns*
Often forgets what was supposed to be doing	45	23	2.7	ns
Impossible to use a bus on own	44	35	1.5	1.6
Often gets confused	38	14	3.8	1.9
Feels the need to have someone present all the time	36	19	2.3	*ns*
Cannot watch and remember a % hour TV programme	33	15	2.8	*ns*
Gets so upset that cannot sit still, paces up and down	31	18	2.0	*ns*
Cannot remember and pass on a message correctly	30	12	3.2	*ns*
Confined to home without assistance	30	23	1.4	*ns*
Cannot write a short letter without assistance	28	6	5.5	2.7
Needs assistance with oral communication	27	8	4.5	*ns*
Severe learning difficulties	26	5	7.4	2.7
Gets so upset that runs away	25	19	1.4	0.5
Often has outbursts of temper with little cause	22	12	2.0	*ns*
Gets so upset that breaks or rips up things	21	11	2.2	*ns*
Often forgets names of family and close friends	21	11	2.0	*ns*
Gets so upset that makes a lot of noise	20	11	2.0	*ns*
Cannot count well enough to handle money	19	3	7.8	*ns*
Cannot read a short newspaper article	16	4	4.9	*ns*
Gets so upset that injures him/herself	15	5	3.2	2.2
Usually gets no warning of a fit/convulsion	14	3	5.4	2.9
Wanders off without realising	14	4	4.2	*ns*
Gets so upset that hits other people	14	6	*2.7*	*ns*
Has fallen 12 times or more in past year	13	8	1.8	2.1
Cannot see to recognise a friend at arm's length	9	1	16.2	17.6
Often forgets to turn off fire, cooker or taps	9	5	2.0	*ns*
Base (= 100%)	*306*	*645*		

* OR adjusted for the effects of one indicator upon another. *ns* = not significant.
Percentages sum to more than 100 because some people have more than one need for help.

Table 6.5b Mobility needs: lower rate awards and rejected cla s (continued)

Type of mobility impairment	**Lower rate** mobility (%)	**Rejected claims** (%)	**OR**	**OR***
Cannot walk for 10 minutes or more without stopping or severe discomfort	25	58	0.2	0.4
Cannot stand for 10 minutes or more unassisted	24	52	0.3	*ns*
Cannot walk 50 yards or more without stopping or severe discomfort	16	35	0.3	*ns*
Cannot stand for 5 minutes or more unassisted	13	31	0.3	*ns*
Cannot walk for 5 minutes or more without stopping or severe discomfort	12	32	0.3	*ns*
Breathlessness severely limits daily life	12	30	0.3	0.3
Constant pain severely limits daily life	11	46	0.1	0.2
Cannot walk at all/can walk only a few steps	5	11	0.4	*ns*
Base (= 100°A))	*306*	*645*		

* OR adjusted for the effects of one indicator upon another. *ns* = not significant.
Percentages sum to more than 100 because some people have more than one need for help.

By comparison, difficulties walking and standing, including pain and breathlessness which might cause some of those difficulties, are associated with unsuccessful applicants (Table 6.5b). In other words, lower rate recipients are less likely to report walking difficulties than unsuccessful applicants. In practice, lower rate recipients are able to walk and would not satisfy the higher rate criteria. Rejected applicants cover two distinct groups of individuals, however: those who can walk but fail to satisfy the need for guidance or supervision, and those who do not require guidance from another person but have great difficulty walking. Because the latter are adjudicated not to satisfy the higher rate criteria, they clearly boost the overall prevalence of walking difficulties among unsuccessful applicants as opposed to lower rate recipients.

No single indicator on its own adequately distinguishes between lower rate recipients and unsuccessful applicants, suggesting that an examination of the multiplicity of needs is required to predict outcomes. The last column of Tables 6.5a and 6.5b shows that combination of indicators which best distinguishes between lower rate mobility recipients and unsuccessful applicants when account is taken of all the mobility needs defined here. It can be seen that the set of 13 indicators includes measures of both walking difficulty and supervision need. Therefore both sets of criteria are required to distinguish between lower rate recipients and unsuccessful claims although this does not mean that these particular indicators, or the needs they represent, were all that informed the adjudication process. When considered with other indicators, `running away' is, contrary to expectation, associated with unsuccessful applicants. It might be that the implied need for supervision in these cases was not thought to be severe enough to warrant a lower rate award.

Table 6.6a Mobility needs: lower rate and higher rate awards

Type of mobility impairment	**Lower rate mobility** (%)	**Higher rate mobility** (%)	**OR**	**OR***
Needs someone to keep a watchful eye during the day	50	34	1.9	ns
Thoughts tend to be muddled or slow	49	13	6.3	2.0
Often loses track in the middle of a conversation	45	16	4.2	*ns*
Often forgets what was supposed to be doing	45	15	4.4	*ns*
Often gets confused	38	13	4.2	*ns*
Feels the need to have someone present all the time	36	14	3.4	2.2
Cannot watch and remember a '/ hour TV programme	33	9	5.2	*ns*
Gets so upset that cannot sit still, paces up and down	31	8	5.0	*ns*
Cannot remember and pass on a message correctly	30	8	5.3	*ns*
Cannot write a short letter without assistance	28	6	5.9	*ns*
Needs assistance with oral communication	27	7	4.9	*ns*
Severe learning difficulties	26	3	11.7	2.6
Gets so upset that runs away	25	9	3.4	*ns*
Often has outbursts of temper with little cause	22	8	3.0	*ns*
Gets so upset that breaks or rips up things	21	6	4.4	2.8
Often forgets names of family and close friends	21	8	2.9	*ns*
Gets so upset that makes a lot of noise	20	6	3.5	*ns*
Cannot count well enough to handle money	19	3	9.4	*ns*
Cannot read a short newspaper article	16	3	5.7	*ns*
Gets so upset that injures him/herself	15	2	8.0	*ns*
Usually gets no warning of a fit/convulsion	14	1	11.6	9.7
Wanders off without realising	14	2	9.7	*ns*
Gets so upset that hits other people	14	3	5.4	*ns*
Cannot see to recognise a friend at arm's length	9	2	5.7	5.7
Often forgets to turn off fire, cooker or taps	9	3	3.0	*ns*
Always needs to be accompanied outdoors	63	62	*ns*	1.7
Base (= 100%)	*306*	*572*		

OR adjusted for the effects of one indicator upon another, *ns* = not significant.
Percentages sum to more than 100 because some people have more than one need for help.

6.3.2 Lower rate and higher rate mobility recipients

As expected, higher rate mobility recipients are more like unsuccessful applicants than lower rate recipients in having fewer needs for guidance and supervision. Table *6.6a* shows that almost all the guidance needs represented by the mobility indicators are more prevalent among lower rate recipients. They are often many more times as likely to report such needs as higher rate recipients. However, a few higher rate recipients report guidance needs rather than walking difficulties, those who `pace up and down', `run away' or `wander off', for example. They reflect one of the more recent conditions of entitlement to a higher rate mobility award: people who can walk but who are severely mentally impaired and display severe behaviour problems and who also satisfy the conditions for a higher rate care award. Such individuals are considered to require prolonged, frequent or continual supervision day and night because of substantial danger to themselves or others.

Table 6.6b Mobility needs: lower rate and higher rate (continued)

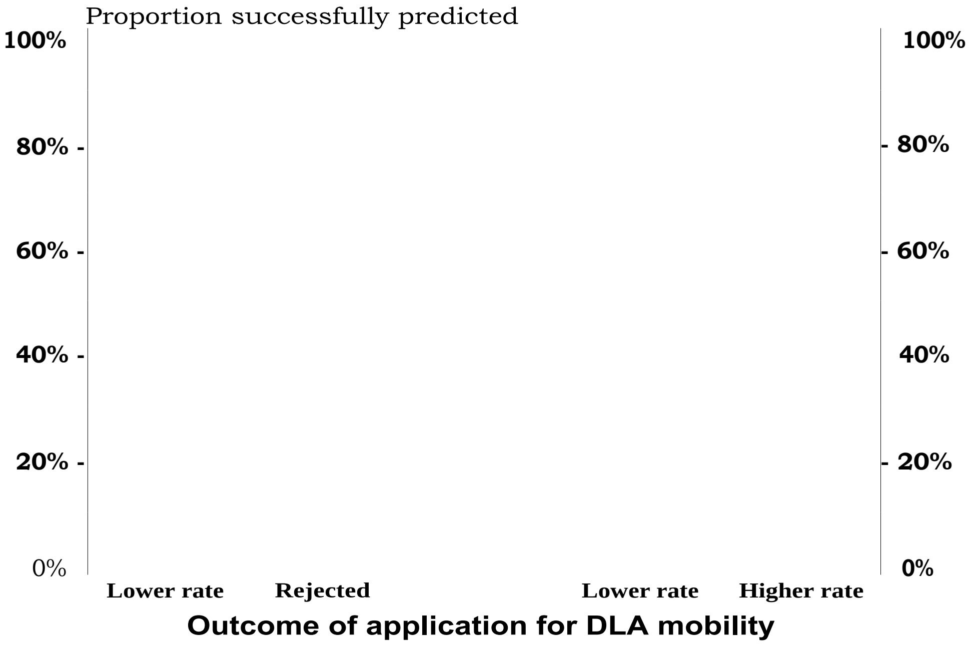
Type of mobility impairment	**Lower rate mobility** (%)	**Higher rate mobility** (%)	**OR**	**OR***
Impossible to use a train on own	52	62	0.7	ns
Impossible to use a bus on own	44	62	0.5	*ns*
Confined to home without assistance	30	45	0.5	*ns*
Cannot walk for 10 minutes or more without stopping or severe discomfort	25	84	0.1	0.3
Cannot stand for 10 minutes or more unassisted	24	76	0.1	*ns*
Cannot walk 50 yards or more without stopping or severe discomfort	16	69	0.1	0.4
Cannot stand for 5 minutes or more unassisted	13	58	0.1	0.4
Cannot walk for 5 minutes or more without stopping or severe discomfort	12	58	0.1	*ns*
Breathlessness severely limits daily life	12	30	0.3	0.4
Constant pain severely limits daily life	11	52	0.1	0.2
Cannot walk at all/can walk only a few steps	5	25	0.1	*ns*
Cannot walk up and down a flight of 12 stairs	5	15	*0.3*	*ns*
Base (= 100%)	*306*	*572*		

* OR adjusted for the effects of one indicator upon another. *ns* = not significant.
Percentages sum to more than 100 because some people have more than one need for help.

Table 6.6b shows further that lower and higher rate mobility recipients are distinguished in terms of physical ability to get out and about. Difficulties walking and standing, including pain and breathlessness and difficulties using public transport, are associated with higher rate recipients. They are ten times as likely to report most of these difficulties as lower rate recipients.

The last column of Tables 6.6a and 6.6b shows that, taken together, 12 indicators best distinguish between lower and higher rate mobility recipients. As might be expected, they include both supervision needs and walking or standing difficulties, including pain and breathlessness. Visual impairment and lack of warning of a fit, both reflecting supervision needs, are the most important predictors but they affect relatively few individuals in this sample. Interestingly, always needing to be accompanied out of doors, shown at the bottom of Table 6.6a, distinguishes between lower and higher rate recipients only *after* other needs are taken into account. It is probable that this indicator was perceived by respondents to include both needs for supervision out of doors and needs for personal attention when out and about. Once the latter set of needs is captured by indicators of physical impairment or incapacity, chiefly severe walking difficulty, the association between the need for a companion out of doors and lower rate awards is revealed.

Figure 6.2 Observed and predicted outcomes: DLA mobility awards



6.3.3 Predicting lower rate mobility awards

Distinguishing between lower rate recipients and unsuccessful applicants on the one hand, and lower and higher rate recipients on the other, produced two predictive models. Figure 6.2 shows that both correctly predicted the vast majority of outcomes of applications for a mobility award. However, the effectiveness of these models is somewhat overstated because many of the predicted outcomes have low probabilities, close to 0.5.

Table 6.7 Lower rate mobility awards: prediction results

Predicted probabilities of a lower rate award	**Lower rate mobility** (5 **0.6) (N)**	**Uncertain** (>_ **0.4< 0.6) (N)**	**Higher rate mobility (<0.4) (N)**	**Missing cases (N)**	**Total** (N)
Lower rate mobility (> 0.6)					135
Uncertain (> 0.4 < 0.6)	41	6	17	1	65
Rejection (< 0.4)	l	26	32	1	73
Missing cases	in	1	3	*	14
Total	190	39	54	4	287

* 19 cases excluded from both analyses because of missing data.

Table 6.7 summarises the predicted outcomes for lower rate recipients in more detail. It can be seen that 44 per cent (125) are correctly predicted, with some confidence, by both models, and a further 26 per cent (75) by one model or the other (the shaded area of the table). Overall, 87 people (30 per cent) of lower rate recipients are predicted *not* to receive a lower rate award, or their status is uncertain according to both models (the unshaded area).

These predictions confirm that poor targeting in respect of overall severity of disability does not reflect inconsistency in the distribution of awards according to mobility needs, at least as measured here. It will be recalled from Chapter 4 that three out of four lower rate mobility recipients miss the intended target severity categories 5-6. Of these, 68 per cent are predicted to receive a lower rate award, including 74 *per* cent of those in categories 7 and above. Lower rate recipients who are predicted not to receive a lower rate award are distributed across all severity levels: those above target are not invariably predicted to receive a higher rate award and those below target are not invariably predicted to receive no award.

In addition to the 87 lower rate recipients whose status is incorrectly predicted, 10 per cent of unsuccessful applicants (59) and 20 per cent of those who did not apply for the mobility component (19) are predicted, with a probability ≥ 0.5, to receive a lower rate award. For these 165 individuals, different outcomes do not necessarily reflect different mobility needs. We shall consider each in turn.

6.3.4 Incorrectly predicted lower rate recipients for a mobility award

Of the 87 lower rate recipients who are predicted not to receive a lower rate award, the outcome of 51 cases is considered to be uncertain by one model or the other, while in the remaining 36 cases, rejection or a higher rate award is predicted. Although all had been adjudicated to need guidance or supervision out of doors, many also have walking difficulties. Compared with other lower rate recipients, for example, these individuals are more likely to report that they could not walk a quarter of a mile without stopping for a rest or without severe discomfort: the proportions are 16 and 63 per cent respectively. The vast majority (96 per cent) reported that their walking difficulties are present all or most of the time, and a sizeable minority said their mobility problems had worsened in recent months. Thus 42 per cent, compared with 25 per cent of other lower rate recipients, reported that their walking difficulties had increased since applying for DLA.

These findings suggest that incorrectly predicted lower rate recipients are more like higher rate recipients *and* unsuccessful applicants in respect of walking difficulties than other recipients of a lower rate award. In particular, their mobility needs are similar to those of unsuccessful applicants who were rejected for a higher rate award because their walking difficulties, though severe, were judged not to meet the higher rate criteria. Although walking difficulties and supervision needs are often distinct, it seems that where both are present there is less certainty, statistically speaking at least, of the precise outcome. As noted in Chapter 5, the mobility component defines essentially two different benefits and some applicants qualify, or almost qualify, for both. As a consequence, these incorrectly predicted lower rate mobility recipients probably tell us more about the poor fit between the structure of the mobility component and the assumptions of the model than about any shortcomings of the adjudication process.

6.3.5 Incorrectly predicted unsuccessful applicants for a mobility award

There are 59 unsuccessful applicants predicted to receive a lower rate mobility award. One individual was actually deemed to meet the disability conditions but failed the three-month qualifying period; the others are classified as not satisfying the disability conditions. Aside from our prediction, however, we could find no firm evidence to indicate that they might have expected a different outcome. Although they are more likely to report psychiatric symptoms than other rejected claimants, there is no difference in the severity of mental health problems between the two groups. In addition, unsuccessful applicants predicted to receive lower rate mobility are no more likely, than other rejected claimants, to report that their mobility needs had increased since applying for DLA. Further, their experience of claiming DLA is reportedly no different to that of others whose claim was rejected.

Compared with lower rate recipients, however, they tend to express negative views about the claim process, reflecting their disappointment at the outcome of their claim. They are less likely, for instance, to feel that the information given on the application form, or to a doctor, adequately represented the disabling effects of their condition. But the differences are small and not statistically significant. Although these unsuccessful applicants are more likely than lower rate recipients to report that they filled in the application form on their own, two-thirds said they had obtained a `supporting' statement from a relative or friend or carer, the same proportion as lower rate recipients and other unsuccessful applicants. And more of them than lower rate recipients were seen by an EMP suggesting that adjudication officers were less likely to rely solely on the application form to make a decision on these cases. So rejection does not seem to stem from a lack of opportunity to present their mobility needs. Nonetheless, 75 per cent of these unsuccessful applicants who are predicted to receive a lower rate award said they were unhappy with the decision on their claim, and most of these said they intended to ask for a review or had already done so.

6.3.6 Incorrectly predicted cases not applying for a mobility award

There are 19 individuals predicted to receive a lower rate award who evidently did not apply for the mobility component. This number is too small for analysis but the information available to us suggests that, in a few cases, adjudication officers could, justifiably, have sought further information about mobility needs, if only to check that these individuals did not qualify for an award. For example, 13 people are recorded on the DLA database as having disabilities which can affect mobility, including six individuals classified as mentally subnormal, one with behaviour disorders and one who is blind. These eight individuals potentially have needs for supervision or guidance outdoors. In addition, 15 of these individuals were awarded lower rate care on account of needing help to prepare a cooked main meal. If this decision is linked to anything other than lack of dexterity skills, mental incapacity or visual impairment, for example, then such reasons are also not too far removed from the supervision criteria for a lower rate mobility award. However, we cannot say that their mobility needs were sufficient to qualify for an award.

6.4 Summary and conclusions

The lower rates of DLA are awarded to disabled people according to their needs for help relating to preparing a cooked main meal, limited attention during the day, or guidance and supervision out of doors. These criteria charted new territory for a disability costs benefit and presented a challenge to the adjudication process. From the outset, the likely scope of DLA was somewhat uncertain.

The findings from this chapter suggest that the lower rate criteria for each component of DLA are well-defined and practical. They identify distinct constituencies of beneficiaries and extend the scope of the former attendance and mobility allowances more or less as policy makers intended. The findings also suggest that adjudication officers are successful for the most part in consistently identifying those who are eligible for lower rate awards.

To summarise:

a. The vast majority of lower rate recipients on each component of DLA can be readily distinguished from other applicants according to the patterns of need reported in our survey. Moreover, the care and mobility needs they report are consistent with the conditions of entitlement. They are more likely than unsuccessful applicants to report the needs specified by the lower rate criteria and less likely than higher or middle rate recipients to report care and mobility needs covered by the middle or higher rate criteria. Moreover, the most widely reported needs among lower rate recipients are precisely those specified in the lower rate criteria: guidance out of doors, preparing a meal, and limited care. Whether lower rate recipients are on, above or below the target severity categories discussed in Chapter 4 does not reflect any significant differences in the observed patterns of need for help with care and mobility.

b. It is the way individuals' needs combine that best predicts lower rate awards, rather than individual prevalence. In other words, individual measures of need are inadequate on their own to distinguish between DLA outcomes, indicating that consideration of the multiplicity of needs is crucial when determining an award. This can complicate the adjudication process. For the care component, the conditions of entitlement largely describe a graded, or cumulative, progression of needs. Evidently, higher rate recipients would satisfy the criteria for a middle rate award, while both higher and middle rate recipients would invariably meet the criteria for a lower rate award. As a consequence, claims and awards are likely to be difficult to determine at the margins. By comparison, mobility needs identified by the higher and lower rate criteria respectively are largely unrelated and in effect define two separate benefits. Failure to meet the lower rate criteria does not mean that the higher rate criteria would not be satisfied. This hampered the prediction of lower rate mobility awards because some individuals satisfy, or almost satisfy, both sets of mobility criteria. Whether the adjudication of mobility awards is thereby complicated is not known. However, it may create uncertainty about the scope of mobility awards, especially among unsuccessful applicants but also among lower rate recipients with severe walking difficulties.

c. There is no firm evidence that lower rate recipients would have qualified for the old-style attendance and mobility allowances. Fears that the introduction of the new lower rates would lead to so-called `down-rating' are not proven. Indeed, the distribution of predicted care outcomes suggests the reverse. Most higher or middle rate recipients are predicted to receive a lower rate care award but this does not imply poor adjudication. As noted above, the higher and middle rate criteria define frequent care needs: prolonged or repeated attention and continual supervision. These criteria are inadequately captured by our survey indicators so predicted outcomes for higher and middle rate care recipients are less than reliable. By comparison most higher rate mobility awards are correctly predicted.

d. The boundary between lower rate recipients and unsuccessful applicants is somewhat blurred, more so on the care than the mobility component. As far as is known, this cannot be attributed directly to the way needs were defined from the survey information. Deterioration would explain why some unsuccessful applicants are predicted to receive a lower rate award. Another possibility, suggested by the analysis, is that the particular care needs of some people with mental health problems may not be sufficient to attract an award or may not be identified in the claiming and adjudication process. Compared with lower rate recipients, many felt they had been unable to give an adequate account of their needs on the claim form or to a visiting doctor, though no more so than other unsuccessful applicants who are correctly predicted. The claim form gives little emphasis to the support that people with mental health problems may require and the examining doctor may lack experience of mental health issues. There may also be genuine difficulties in adjudicating awards at the margins of eligibility, especially if these arise from mental health problems. Further research is required to test this hypothesis.

e. A sizeable minority of applicants who applied for one component only are predicted to receive a lower rate award of the other component. Applicants for mobility awards in particular are less likely to apply for a care award than the other way round, yet our survey information often suggests that they have care needs. As noted above, they may have been considered for a care award, but we cannot be certain that adjudication officers were aware of any care needs or requested such information, or that the evidence emerged in the course of investigating such claims. Unless there are strong grounds for not doing so, it would seem that applicants are best advised to complete the whole of Section 2 of the application form, covering both care and mobility needs.

f. It is surprising how little information is required to predict a large proportion of lower rate care and mobility awards. Overall, no more than two dozen indicators enter the models when individuals' needs are considered simultaneously. Unlike the DLA application form, very few of our needs indicators represent the frequency or amount of different needs yet this does not seem to undermine the prediction of lower rate awards. We also found when developing operational definitions of `needs' that there is much in common between the conditions of entitlement relating to care and mobility awards. It is often possible to use the same indicators for representing supervision and guidance needs, for example, especially where these arise from behaviour problems and mental impairment.

g. These observations suggest that there is scope for shortening and simplifying the DLA application form though possibly at the risk of excluding eligible claimants whose disabilities and needs might be overlooked. It might also be possible to integrate those parts of the claim for in which cover separately the care and mobility components, addressing the issue raised in `d.' above. If so, all applicants would provide information relating to both components. But the current claim form is long and demanding; requiring applicants to complete it in full might deter potential beneficiaries. Our research was not designed to evaluate the DLA application form. It is clear, however, that any revisions must strike a balance between the need for a comprehensive form and one that is easy to complete.

h. It is also surprising how many lower rate recipients are confidently predicted to receive a lower rate award, suggesting that it might be possible to develop a computerised, knowledge-based system to `adjudicate' a large proportion of claims successfully or at least aid the adjudication process. If so, the potential for cost savings in the administration of DLA warrants further investigation.

In this chapter we have evaluated the distribution of lower rate awards according to the accuracy of predictions from a survey assessment of recipients' care and mobility needs. A majority of incorrectly predicted applicants told us that they intended to ask for a review of the initial decision on their claim or had already done so. Others reported that their condition had deteriorated and said that their care or mobility needs had increased since first applying for DLA. They too may decide to ask for a review. The initial distribution of DLA awards represents, therefore, a snapshot of changing needs and possible re-examination of claims and awards. This is the subject of the next chapter.

ANNEX 6.1

Care needs

Needs related to preparing a cooked main meal
Needs help making a hot drink
Needs help preparing a snack
Needs help preparing a hot meal
Needs help washing up and drying dishes
Cannot turn a tap on or off
Cannot pick up and hold a mug of tea or coffee
Cannot turn the control knobs on a cooker*
Cannot unscrew the lid of a coffee jar
Cannot pick up and pour from a full kettle
Cannot serve food from a pan using a spoon or ladle

Supervision needs
Needs someone to keep a watchful eye day and night
Needs someone to keep a watchful eye day or night*
Feels the need to have someone present all the time
Gets so upset that breaks or rips up things
Gets so upset that injures himlherself
Gets so upset that hits other people
Gets so upset that runs away
Wanders off without realising
Often forgets to turn off fire, cooker or taps
Often gets confused about time of day, place or who is keeping company
Usually gets no warning or a fit/convulsion

Attendance needs
Occasionally needs help during the day or night
Needs help every few hours during day/most nights
Needs a lot of help/attention throughout day or night
Needs less than 20 hours help a week
Needs 20 hours or more help a week
Needs help getting in and out of bed
Needs help getting in and out of a chair*
Needs help washing hands and face
Needs help washing all over
Needs help dressing and undressing
Needs help feeding including cutting up food
Needs help drinking from a cup or mug
Needs help getting to the toilet
Needs help using the toilet
Needs assistance rising from sitting*
Always needs to hold on to something to keep balance*
Needs help with medical treatment
Needs to be accompanied outdoors
Needs help with oral communication

Indicators not listed in Tables 6.1 or 6.2.

ANNEX 6.2

Mobility **needs**

Walking difficulties
Cannot walk at all/can walk only a few steps
Cannot walk for 5 minutes or more without stopping or severe discomfort
Cannot walk for 10 minutes or more without stopping or severe discomfort
Cannot walk 50 yards or more without stopping or severe discomfort
Cannot walk up and down a flight of 12 stairs
Cannot stand for 5 minutes or more unassisted
Cannot stand for 10 minutes or more unassisted

Guidance needs
Always needs to be accompanied outdoors
Needs someone to keep a watchful eye during the day
Feels the need to have someone present all the time
Usually gets no warning of a fit/convulsion
Has fallen 12 times or more in past year

Mental impairment
Thoughts tend to be muddled or slow
Often loses track in the middle of a conversation
Often forgets what was supposed to be doing
Often forgets names of family and close friends
Often forgets to turn off fire, cooker or taps
Often gets confused about time of day, place or who is keeping company
Cannot watch and remember a 'h hour television programme
Cannot remember and pass on a message correctly
Severe learning difficulties
Cannot read a short newspaper article
Cannot count well enough to handle money
Cannot write a short letter without assistance

Behaviour problems
Gets so upset that breaks or rips up things
Gets so upset that injures him/herself
Gets so upset that hits other people
Gets so upset that runs away
Gets so upset that cannot sit still, paces up and down
Gets so upset that makes a lot of noise
Wanders off without realising
Often has outbursts of temper with little cause

Other mobility-related needs
Cannot see to recognise a friend at arm's length
Breathlessness severely limits daily life
Constant pain severely limits daily life
Needs assistance with oral communication
Confined to home (indicator not listed in Tables 6.5 or 6.6)
Confined to home without assistance
Impossible to use a train on own
Impossible to use a bus on own

Chapter 7 Change of Circumstances

7.1 Introduction

Disability is rarely a constant, unchanging experience. The disabling effects of some conditions fluctuate from day to day or over longer periods of time. Some may show gradual deterioration, others partial recovery. Rehabilitation and learning new skills can help disabled people become more independent and gain control over their lives. Medication and other therapies, environmental adaptations including the use of special equipment, and changes in social networks and support, can alter the extent to which disability limits or prevents an individual leading an ordinary life. Yet most assessments of disability, including the one used in our survey, relate to a single moment or to what is considered `usual'.

Such snapshot pictures are potentially misleading. They are also a source of uncertainty for those claiming a benefit based on disability criteria and for the adjudication process. In the case of DLA, these difficulties are recognised chiefly by informing applicants of their rights to ask for their claims to be re-examined. If an applicant is dissatisfied with the initial decision on their claim, or their circumstances change, an internal review is conducted in the first instance. This is carried out by a different adjudication officer at the central DLA Unit rather than an officer at one of the regional Disability Benefits Centres (DBCs) where most claims are first decided. If this review also leads to rejection on disability grounds, or to a lower rate of award than expected, an appeal can be made to an independent DAT.[23] Apart from the review and appeal procedures, adjudication officers can award DLA for a fixed period, usually between one and five years, if it is thought that care or mobility needs will *decrease.* The minimum period is six months. The disability criteria must also be satisfied for three months before the date on which the award would begin though, mindful of the fluctuating conditions of many disabled people, needs over the period as a whole are considered rather than on a particular day.[24]

Claiming DLA, therefore, is not necessarily once and for all; for some applicants it may be a recurrent process of claim, review, appeal or renewal. In short, DLA customers are a moving target. Individuals may move between rates and components, lose and regain benefit as their condition changes. To investigate this process adequately would require a longitudinal study in which cohorts of applicants are repeatedly reassessed and changes in their claim are charted. This approach was beyond the resources available for the present study though we did collect information on applicants' intentions to seek a review. In addition, we re-examined the status of their claims on the DLA database in November 1994, which was around nine months after the initial decisions. The aim here was to discover who had actually asked for a review and, where a different decision had been made, what rate and award was currently received.

When applicants challenge the initial decision on their claim for DLA, is this a response to their changing circumstances, or does it reflect awards that were poorly targeted at the outset? Or, do applicants seek a review because they feel that the evidence presented with their initial claim was incomplete and prevented the `right'

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[23] In addition, the Secretary of State can be asked to review a case in which there has been an error in law. An appeal on a point of law must go to the Commissioner and then to the Court of Appeal before the Law Lords, but very few cases go that far.

[24] The three-month qualifying period is waived if a claim is for someone with a terminal illness.

decision? Where applicants receive an award on review, or an improved award, because their care or mobility needs have increased, or because a fuller account of their needs is provided, this might be interpreted as `fine-tuning' the targeting of DLA. Such a process would suggest a degree of flexibility in the consideration of claims to enable justice to be done in varying circumstances. If, however, poor initial targeting is the reason for subsequent changes of award, it suggests that the current assessment and adjudication process is less than reliable for determining an award. This would be a major concern of policy makers: inconsistent decisions can cause distress for applicants and create inefficiencies for the administration of DLA.

In the next section we define four measures indicative of a change, or a potential change, in applicants' claims and awards, and discuss possible explanations for such events. Subsequent sections are then devoted to examining each indicator in turn. The findings show that requests for a review of lower rate awards and disallowed claims are chiefly associated with applicants' changes in circumstances. Changes in DLA awards on review are also associated with increasing needs. The evidence suggests that decisions on applications for a mobility award are more likely to be challenged and changed than those relating to the care component. The findings further suggest that some initial decisions were altered because a more accurate picture of the applicant's needs was presented on review. But there is no firm evidence of inconsistency in the initial distribution of lower rate awards. Whether applicants challenge the original decision on their claims, and whether these are subsequently altered, could be attributed to circumstances not present at the time the initial claim was made.

7.2 Measuring and explaining change

Short of following applicants through the claiming and adjudication processes, and beyond, we captured a series of events or decisions which provide an indication of the relationship between changes in claimants' circumstances and changes in the status of their claims. Information from the DLA database and the *Quality of Service* study for new claims (see Part Two of this report) enable us to classify respondents in three ways:

a. Respondents who said they had asked for a review, or intended to do so, are compared with those who said they were satisfied with the outcome of their claim.

b. Respondents who had actually initiated a review by November 1994 are compared with those who had not done so.

c. Respondents whose award had been changed by November 1994 are compared with those whose rate of award was unchanged.

In addition, recipients who were initially awarded DLA for a limited term are compared with those given a lifetime award to examine an `anticipated' change of circumstances.

The overall objective is to discover whether these classifications of respondents, and the events they signal, could be `explained' by three sets of factors:

The claim

We hypothesised that any perceived inadequacies of the claiming process might prompt applicants to challenge the initial decision on their claim. To investigate this, we drew on information collected for the *Quality of Service* study which, among other things, asked respondents if they felt the application form was helpful in describing their disability or illness and its effects on their daily life, and whether it enabled them to present an accurate picture of their needs and circumstances. We also considered the help applicants may have received when completing their claim and the use of additional evidence to decide their claim, including contact from the Benefits

Agency or DBC handling the claim, and a visit from an EMP.[25] The aim here was to test the hypothesis that if applicants felt that they had provided an exhaustive, verified account of their needs, and that these had been fully addressed in the adjudication process, then they would be more likely to accept the outcome of their claim.

- *Changes in circumstances*

  If applicants' needs have increased since the initial decision on their claim, they might decide to seek a review and, as a result, their new circumstances might be judged sufficient to meet the criteria for an award, or for an improved award. A change of circumstances is clearly difficult to quantify without a repeat assessment. All that was possible here was to ask respondents whether their needs for care or supervision, and their walking difficulties, had changed since first applying for DLA. Respondents were also asked if they felt they needed more hours of care or supervision a week than they currently received.

- *Inconsistent decisions*

  If, despite presenting a comprehensive, up-to-date account of their care and mobility needs, applicants or their advisers think that the decision on their claim is inconsistent with the conditions of entitlement, a challenge might be mounted. To test this hypothesis, we would need to know what decision *should* have been made on the basis of the evidence considered with the initial claim. Clearly we do not know. Our approach is to use the estimated probabilities reported in Chapter 6 to predict outcomes that are at least consistent with the evidence we collected.[26] We recognise that these predictions are based on a survey assessment of respondents' care and mobility needs that does not necessarily represent the patterns of needs considered by adjudication officers. However, self-reported changes in needs since that time provide a check on whether the predicted outcomes reflect respondents' previous or current circumstances. For example, if unsuccessful applicants said there had been no change in their circumstances and our assessments predicted that they should receive an award, this might be interpreted as inconsistency in the original decisions on their claims. If circumstances are reported to have changed by the time of our survey, however, our assessments should describe the new situation so any predictions would be *less* likely to reflect the pattern of needs at the time of the initial claim.

The aim of the analysis is to identify those factors which are associated with applicants who said they were unhappy with the outcome of their claim for DLA, decide to seek a review, and obtain an improved award. It is recognised that the comparatively short time between initial claims and our survey, less than four months in most cases, might limit the extent to which individuals' care and mobility needs had changed. If so, this would reduce the possibility of attributing events to a change of circumstances. Indeed, most reviews requested within three months of an initial claim probably reflect dissatisfaction with the outcome, or are a response to additional evidence rather than a change of circumstances. Beyond three months, applicants requesting a review are asked to fill in another claim pack to provide an up-to-date profile of their needs. However, we have no account of changes of circumstances between our survey and November 1994, around five months, so caution is required before attributing events too readily to supposed incorrect decisions on the initial claim.

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[25] We ignored medical reports from GPs and hospitals because applicants often do not know whether such evidence was obtained to decide their claim.

[26] Predicted outcomes with a probability 0.60 are used throughout.

We are interested chiefly in the needs and circumstances of lower rate recipients and unsuccessful applicants. These two groups are considered separately here to avoid the possibility of an `outcome effect' on their views and experiences of making a claim. However, we often do not know which component of DLA is implicated by those seeking a review, so all lower rate recipients are considered together. To simplify the analysis, recipients of middle or higher rate awards are excluded even if one component is awarded at the lower rate. This left 439 respondents who received either a dual lower rate award (115) or one component only at the lower rate (275 for care, 49 for mobility). Unsuccessful applicants comprise 454 respondents whose claim for DLA was disallowed altogether: 265 had applied for both components, 170 for mobility alone and 19 for care alone (see Table 3.1).

7.3 Seeking a review

While the vast majority of respondents said they were happy with the decision on their claim for DLA, 358 or 23 per cent said they had already asked for a review, or intended to do so. Not surprisingly, most of these (251) received no award at all on their initial claim: 148 were rejected for both components, and a further 96 had applied for a mobility award alone and been rejected. Most of the remainder, 70 of those seeking or intending to seek a review, had one lower rate award, usually for care alone (52).

7.3.1 Lower rate recipients seeking a review

Among lower rate recipients, the prospect of seeking a review is associated with some aspects of their experience of claiming DLA and their changing circumstances. Table 7.1 shows the frequency of each `explanatory' factor and its association with a reported intention to seek a review of the claim. The format of this table is repeated throughout the chapter so it will be described in some detail on this first occasion.

The first four entries in the table summarise the outcome of the initial claim for DLA to show which component is most likely to be associated with the decision to seek a review. Next there follow ten items describing different aspects of the claiming process. Most are self-explanatory. Informal help refers to the assistance of family or friends in completing the claim form, while professional help covers chiefly Benefits Agency staff, health and social care providers including social workers and residential home staff, and advice agencies. Difficulties filling in the claim form are those reported by the applicant, not a helper. Statements 1 and 2 refer to the written reports at the end of the claim pack which serve principally to verify the identity of claimants but often provide valuable information about their disability or illness and how it affects them. Statement 1 is usually completed by a relative, or friend, or carer, while Statement 2 is provided by a professional worker who knows most about the applicant's disability. Contact from the Benefits Agency refers chiefly to telephone calls, letters or visits from staff at the DBC to obtain further information or check something, *after* the claim was submitted. The next section of the table shows self-reported changes in care and mobility needs, and the final section summarises the predicted outcomes described in Chapter 6.

The second and third column report the proportion of individuals described by each of the factors listed. Thus 22 per cent of lower rate recipients who said they would seek a review also said they had filled in the claim form completely on their own. This compares with 24 per cent of lower rate recipients not intending to seek a review. The last column shows the strength of association, measured by ORs. A ratio significantly greater than one indicates that the `explanatory' factor is positively associated with, that is, more prevalent among, applicants intending to seek a review. A ratio of less than one indicates a negative association. Here each OR shows an individual association unadjusted for the effects of other factors, (Appendix 4 provides further details on the interpretation of ORs.)

Table 7.1 Lower rate recipients seeking a review

Appellant status	**Review in prospect** (%)	**Review not sought** (%)	**OR***
Receiving lower rate care	87	90	*ns*
Receiving lower rate mobility	26	40	0.5
Rejected for DLA care	11	4	3.1
Rejected for DLA mobility	63	40	2.5
Applicant filled in claim form on own	22	24	*ns*
Informal help filling in claim form	65	44	2.3
Professional help filling in claim form	21	39	0.4
Claim form `not helpful' describing disability	24	27	*ns*
Claim form `not helpful' describing daily life	25	24	*ns*
Claim form `made me seem better than I am'	48	22	3.3
Supporting Statement 1	38	28	*ns*
Supporting Statement 2	67	77	*ns*
Contact from the Benefits Agency after submitting claim	28	28	*ns*
Visit from an EMP	39	27	*ns*
Increased needs overall:	61	25	4.7
More personal attention needed	31	11	3.8
More hours of care/supervision needed	16	8	*ns*
Greater supervision needed	21	6	4.1
Walking difficulties increased	41	15	4.0
Higher/middle rate care predicted	9	5	*ns*
Lower rate care predicted	71	57	1.8
Higher rate mobility predicted	62	39	2.6
Lower rate mobility predicted	17	26	*ns*
Base (= 100%)	*70*	*349*	

* *ns* = not significant (95 per cent confidence interval includes 1.0). 20 missing cases.

The evidence suggests that lower rate recipients who said they would seek a review are more likely to do so in respect of a claim for the mobility component. Table 7.1 shows that the vast majority already received lower rate care while most had been rejected for a mobility award. Indeed, 71 per cent of those who applied for a mobility award were rejected. This is a higher rejection rate than that of lower rate recipients not anticipating a review (50 per cent). Very few had been rejected for a care award although those looking to a review are more likely to have been unsuccessful than those not doing so.

How the initial claim for DLA was compiled seems to shape lower rate recipients' acceptance of the outcome. Those who received informal help filling in their claim form are twice as likely to consider asking for a review as not, suggesting that family or friends who assist with the initial claim continue to encourage the applicant to expect a more favourable outcome. By comparison, lower rate recipients who were helped by a professional to complete their claim form are less likely to feel that the initial decision on their claim was unfair, perhaps because they felt their claim had been adequately presented. Interestingly, those who said they had not received any help with the claim form are just as likely to be satisfied with the outcome of their claim as not.

Reflections on the adequacy of the claim form might prompt some lower rate recipients to feel that they should seek a review. Almost half of those who intended to ask for a review, or had already done so, thought that what they had written on the claim form did not accurately portray the effects of their disability and made their needs seem less urgent than was the case. They are more than three times as likely to feel this way as those not intending to seek a review. One in four lower rate recipients also felt that the claim form was unhelpful in covering their needs and circumstances but such views were expressed irrespective of whether or not individuals were motivated to seek a review.

Contrary to expectation, there is no support for the notion that submitting a fully supported claim form and being aware that further, perhaps more detailed, evidence was taken into account does not ensure lower rate recipients' acceptance of the initial decision. Plans to seek a review are as likely to be considered whether or not there had been further contact from the DBC or an EMP visit.

Lower rate recipients motivated by the prospect of a review are more likely than those who accepted the outcome of their claim to report that their circumstances had changed for the worse since claiming DLA. Table 7.1 shows that needs reportedly increased across the broad categories considered here: increased attention, supervision and walking needs are each associated with the expectation of a more favourable outcome. Despite this, most of those looking to a review are predicted to receive a lower rate care award. By comparison, a majority of lower rate recipients anticipating a review are predicted to receive higher rate mobility. However, this does not mean that mobility awards were necessarily wrongly targeted at the outset because those predicted to receive higher rate mobility are also more likely to report increased walking difficulties (OR = 5.3). In other words, our predictions of a more favourable outcome are probably shaped by a subsequent change of circumstances. It is difficult then to argue that the likelihood of lower rate recipients requesting a review reflects inconsistency in the decisions on their initial claim.

7.3.2 Unsuccessful applicants seeking a review

As might be expected, applicants whose claims for DLA were disallowed present a mixed picture. Almost all unsuccessful applicants were rejected for a mobility award while nearly two-thirds were rejected for a care award. However, Table 7.2 shows that these proportions do not vary according to whether or not they might seek a review. It is not clear, therefore, whether disappointment with the outcome of a claim for either component, or both, is a motive in seeking a review.

Table 7,2 Unsuccessful applicants seeking a review

Appellant status	**Review in prospect** (%)	**Review not sought** (%)	**OR***
Rejected for DLA care	62	63	*ns*
Rejected for DLA mobility	97	95	*ns*
Applicant filled in claim form on own	39	38	*ns*
Informal help filling in claim form	40	37	*ns*
Professional help filling in claim form	27	27	*ns*
Claim form `not helpful' describing disability	41	41	*ns*
Claim form `not helpful' describing daily life	42	44	*ns*
Claim form `made me seem better than I am'	44	43	*ns*
Supporting Statement 1	26	17	*ns*
Supporting Statement 2	69	59	*ns*
Contact from the Benefits Agency after submitting claim	19	21	*ns*
Visit from an EMP	22	17	*ns*
Increased needs overall:	40	30	1.5
More personal attention needed	12	5	2.8
More hours of care/supervision needed	9	9	*ns*
Greater supervision needed	7	4	*ns*
Walking difficulties increased	33	19	2.0
Higher/middle rate care predicted	8	3	*ns*
Lower rate care predicted	32	17	2.3
Higher rate mobility predicted	72	64	*ns*
Lower rate mobility predicted	6	3	*ns*
Base (= 100%)	*251*	*165*	

* *ns* = not significant (95 per cent confidence interval includes 1.0). 38 missing cases.

The findings further suggest that unsuccessful applicants' experience of claiming DLA does not influence satisfaction with the outcome. Perceived difficulties with the application form, lack of help when filling one in, and the absence of additional evidence, do not seem to have prompted them to consider asking for a review. Although many are critical of the claim form, difficulty filling it in does not distinguish between those aspiring to a review and those who accepted the decision on their claim.

Overall, those looking to a review are somewhat more likely than other unsuccessful applicants to report increased needs. A reported increase in walking difficulties and increased needs for attention are mainly implicated, though the latter are mentioned by a small minority. Our assessment of needs further suggests that most of those looking to a review might be eligible for a higher rate mobility award but this is also the case for a majority of those not aspiring to a review. Moreover, those predicted to receive higher rate mobility are also more likely to report greater difficulties walking since applying for DLA (OR = 4.2). Although significantly more of those aspiring to a review than not are predicted to receive lower rate care, this too must be set within the context of a reported increase in needs for attention.

No doubt many unsuccessful applicants who said they would appeal, or had already done so, felt that the initial decision on their claim was unfair. However, the findings show that dissatisfaction with the initial outcome is associated with increasing difficulties with self-care and walking. As a consequence, predictions of an award from our assessments are likely to reflect increased needs since applying for DLA. So it cannot be inferred that decisions on initial claims were necessarily inconsistent with the evidence submitted at the time.

7.4 Review cases

According to the database at the central DLA Unit, 609 applicants, 37 per cent of our sample, were the subject of a `business event' between their initial claims and November 1994. As far as is known, more than nine out of ten of these events relate to an internal review of the claim; a few cases had moved to the appeal stage. Just over a third of these events (225 cases) concern disallowed claims; a further 159 relate to lower rate awards only.

7.4.1 Reviews of lower rate awards

Findings relating to lower rate recipients who actually asked for a review are, not surprisingly, very similar to those for lower rate recipients who said that they intended to do so (compare Tables 7.1 and 7.3). The vast majority of recipients requesting a review of their claim were initially awarded lower rate care. Table 7.3 also shows that lower rate recipients who asked for a review were more likely to have been rejected for a mobility award and less likely to have been awarded lower rate mobility. This suggests that lack of success in respect of the mobility component may have prompted them to seek a review.

Table 7.3 Lower rate awards under review

Appellant status	**Review cases**	**Non-review cases** (%)	**OR***
Receiving lower rate care	92	87	*ns*
Receiving lower rate mobility	28	43	0.5
Rejected for DLA care	5	5	*ns*
Rejected for DLA mobility	53	39	1.7
Applicant filled in claim form on own	28	21	*ns*
Informal help filling in claim form	55	45	1.5
Professional help filling in claim form	27	41	0.5
Claim form `not helpful' describing disability	26	27	*ns*
Claim form 'not helpful' describing daily life	25	24	*ns*
Claim form 'made me seem better than I am'	39	19	2.7
Supporting Statement 1	33	28	*ns*
Supporting Statement 2	74	76	*ns*
Contact from the Benefits Agency after submitting claim	28	28	*ns*
Visit from an EMP	30	28	*ns*
Increased needs overall	50	20	3.9
More personal attention needed	28	7	5.0
More hours of care/supervision needed	13	8	*ns*
Greater supervision needed	18	4	5.8
Walking difficulties increased	31	13	3.2
Higher/middle rate care predicted	10	4	2.7
Lower rate care predicted	67	56	1.6
Higher rate mobility predicted	60	34	2.9
Lower rate mobility predicted	14	32	0.3
Base (= 100%)	159	*280*	

* *ns* = not significant (95 per cent confidence interval includes 1.0).

As expected, having professional help to fill in the claim form reduced the likelihood of lower rate recipients asking for a review but the support of family and friends would seem to encourage them to continue seeking a more favourable outcome. A substantial minority of lower rate recipients complained about the adequacy of the claim form irrespective of whether their claim was the subject of a review. However, twice as many of those under review as not felt that what they had written on the claim form made light of the effects of disability on their daily lives. Almost two out of five felt this was the case, and our analysis suggests that they used the opportunity of a review to present a more accurate account of their needs.

Lower rate recipients subject to a review are much more likely than not to report an increase in both care and mobility needs since their initial claim for DLA. Increased needs for attention with personal care and for supervision are both significantly associated with review cases. These may have prompted a minority of lower rate recipients to challenge the outcome of their initial claim although most are predicted to remain as recipients of a lower rate care award.

As suggested above, most requests for review probably arise in respect of the mobility component. Table 7.3 shows that scarcely more than a quarter of those asking for a review currently received lower rate mobility. In fact, over half (84) of review cases had applied for a mobility award and been rejected. This is a lower success rate for a mobility award than that of recipients not under review (34 and 52 per cent respectively). Our assessment of mobility needs predicts that a majority of lower rate recipients seeking a review might satisfy the conditions for a higher rate mobility award but this prediction must be interpreted with caution. Almost a third report increased difficulties walking since claiming DLA, and those who do so are most likely to be predicted to receive a higher rate mobility award (OR = 10.0). It may be that these findings reflect some uncertainty about the mobility needs of these recipients, at least as measured here. However, it is difficult to reject the inference that our predictions of an improved award reflect a worsening condition rather than inconsistency in the initial distribution of awards. The findings suggest that many reviews centre around the determination of eligibility for a higher rate mobility award.

7.4.2 *Reviews of disallowed claims*

It seems that unsuccessful applicants might also seek a review in respect of the mobility rather than the care component. Overall, 58 per cent had applied for both awards, a further 38 per cent had applied for a mobility award alone and been rejected, while the remaining four per cent had applied only for a care award. However, the proportions rejected for either component of DLA are almost identical irrespective of whether or not individuals had asked for a review (Table 7.4).

Table 7.4 Disallowed claims under review

Appellant status	**Review cases** (%0)	**Non-review cases** (%)	**OR***
Rejected for DLA care	65	60	ns
Rejected for DLA mobility	97	*94*	*ns*
Applicant filled in claim form on own	39	38	*ns*
Informal help filling in claim form	35	43	*ns*
Professional help filling in claim form	32	21	1.8
Claim form `not helpful' describing disability	44	35	ns
Claim form `not helpful' describing daily life	44	40	*ns*
Claim form *made me seem better than I am'	42	41	*ns*
Supporting Statement 1	27	17	1.8
Supporting Statement 2	70	58	1.7
Contact from the Benefits Agency after submitting claim	21	19	*ns*
Visit from an EMP	21	19	*ns*
Increased needs overall	43	30	1.7
More personal attention needed	12	7	2.1
More hours of carelsupervision needed	13	8	*ns*
Greater supervision needed	8	5	*ns*
Walking difficulties increased	32	23	1.6
Higher/middle rate care predicted	6	6	*ns*
Lower rate care predicted	31	23	1.6
Higher rate mobility predicted	72	65	*ns*
Lower rate mobility predicted	5	5	*ns*
Base (= 100%)	*225*	*229*	

* ns = not significant (95 per cent confidence interval includes 1.0).

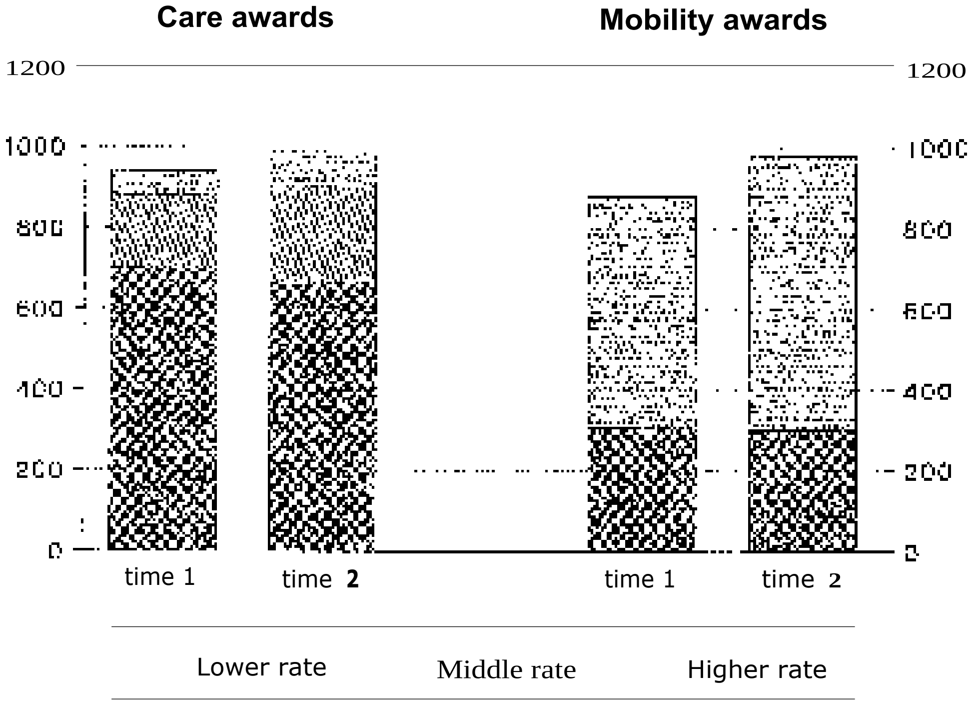
Table 7.4 shows further that any difficulties unsuccessful applicants may have had with filling in the application form are not associated with the decision to seek a review. And contrary to expectation, professional help with filling in the form, and obtaining a supporting statement, evidently increased the likelihood of these applicants asking for a review of their claim.

In addition, a change of circumstances is more likely to be reported by unsuccessful applicants who asked for a review. Increased needs for attention, and the prediction of a lower rate care award, are both significantly associated with the decision to seek a review, though these concern a minority of unsuccessful applicants. By comparison, a substantial majority are predicted to receive a mobility award at the higher rate but this is the case irrespective of the decision to seek a review. Moreover, a third reported that their walking difficulties had increased since applying for DLA and such reports are significantly associated with the prediction of a higher rate mobility award (OR = 4.1). Despite predictions of a more favourable outcome, therefore, it is not possible to suggest that decisions on initial claims were necessarily unfair. However, some unsuccessful applicants may subsequently have met the disability conditions, particularly for higher rate mobility.

7.5 Changes in lower rate awards

Figure 7.1 shows very little net change in the distribution of DLA awards between the initial decisions in early 1994 *(time 1)* and November of that year *(time 2).* No doubt this reflects the comparatively short time, around nine months, that had elapsed. The number of lower rate care awards fell slightly but this masks a number of moves into and out of this group which cancel each other out. The number of lower rate mobility awards was virtually unchanged and, as we shall see, most of the additional mobility awards relate to formerly unsuccessful applicants awarded the higher rate on review.

Figure 7.1 Distribution of DLA awards, March and November 1994



7.5.1 *Changing lower rate care awards*

Altogether 86 individuals moved into or out of lower rate care as a consequence of a decision to *increase* their award: 27 formerly without a care award were awarded lower rate care while 59 former recipients of lower rate care moved to a middle or higher rate award. An additional eight individuals appear to have had their care award *reduced:* four moved from middle or higher rate care to a lower rate award, and four lost their lower rate care award altogether. By comparison, 636 applicants who initially received lower rate care continued to do so up to November 1994. It was decided to compare these 636 individuals with the 86 whose improved award may have been prompted by increased care needs. We recognise that differences between these two groups may be diluted because not all reviews and appeals had been decided by November 1994, but these cases cannot be separately identified. Nor can we assume that everyone whose circumstances had changed had necessarily asked for a review of their initial claim.

Table 7.5 Change in lower rate care awards

Appellant status	**Improved award** (%)	No **change** (%)	**OR***
Applicant filled in claim form on own	29	26	*ns*
Informal help filling in claim form	47	49	*ns*
Professional help filling in claim form	34	33	*ns*
Claim form `not helpful' describing disability	29	22	*ns*
Claim form `not helpful' describing daily life	19	22	*ns*
Claim form `made me seem better than I am'	32	22	
Supporting Statement 1	28	28	*ns*
Supporting Statement 2	78	79	*ns*
Contact from the Benefits Agency after submitting claim	23	26	*ns*
Visit from an EMP	33	36	*ns*
Increased care needs overall	44	22	2.8
More personal attention needed	28	15	2.2
More hours of care/supervision needed	12	10	*ns*
Greater supervision needed	21	9	2.7
Higher/middle rate care predicted	9	2	4.6
Lower rate care predicted	71	66	*ns*
Base (= 100%)	*86*	*636*	

* *ns* = not significant (95 per cent confidence interval includes 1.0).

Table 7.5 summarises the findings. Difficulties with the application form do not explain why some awards are changed and others not. Although those benefitting from an improved care award are more likely to say that they had difficulty describing the effects of their disability on the claim form, the proportion doing so is not significantly different from that of those who continued to receive lower rate care throughout the period since their initial claim. Similarly, the nature of any help applicants may have received in completing their claim form and the extent to which other evidence was taken into account does not distinguish between applicants whose award was or was not increased on review.

As expected, changes of circumstances are positively associated with decisions to increase the level of care awards. Increased care needs are much more likely to be reported by those with an improved care award than by lower rate recipients with an unchanged award. However, the findings are not wholly convincing. Fewer than half of those with an improved award actually report increased care needs though we have no record of any change of circumstances *after* our survey. It is also possible that some initial decisions were inconsistent but our care needs assessment predicts that the vast majority (71 per cent) should receive lower rate care. Indeed, fewer than one in ten of those with an improved care award are predicted to receive a middle or higher rate care award according to our assessment of care needs.

Although the prediction to receive a middle or higher rate award distinguishes clearly between those who received an improved award and those who did not (OR = 4.6), it can hardly be deemed successful. No more than seven of the 59 individuals (12 per cent) moving to a middle or higher rate care are predicted to do so. We had more success predicting applicants whose initial claims had been rejected, correctly predicting 19 of the 27 individuals (70 per cent) who were subsequently awarded lower rate care.

Taken together, these findings suggest that the improved rates of award observed here are mostly a response to increased needs for care. The evidence further suggests that decisions to improve care awards on review do not necessarily cast doubt on the initial consideration of claims, or suggest that they arise from the difficulties applicants may have had in presenting their initial claim. If there are inconsistent decisions subsequently corrected on review, they are more likely to relate to initially unsuccessful applicants than to those initially awarded lower rate care.

7.5.2 Changing lower rate mobility awards

The sample of lower rate mobility awards hardly changed between the initial decision on the claim and November 1994. Seventeen individuals moved from a lower to a higher rate award, while 16 individuals, formerly unsuccessful, were eventually awarded lower rate mobility. In addition, two individuals moved from a higher to a lower award and five lost their lower rate award. By comparison, 283 lower rate awards were unchanged during the period under consideration.

The number of moves into and out of the lower rate mobility subsample is too small to warrant further analysis. The more interesting observation is that 98 initially unsuccessful applicants were awarded *higher* rate mobility on review. They comprise the largest single proportion of all increased awards: 75 per cent of improved mobility awards and 38 per cent of all recorded increases in level of award, both care and mobility. (The next largest group, those moving from lower to middle or higher rate care, comprise 23 per cent of all increased awards.)

7.6 Fixed term awards

The vast majority of awards are for life, 73 per cent in the sample as a whole. Awards for a fixed period are typically for one, two, three or five years. In the case of dual awards with one component for life, we do not know which component is fixed. However, if neither is for life, both components must be awarded for the same period. Here we shall compare those with and without a fixed term award, focusing on recipients of lower rate awards alone. The aim is to discover whether those with a fixed lower rate award are more likely to report a *decrease* in their care or mobility needs than recipients of lifetime awards.

There are 117 lower rate recipients whose award is for a fixed period. Most receive lower rate care: 22 have a dual award, 80 lower rate care alone, and 15 lower rate mobility alone. The remaining lower rate recipients (322) were awarded DLA for life.

Table 7.6 Duration of lower rate awards

Appellant status	**Fixed award** (%)	**Lifetime award**	**OR***
Receiving lower rate care	87	89	*ns*
Receiving lower rate mobility	32	39	*ns*
Applicant filled in claim form on own	29	21	*ns*
Informal help filling in claim form	45	50	*ns*
Professional help filling claim form	35	36	*ns*
Claim form 'not helpful' describing disability	24	27	*ns*
Claim form not helpful' describing daily life	24	24	*ns*
Claim form 'made me seem better than I am'	30	26	*ns*
Supporting Statement 1	23	33	*ns*
Supporting Statement 2	81	73	*ns*
Contact from BA after submitting claim	35	26	*ns*
Visit from an EMP	23	31	*ns*
Less personal attention needed	3	1	*ns*
Fewer hours of care/supervision needed	1	1	*ns*
Less supervision needed		1	*ns*
Fewer walking difficulties	4	0	14.3
Higher/middle rate care predicted	11	4	3.1
Lower rate care predicted	62	60	*ns*
Higher rate mobility predicted	44	43	*ns*
Lower rate mobility predicted	16	29	0.5
Base (= 100%)	*117*	*322*	

* *ns* = not significant (95 per cent confidence interval includes 1.0).

Less than one in 20 reported any decrease in their care or mobility needs, although recipients with a fixed award are more likely to do so than other lower rate recipients: the proportions are six and three per cent respectively. Table 7.6 shows that the most striking difference relates to difficulties walking but no more than four per cent of those with a fixed award said that these had decreased. There is no evidence to suggest that any difficulties applicants may have had in providing an account of their needs on the claim form led adjudication officers to think that these needs might decrease within the foreseeable future. However, applicants with a fixed term award are more likely to have filled in the claim form on their own. They are also more likely than those with a lifetime award to have obtained a supporting statement from their GP or other health professional and to have been contacted by the Benefits Agency after submitting their claim. But these differences between those with and without a lifetime award are not statistically significant so it is difficult to suggest that such factors might `explain' who gets a fixed term award.

Our needs assessment provides little indication of why some lower rate recipients were given a fixed award and others a lifetime award. Entitlement to lower rate care within three to four months of the initial claim is confirmed by our predictions for a majority of those with a fixed term award. Interestingly, the proportion predicted thus is somewhat less than the actual proportion of recipients, 62 and 87 per cent respectively. This might reflect a degree of uncertainty in assessing their continuing care needs but no more so than among those with a lifetime award, 60 per cent of whom are predicted to receive lower rate care compared with 89 per cent who actually do so. One in ten with a fixed term award are predicted to receive a middle or higher rate care award, suggesting an *increase* in their care needs. A substantial minority is predicted to receive higher rate mobility irrespective of the duration of their award. However, significantly fewer recipients with a fixed term award, than those with a lifetime award, are predicted to receive a lower rate mobility award. Sixteen per cent are predicted to receive such an award, half the proportion who actually do so, suggesting that the assessment of guidance needs is particularly uncertain in such cases.

The evidence then is inconclusive. The information available to us possibly does not touch on any of the factors that adjudication officers took into account when deciding not to make an award for life. Medical evidence from the applicants' own doctor or an EMP is likely to be particularly important, but this is not available for inspection. As far as we can judge, however, most doubts about entitlement in the longer term would seem to relate to the mobility component.

7.7 Summary and conclusions

This chapter has attempted to examine what might be termed the retargeting of DLA awards. The determination of claims and awards can be based only on the information presented at the time of the claim. As care and mobility needs increase or decrease, initial decisions can be reviewed and some may change as a consequence. Important questions for policy makers are the extent to which a change of circumstances is brought to the attention of adjudication officers and whether initial decisions are consistent.

Investigating changes in circumstances is clearly problematic using large-scale social survey methods and a cross-sectional design. We have stressed from the outset that such methods differ substantially from those used in the adjudication process and do not replicate the detailed consideration of individual circumstances that underpin decisions on entitlement to benefit. However, it could be argued that if any decisions are inconsistent, then we had the best opportunity of detecting them. Our detailed and comprehensive assessment of care and mobility needs was conducted within a few months of applicants submitting their claims, so the information available from the survey should be very similar to that presented to adjudication officers. It is possible that our assessments prompted some applicants to think that they could expect a more favourable outcome. Moreover we asked applicants within a relatively short time after the initial decision on their claim whether they were happy with the outcome and whether they intended to seek a review. Arguably, any decisions thought to be inconsistent with the evidence are most likely to be challenged soon after the event. The longer the delay in seeking a review, the more likely circumstances are to change and to prompt individuals to seek a review.

Our research was not designed to investigate the process of claiming, adjudicating and reviewing claims for DLA. And, as noted above, not all claims subject to review had been determined by November 1994. No firm conclusions, therefore, can be drawn about why applicants ask for a review of their claim and the explanation for the eventual outcome. Our findings in relation to lower rate recipients and unsuccessful applicants suggest that:

a. There is no firm evidence to indicate that initial decisions to award a lower rate or disallow a claim were wrong. One factor repeatedly identified by our analysis is that a change of circumstances is associated with the decisions of both lower rate recipients and unsuccessful applicants to seek a review of their claim. Although a change of circumstances is not the only, or even the main, reason for questioning initial decisions, it could not be rejected as an important contributory factor in accounting for individuals' behaviour. The outcome of reviews conducted during the course of this study largely reflect increased needs. In addition, the more favourable outcomes predicted for some individuals are often associated with a reported increase in needs and cannot, therefore, be said to point to inconsistency in decisions on initial claims.

b. These findings appear to be inconsistent with the more qualitative evidence of the *Quality of Service* presented in Part Two of this report. When asked why they were seeking a review, a majority said it was because they thought the initial decision on their claim was wrong or unfair; less than one in ten actually said they would apply for a review because their condition had worsened or their needs had increased. However, the inconsistency between the findings of the two studies does not mean that they necessarily contradict each other. Respondents with a worsening condition may have felt by the time we interviewed them some months after submitting a claim that their changing circumstances `proved' that the initial decision was wrong. Notions of unfairness probably also tell us as much about how disappointed applicants reflect on an unfavourable outcome as about the merits of their initial claims. We recognise, too, that claiming DLA is a learning process for many applicants. Some may under-represent the true level of their disability and subsequently provide a fuller account of their care or mobility needs on review.

c. A third of applicants felt that it was difficult to describe the effects of their disability on the claim form, and this view among lower rate recipients in particular is associated with their intention to seek a review and actually doing so. Findings from the *Quality of Service* study suggest that the application form does not enable some applicants to present a comprehensive or reliable account of their needs and circumstances, especially those with fluctuating conditions or mental health problems. It may also be that improved advice and guidance would help applicants provide a full account of their illness or disability and its effects on their lives. Our findings show that where lower rate recipients had received professional help to fill in the claim form, they were *less* likely to question the decision on their initial claim. Such help may reassure some applicants that their care or mobility needs have had not been overlooked or played down.

d. Other aspects of the claiming and adjudication process, the availability of supporting statements, contact from the Benefits Agency after the initial claim, and an EMP report, were expected to *reduce* the likelihood of applicants challenging the decision on their initial claims. It was thought that such `interventions' might persuade applicants to feel that their claim was given thorough consideration so that the outcome, favourable or otherwise, would be more acceptable. There was little support for this notion. Nor are these interventions associated with a more favourable outcome on review, but this is as it should be. The additional information provided by such means can help to clarify individuals' needs, adjudicate particularly difficult cases, and resolve conflicts in evidence. However, a different adjudication officer is not expected to come to a different decision on the basis of the same evidence.

e. The outcome of claims for a mobility award, rather than a care award, is more likely to be implicated where applicants are unhappy with the decision and seek a review. However, there were very few changes to the sample of lower rate mobility recipients, although we do not know how outstanding reviews will be determined. Interestingly, most changes in mobility outcomes following review relate to the award of higher rate to applicants whose claims were initially rejected. Whether these claims were in respect of walking difficulties or the other criteria for a higher rate award we cannot tell. Taken together, these observations suggest some difficulty for both applicants and adjudication officers in establishing mobility needs.

f. Between 20 and 30 per cent of applicants not seeking a review, or not intending to challenge the initial decision on their claim, said their care or mobility needs had subsequently increased. By how much we cannot say. Nor do we know whether the nature and frequency of their needs would now mean that they are entitled to an award, though our needs assessment suggests that some of them might be. Findings from the *Quality of Service* study show that some are undecided about seeking a review while a few are unaware that they could challenge the decision on their claim. Others may be `discouraged' applicants. Whatever the reason, wider access to the review and appeal procedures could be encouraged.

Chapter 8 The Targeting Study: Children

8.1 Introduction

So far we have examined the distribution of DLA awards among adult claimants. In this chapter, we consider the outcome of applications made on behalf of children in relation to patterns of disability and the conditions causing disability. Children, who are defined as under 16 years of age for social security purposes, are treated somewhat differently from adults in the claiming and adjudication process. Although the conditions of entitlement are not substantially different, assessment for eligibility has to take into account the normal stages of development of a growing child. Accordingly, child claimants and the distribution of awards to children need to be considered separately from those of adults. As noted in Chapter 2, a separate sample of children was not drawn and applications on behalf of children aged five and over were included as part of the overall sample design (see Appendix 1).

8.2 Applications for DLA on behalf of a child

All children require care and supervision at some stage, and such needs can often be considerable, especially for infants and young children. Although the care and mobility needs of a disabled child may differ from those of a healthy child, it is the amount of attention, guidance and supervision required by a child as a result of disablement that determines eligibility for DLA. Thus disabled children of any age may be eligible for a care award but they must need *substantially more* help than a child of the same age who does not have a disability. The `main meal' test, which is a distinctive and specific criteria for the lower rate care component of DLA for adults, does not apply to children.

Like MobA before it, the mobility component of DLA is available only to disabled children who are five or more years old, To be eligible for the new lower rate mobility component, disabled children who can walk must need *substantially more* guidance or supervision than children of the same age who do not have a disability.

Children qualify for DLA in their own right but the application must be made by a responsible adult, usually a parent. However, there is no separate DLA application form for children. The form contains guidance at several points for people claiming on behalf of a child and claimants can use the free telephone help line if they want advice or assistance. Nevertheless, there has been criticism of the application form from professionals and parents who think that a special form for children would be more appropriate. For example, a survey of agencies and claimants carried out by the Royal Association for Disability and Rehabilitation (RADAR) found that the claim form was `geared to adults'. Further, parents found it difficult to compare the care and mobility needs of their disabled child with those of a child of the same age without a disability (Hadjipateras and Howard, 1992).

8.3 The OPCS disability scales for children

A major aim of this study was to evaluate the distribution of DLA awards in relation to the measures of disability developed by OPCS, in particular, levels of overall severity. Clearly, childhood disablement cannot be described using scales developed for adults. Moreover, the abilities, behaviour and activities of children widen with age, irrespective of any physical or mental impairment. Therefore, some notion of social and physiological development is necessary for assessing different types and levels of disability in children. It was this consideration that led the OPCS researchers to develop sets of questions to define disabilities and overall severity in children which differed from those for adults. These separate questions were used in the present study when conducting interviews with parents or carers of disabled children.

In practice, OPCS researchers developed two child-oriented questionnaires: one for children aged five to 15 which differed from the adult version by the inclusion of specific child-related activities; and another for children under five which took account of the rapid developmental changes in the pre-school years. Children under five were excluded from the present study because they are not entitled to the mobility component of DLA, so only the first of these schedules was required. In view of the short time-scale for this study, the questionnaire for those aged five to 15 was not adapted or extended in the same way as the adult schedule. However, both provide measures of 13 different types of disability which can be combined to form a scale of overall severity (see Annex 2.2) and which are used in this chapter to evaluate DLA outcomes. A full description of the development of the children's disability scales and the methods used to relate them to those for disabled adults can be found in the OPCS survey report (Bone and Meltzer, 1989).

8.4 Characteristics of the children's sample

The sample design reflected the study's focus on the targeting of lower rate awards and the boundary between lower rate awards and rejected claims. The study included only recent claims and the achieved sample comprised 1818 interviews of which 192 (just over ten per cent) were recent claims on behalf of children aged five to 15 (see Appendix 2).

Table 8.1 shows the distribution of DLA awards in the children's sample and compares it to that of the adult sample. The adult sample reflected the sample design with some accuracy. By comparison, the children's sample was skewed towards awards and rejected claims were under-represented. Lower rate plus middle or higher rate awards predominated, and there were comparatively few middle and higher rate only awards. Thus 35 claims were rejected on disability grounds, 136 were awards that included a lower rate component, and 21 were awards of middle and higher rate components only. Of the 53 lower rate only awards just four were dual lower rate awards.

Table 8.1 Structure of the children's sample

	Children's sample		**Adult sample**
Result of claim	(N)	(Vol	(%)
Higher/middle rate only	21		17
Lower rate plus higher/middle rate	83	43	28
Lower rate only	53		27
Unsuccessful	35	18	28
Total	192	100	100

Source: DLA database.

Table 8.2 shows further the different combinations of awards in the sample at the time it was drawn. Children not receiving one of the components are classified in two ways: those who were `rejected' as not satisfying the disability conditions; and those who had `not claimed' the particular component and where there is no evidence to support entitlement to it. Because we do not know what the outcome would have been if a claim for that component had been made, they are retained as a separate category.

Table 8.2 Sample dis bution of DLA awards - children

Care component	Higher rate mobility (N)	Lower rate mobility (N)	Rejected claims (N)	Not claimed (N)	Total (N)
	Mobility component				
Higher rate care	1	10	–	4	15
Middle rate care	2	71	3	10	86
Lower rate care	2	4	15	21	42
Rejected claims		10	23	8	41
Not claimed	1	3	4		8
Total	6	98	45	43	192

Source: DLA database.

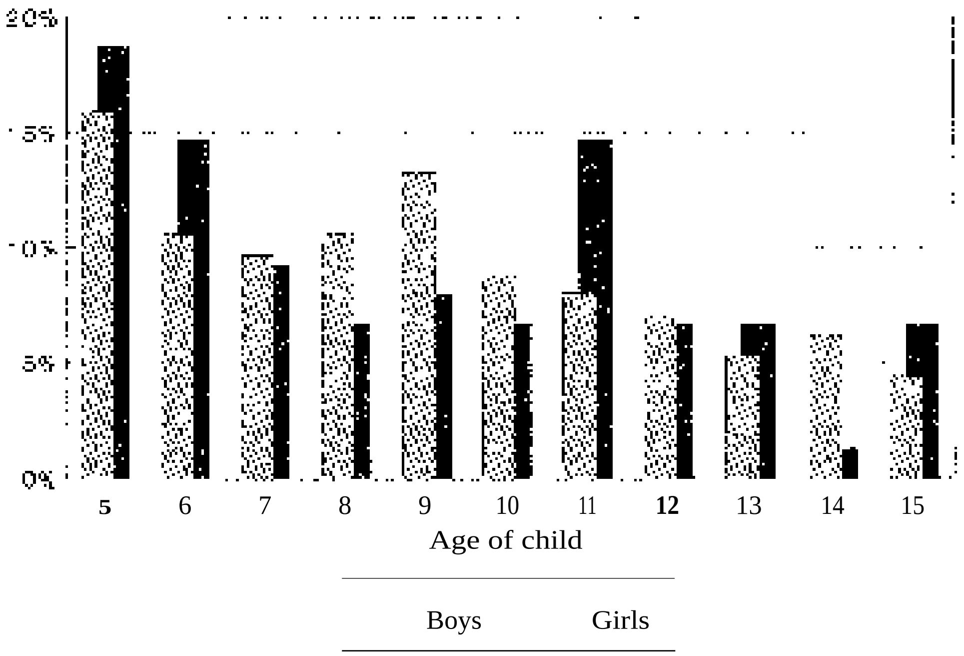
Only eight of the sample had `not claimed' the care component whereas 43, five times as many, had 'not claimed' the mobility component. This is in direct contrast with the adult sample where three times as many had 'not claimed' the care component than had 'not claimed' the mobility component. The children's sample contained equal numbers of rejected claims for the two components. In the adult sample almost twice as many claims for the mobility component were rejected as for the care component. The structure of successful claims across the sample is also different from that of the adult sample. For example, in the adult sample more than twice as many were receiving the lower rate care component than were receiving the lower rate mobility component. For children this pattern was reversed. Although these differences in the sample structure are, in part, likely to be due to chance they are also an indication of the essentially different nature of children as a claimant group.

As with adults, the group of particular interest to this study comprises those who would not have qualified for benefit under the old system, that is those receiving only lower rate awards. In the remainder of the chapter, therefore, children are divided into three groups; those receiving any middle or higher rate awards irrespective of whether the other component is awarded at the lower rate (104); those receiving lower rate awards only (53); and those whose application was disallowed altogether (35).

8.4.1 Age and sex

It is well known that disability is more prevalent in boys than in girls, and this is reflected here. Sixty per cent of the children's sample were male and 40 per cent were female. The sample was relatively evenly spread across all ages but with more five-year-olds and slightly fewer at the top end of the range (Figure 8.1). The number of five-year-olds probably reflects a surge in applications for DLA associated with the qualifying age for the mobility component.

Figure 8.1 Age distribution for boys and girls



When differences across DLA outcomes are investigated, girls are more likely than boys to have received a lower rate award only and those aged between five and seven are more likely to have received a lower rate award only than the older children (Table 8.3). It would seem then that some younger children with disabilities, who might not have been eligible for an award under the old AA and MobA, have benefited from the introduction of the new lower rate.

Table 8.3 DLA awards by sex and age

Characteristics	Higher/middle rate recipients (%)	Lower rate recipients (%)	Unsuccessful claimants (%)	All (%)
Sex				
Boys	68	44	62	60
Girls	32	56	38	40
Base (= 100%)	*102*	*52*	*34*	*188*
Age				
5-7	28	54	50	39
8-10	39	17	12	28
11-15	33	29	38	33
Base (= 100%)	*102*	*52*	*34*	*188*

8.4.2 Ethnicity and family composition

As with the adult sample the great majority of the children (90 per cent) were white. The remaining 18 children were from a variety of ethnic backgrounds: Indian, Pakistani, Bangladeshi, Black Caribbean, Black African and mixed race. Fifteen of the 18 `non-white' children were in receipt of middle or higher rate awards. two were in receipt of a lower rate award and only one had been rejected.

Almost all the children lived with a parent or parents, and most had brothers or sisters. There were three exceptions. One child lived with two grandparents. another lived with one grandparent, and a third was fostered, along with a natural sibling, in a two-parent family. One-third of the children lived in single-parent households but there was no difference in DLA outcomes according to family type.

8.4.3 Sources and levels of family income

It was not possible within the scope of this study to collect more than summary information about sources and level of income. Table 8.4 summarises the findings. Dependence on benefit in the sample of families with children was high. More than half had income mainly from benefit while 42 per cent of the sample had income mainly from earnings. Differences between DLA outcomes were small although more lower rate recipients and unsuccessful claimants had income mainly from benefits.

Table 8.4 Main source and level of family income

Family income	**Higherlmiddle rate recipients** (%)	**Lower rate recipients** (%)	**Unsuccessful claimants** (%)	All (%)
Main source of				
Benefits	53	60	62	56
Earnings	47	40	27	42
Other sources			11	2
Base (= 100%)	*102*	*52*	*34*	*188*
Income level				
Less than £100	13	27	49	24
£100 to £149	29	25	13	25
£150 to £199	24	19	17	21
£200 to £249	16	6	10	12
£250 to £299	5	6	10	7
£300 to £399	8	13		8
£400 and over	4	4		4
Base (= 100%)	92	*48*	*30*	*170*

Although few families could be described as having more than moderate income levels, and dependence on benefits was high, comparison with the adult sample suggests that disability has a more profound effect on the financial circumstances of adults than on families with a disabled child. In the adult sample 68 per cent of families were dependent mainly on benefits and almost 40 per cent reported incomes below £100 per week.

In line with the OPCS disability surveys, respondents were also asked to give a subjective judgement about their financial situation and their standard of living. They were asked how they were managing on their money at the moment and how satisfied they felt with their standard of living. Although the respondents in the children's sample reported less dependence on benefits and higher levels of family income than adult claimants, they did not report managing any better and they were no more satisfied with their standard of living (Table 8.5). Differences across DLA outcomes were small, although higher and middle rate recipients were more likely to report managing quite well while unsuccessful claimants were most dissatisfied with their standard of living.

Table 8.5 Subjective perceptions of financial situation and standard of living

Financial situation! standard of living	**Higher/middle rate recipients** (%)	**Lower rate recipients** (%)	**Unsuccessful claimants** (%)	All (%)
Managing on money				
Managing quite well	24	19	12	20
Just getting by	60	51	59	57
Getting into difficulties	17	30	29	23
Base (= 100%)	*102*	*53*	*34*	*189*
Satisfaction with standard of living				
Very satisfied	8	6	3	6
Fairly satisfied	45	47	31	43
Neither satisfied nor dissatisfied	28	21	20	25
Fairly dissatisfied	14	11	29	16
Very dissatisfied	6	15	17	11
Base (=100%)	*103*	*53*	*35*	*191*

Respondents were also invited to reflect on how they were managing on their money one year previously, before receipt of any DLA award. Overall, 28 per cent said they were managing better in the current year, 13 per cent better in the past year. Those who had been awarded DLA were more likely to report an improvement in their financial situation.

8.4.4 Conditions causing disability

There were two sources of data available on conditions causing disability. At the beginning of the interview, respondents were asked to describe up to three health problems or medical conditions which gave rise to disability in the child. Responses were then coded according to a lengthy classification and grouped according to a modified version of the *International Classification of Diseases* (WHO, 1980) developed by OPCS researchers (Martin *et al.,* 1988). The majority of children (60 per cent) had only one complaint, 23 per cent had two and 16 per cent specified three. Information was also available from the DLA database on the main disabling condition used in the assessment of claims. In most cases the two classifications were found to be compatible and so the analysis uses only the questionnaire responses which provide a fuller picture than the single DLA database code.

Conditions causing disability in children are intrinsically different from those that cause disability in adults. Many of the conditions that predominate in the adult sample, such as rheumatism, arthritis and heart disease develop later in life. Children, on the other hand, are more likely to have a congenital impairment. Our sample of children, moreover, excludes any children awarded DLA before the age of five, who would typically have been significantly disabled from birth or early infancy.

Because the classification of conditions is wide, the numbers of children in some of the categories were too small to report. The analysis has therefore been cast differently from that of adults to provide a clearer picture. Conditions that are more generally associated with children are kept separate, and other conditions are grouped in ways appropriate to children. Table 8.6 summarises the results.

Table 8.6 Frequency of complaints causing disability

Complaints causing disability	**Higher/middle rate recipients** (%)	**Lower rate recipients** (%)	**Unsuccessful claimants** (%)	All (%)
Learning disorders	36	17	17	27
Asthma	13	26	46	22
Behaviour disorders	27	6	9	18
Eczema or dermatitis	5	21	20	12
Epilepsy	14	4	6	10
Digestive & excretory system	11	4	14	9
Diabetes	6	13	6	8
Deafness & ear complaints	9	6	11	8
Vision disorders	7	9	6	7
Musculo-skeletal system	5	9		5
Cerebral palsy	(5)		(1)	(6)
Heart conditions	(3)	(2)		*(5)*
Cystic fibrosis		(4)		(4)
Base (=100%)	*104*	*53*	*35*	*192*

Percentages sum to more than 100 because some children reported two or three conditions.
(} represents actual numbers rather than percentages.
'Learning disabilities' includes two children with Down's syndrome.
`Asthma' includes one child with another respiratory allergy.

It can be seen that learning disorders and asthma predominate (27 per cent and 22 per cent respectively) followed by behaviour disorders and eczema. Children with learning and/or behaviour disorders were more likely to have been awarded a middle or higher rate whereas asthma and eczema were associated with lower rate awards. Asthma and eczema also predominated among rejected claims. Lower rate awards were also associated with diabetes and marginally with vision disorders. The distribution of conditions causing disability in the sample suggests that the extra care and supervision required by children who have conditions such as asthma, eczema and diabetes is being recognised particularly by awards of the new lower rate of DLA. This will be explored further later in the chapter.

8.4.5 *Different types of disability and overall severity*

A requirement for this study was the measurement of 13 types of disability to form the composite scale of overall disability developed by OPCS researchers. Figure 8.2 shows the prevalence of each of the 13 disabilities in this sample of children. Behaviour was the most prevalent disability followed by locomotion, personal care and communication. Most of the children had more than one disability; typically they had three or four.

The prevalence of different types of disability again highlights a distinction between child and adult disablement. Locomotion disability was the most prevalent for the adult sample (82 per cent), followed by personal care (66 per cent) and dexterity (44 per cent). For children, behaviour problems were the most prevalent (76 per cent), followed by locomotion disability (58 per cent), personal care disability (55 per cent) and communication disability (53 per cent). For adults, behaviour problems and communication disabilities occurred in only a third and a fifth of the sample respectively.

Figure 8.2 Prevalence of different types of disability - children

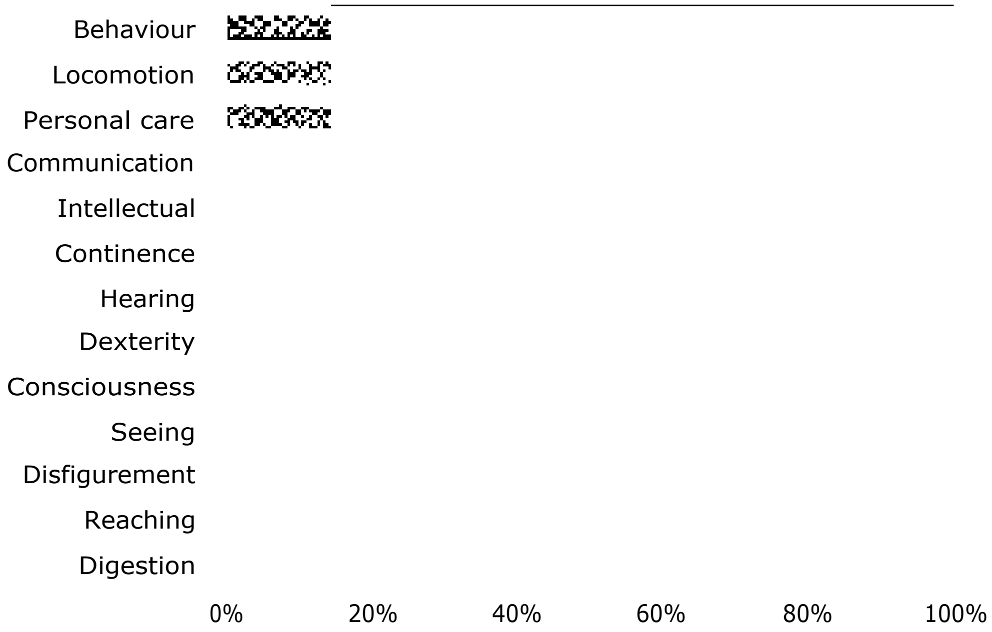
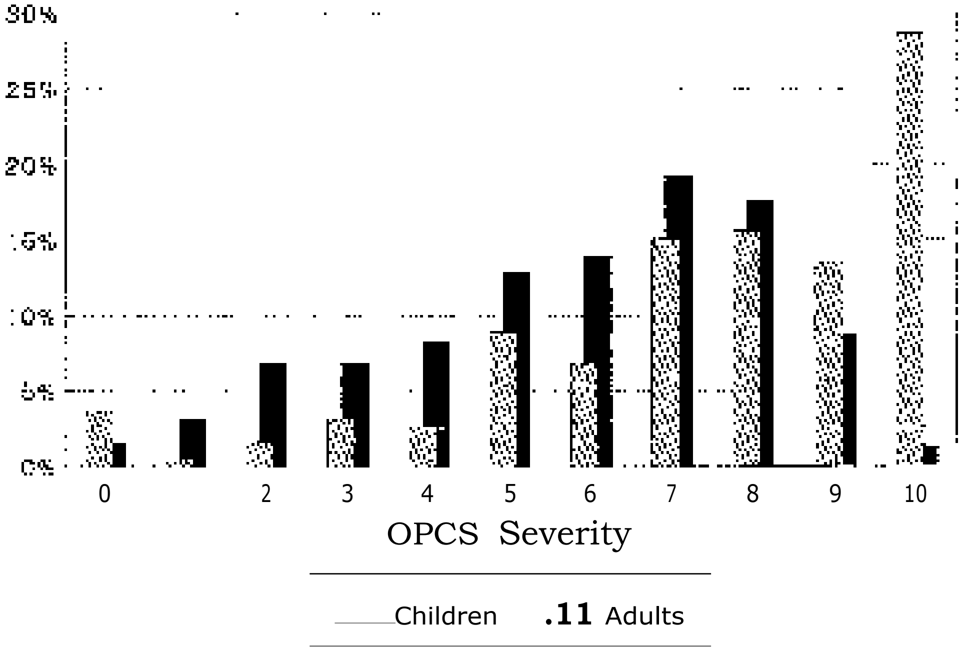


Figure 8.3 shows the proportion of children in each of the ten severity categories alongside the distribution for the adult sample. It is clear that overall scores for the majority of the children in the sample were high. The mean score was 7.5 compared with 5.8 for adults. Over a quarter had a maximum score of ten. Only 22 (ten per cent) had scores of less than five. Seven children fell below the threshold of severity as defined by OPCS and are allocated a score of zero. Of these, four suffered from diabetes, two from asthma and one from cystic fibrosis. The distribution of severity is quite surprising. It was expected that a study which focused on lower rate awards and rejected claims would include mostly children with minor to moderate severity levels. The relationship between overall severity and level of award is discussed further in the next section.

Figure 8.3 Severity of overall disability - adults and children



8.5 Severity of disability

Our evaluation of DLA focuses on the extent to which the new lower rate is successfully extending help to less severely disabled people. Here we consider the relationship between DLA awards and overall severity of disability using the ten-point scale developed by OPCS. Care awards and mobility awards are considered separately.

There are two aspects of the children's sample that limit the analysis and the interpretation of results. First, as noted above, overall severity scores for the children were generally high and skewed towards the top end of the distribution. Second, three groups contained very small numbers. Fifteen children were in receipt of the higher rate care component, six were in receipt of the higher rate mobility component, and eight had `not claimed' the care component. Because these three groups are small their distributions are shown as numbers rather than percentages in the tables that follow.

The intention to target lower rate awards on people in OPCS severity categories 5 and 6 was based on evidence from the survey of disabled adults and is described earlier. Since there was no similar analysis carried out on the data for children, the evaluative criterion relating to severity categories 5 and 6 does not apply and is not given specific consideration.

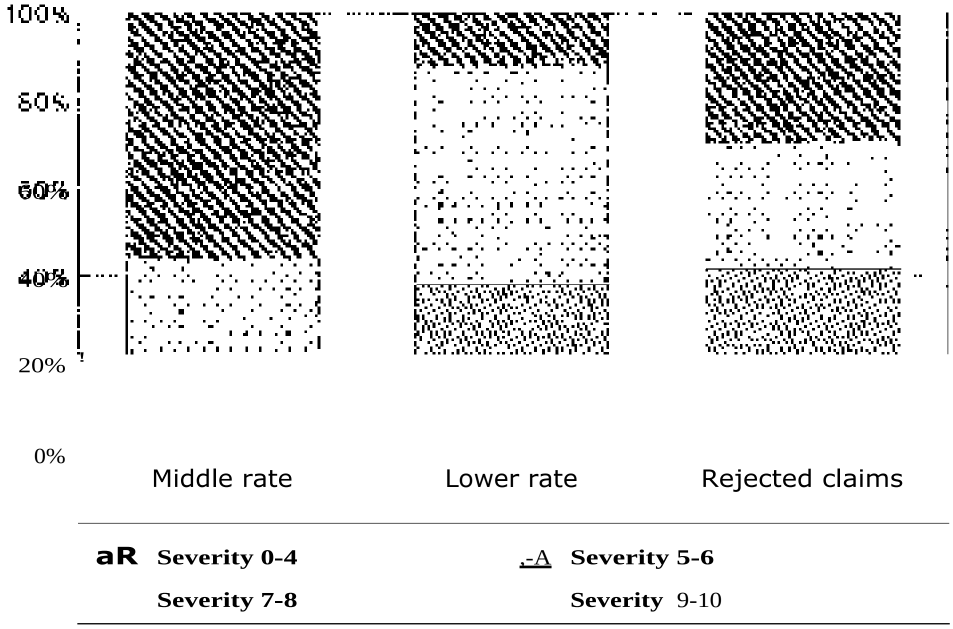
8.5.1 DLA care awards and overall severity

For children the `meals test', which is a major criterion for the lower rate care component for adults, does not apply. In consequence it is only the need for personal care that determines eligibility for an award. Taking age into account, the level of award should reflect a level and frequency of care which is substantially in excess of that which a child of the same age in normal physical and mental health would require. It might be expected, therefore, that there would be a moderate association between overall severity of disability and level of award. Table 8.7 and Figure 8.4 show the distribution of care awards across different severity levels.

Table 8.7 DLA care awards by OPCS severity category - children

Severity category	**Higher rate care (N)**	**Middle rate care** (%)	**Lower rate care** (%)	**Rejected claims** (%)	**Not claimed** (N)
9-10	(12)	56	12	29	(4)
7-8	(1)	27	50	29	(2)
5-6	(1)	13	19	24	
3-4	(1)	4	5	7	(2)
1-2		-	7	2	
0		1	7	7	-
Base (4 100%)	15	86	42	41	8

Figure 8.4 DLA care awards by OPCS severity category - children



As with adults there is some evidence of a severity gradient across DLA outcomes but there is, also, considerable overlap. Recipients of a higher or middle rate award were generally more severely disabled than recipients of a lower rate award. For example, 56 per cent of middle rate recipients were in severity categories 9 and 10 compared with only 12 per cent of lower rate recipients; and only five per cent of middle rate recipients were in severity categories 0 to 4 compared with 19 per cent of lower rate recipients. However, there was little distinction between lower rate awards and rejected claims. Indeed unsuccessful claimants were generally more severely disabled than lower rate recipients. Almost 60 per cent of unsuccessful claimants were in severity categories seven or over. Six of the eight non-claimants were also assessed as severely disabled. Hence we must conclude, as we did for adults, that overall severity scores do not discriminate well between DLA care outcomes.

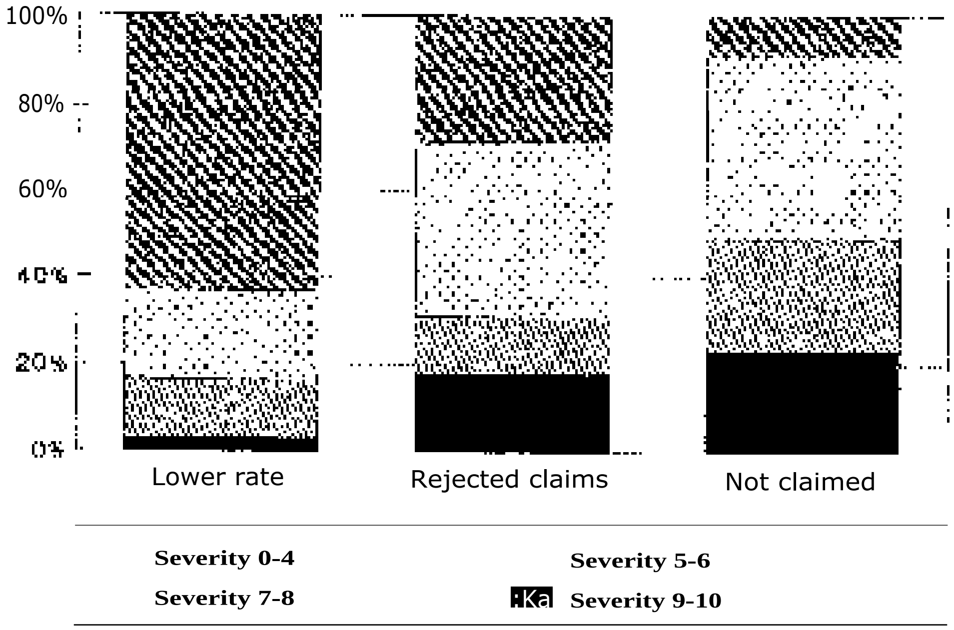
8.5.2 DLA mobility awards and overall severity

Only six mobility claims in the sample had resulted in a higher rate award. The analysis of mobility awards is therefore restricted to the boundaries between lower rate awards and rejected claims and between rejected claims and non-claimants. The criteria for the lower rate mobility component have regard for the need for supervision or guidance when out and about rather than physical problems with walking. A child cannot satisfy the guidance or supervision condition unless he or she needs guidance or supervision that a child of the same age in normal physical and mental health would not require. According to the adult analysis, it might be inferred that there is less correspondence between overall severity and mobility awards than between overall severity and care awards. Table 8.8 and Figure 8.5 show otherwise.

Table 8.8 DLA mobility awards by OPCS severity category - children

Severity category	Higher rate mobility (N)	Lower rate mobility (%)	Rejected claims (%)	Not claimed
9-10	(2)	63	29	9
7-8		20	40	42
5-6	-	13	13	26
3-4		3	11	7
1-2	(1)		4	2
0	-	2		4
Base (= 100%)	6	*98*	*45*	*43*

Figure 8.5 DLA mobility awards by OPCS severity category - children



8.5.3 *Lower rate recipients and overall severity*

Recasting the analysis according to overall DLA outcome (Table 8.9) does not make much difference to the findings. Recipients of lower rate awards are, on the whole, less severely disabled than higher or middle rate recipients but they are also not significantly different from children who were rejected. Fifty-nine per cent of lower rate only recipients and 66 per cent of children who were rejected have severity scores of seven or over.

Table 8.9 DLA awards by OPCS severity category - children

Severity category	Higher/middle rate recipients (%)	Lower rate recipients (%)	Unsuccessful claimants (%)	All (%)
9-10	59	19	29	42
7-8	24	40	37	31
5-6	12	25	14	16
3-4	4	8	9	6
1-2		4	3	2
0	1	6	9	4
Base (= 100%)	*104*	*53*	*35*	*192*

8.5.4 *The influence of age*

OPCS severity scores for children take age and stages of development into account and, in this sample, there is no variation in severity levels by age. However, as children get older they may be judged to be better able to cope with a particular disability. Similarly, they may need a lower level of help or less frequent help from others to look after themselves or get around. Thus older children may be more likely to be rejected or awarded a lower rate than a younger child with the same disabilities.

Figure 8.6 shows the distribution of DLA care awards (excluding higher rate recipients and those not claiming care because of small numbers) by age. The figure shows that recipients of lower rate care awards were generally younger than those whose claims were rejected but also younger than those awarded middle/higher rate care. These findings suggest that it is only at lower levels of severity that some older children are able to take some responsibility for their own care needs.

Figure 8.6 *DLA* care awards and age

Whereas some disabled children may be able to look after their own personal care needs as they get older, those with sensory disabilities, behaviour problems or learning difficulties may continue to need guidance and supervision when out and about. Indeed they may pose a greater burden in this respect for their carers than a younger child with the same need for guidance or supervision. An association between age and lower rate mobility awards might therefore be expected. Figure 8.7 shows that with increasing age children are more likely to receive a lower rate mobility award.

Figure 8.7 DLA mobility awards and *age*

8.6 Different types of disability

The conditions of entitlement to DLA for children are more complex than for adults because care and mobility needs have to be substantially in excess of those required by a child of the same age. Thus for children who are, say, five years old, there are many things that parents expect to have to help with - washing, dressing and going to the toilet, for example. All five-year-olds too need watching over and cannot be out and about without some supervision. As children get older there is a natural expectation that they will become independent in all areas of care, and the adjudication process must take normal development into account. Despite the complexity of these considerations, and bearing in mind that it was not possible in this study to assess the level or frequency of need, it might be expected that there would be some correspondence between disabilities that reflect the DLA criteria, particularly personal care disability and locomotion disability, and the outcome of DLA applications.

As with the adult sample the 13 scales of disability developed by OPCS researchers were replicated in our study and the scales are used separately to focus in turn on the prevalence and severity of each type of disability. The analysis is again subject to some difficulty because of the small numbers awarded the higher rate of each component. Nevertheless our focus is more particularly on the boundary between lower rate awards and rejected claims for which numbers are just about adequate.

8.6.1 *DLA care awards and the prevalence and severity of different types of disability*

In the adult sample, lower rate care recipients were distinguished by disabilities which reflected the criteria for a lower rate award, particularly personal care, dexterity, seeing and communication. On the whole, this cannot be said to be the case for children (Table 8.10). Most of the 13 disabilities were equally or less prevalent among lower rate recipients than middle rate recipients. The exceptions were disfigurement and reaching/stretching where prevalence is in any case low right across the sample. Personal care disability, continence and dexterity were equally prevalent across the boundary between middle rate and lower rate but less prevalent among children who were rejected. Behaviour problems and consciousness disability, which describes a susceptibility to fits or convulsions, were more prevalent among middle or higher rate recipients, but equally prevalent across the boundary between lower rate recipients and children who were rejected. Communication disability, intellectual function and hearing were less prevalent among lower rate recipients than among children awarded the middle rate or children who were rejected.

Table 8.10 Prevalence of different types of disability by DLA care awards

Type of **disability**	**Higher rate care** (N)	**Middle rate care** (%)	**Lower rate care** (%)	**Rejected claims** (%)	**Not claimed** (N)
Behaviour	(13)	92	57	61	(4)
Locomotion	(8)	57	57	61	(5)
Personal care	(12)	62	60	32	(3)
Communication	(8)	70	24	49	(4)
Intellectual functioning	(8)	49	14	24	(3)
Continence	(7)	34	38	24	(2)
Hearing	(5)	29	14	32	(3)
Dexterity	(6)	21	19	7	(2)
Consciousness	(3)	21	10	10	
Seeing	(4)	12	10	10	(3)
Disfigurement	(4)	4	12	2	(1)
Reaching and stretching	(2)	2	7	5	(1)
Eating. drinking, digesting	(1)	5	2	2	
Base (= 100%)	15	86	42	41	8

The findings here suggest that some disabilities are more likely to attract an award than not, but there does not appear to be a relationship between level of award and prevalence of disability. For example, 24 per cent of children who were rejected have a continence disability compared with 38 per cent of lower rate recipients and 34 per cent of middle rate recipients. Severity of disability might distinguish better between outcomes than prevalence rates.

Table 8.11 shows the disability scores by DLA care outcome. On the whole lower rate recipients are less severely disabled than recipients of middle rate awards. The differences, however, are not large. There is no such difference in severity between lower rate recipients and children who were rejected. Indeed for some disabilities children who were rejected appear to be more severely affected. Perhaps the absence of the `meals test' for children makes adjudication on this boundary particularly difficult.

Table 8.11 Severity of different ypes of disability by DLA care awards

Type of disability	Higher rate care Mean (SD)	Middle rate care Mean (SD)	Lower rate care Mean (SD)	Rejected claims Mean (SD)	Not claimed Mean (SD)
Behaviour	12.4	11.0	9.3	10.0	10.5
	(2.3)	(2.8)	(3.0)	(3.2)	(6.1)
Locomotion	7.4	4.9	5.0	5 0	6.9
	(3.6)	(1.9)	(2.4)	(2.4)	(2.2)
Personal care	9.0	9.6	9.1	9.6	9.3
	(2.7)	(2.3)	(2.2)	(2.0)	(3.3)
Communication	10.8	9.0	7.6	8.1	8.3
	(2.7)	(2.7)	(3.7)	(3.2)	(2.0)
Intellectual functioning	7.0	5.7	3.3	5.4	5.1
	(4.2)	(3.0)	(2.0)	(2.8)	(2.9)
Continence	8.0	6.0	4.9	5.5	6.2
	(3.1)	(3.7)	(3.1)	(3.3)	(0.1)
Hearing	6.3	7.0	4.7	7.1	5.9
	(2.3)	(2.0)	(0.0)	(1.5)	(1.1)
Dexterity	6.5	6.4	6.4	6.3	5.1
	(0.9)	(0.9)	(0.7)	(0.9)	(2.5)
Consciousness	7.2	8.2	7.0	9.6	
	73.8)	(2.8)	(2.4)	(2.5)	
Seeing	6.6	6.6	6.3	8.5	8.7
	(1.5)	(2.0)	(1.9)	(2.4)	(0.9)
Reaching and stretching	5.9	5.9	2.2	5.9	1.2
	(2.0)	(2.0)	(1.9)	(2.0)	(-)

* Excludes children below the minimum threshold for each disability.
Severity levels for disfigurement and digestion disabilities were not defined.

8.6.2 *DLA mobility awards and the prevalence and severity of different types of disability*

The OPCS scale of locomotion disability covers difficulties associated with walking and climbing and, for children, takes into account activities such as running.

Table 8.12 shows the prevalence of different types of disability by DLA mobility outcome. As might be expected, all six recipients of higher rate mobility had a locomotion disability; they also had a personal care disability. The table also shows that, as for adults, disabilities associated with mental impairment - behaviour, communication and intellectual functioning - are most prevalent among lower rate recipients. This reflects the guidance and supervision criteria for lower rate mobility awards. There is no association, however, between receipt of lower rate and visual impairment, as there was for adults. Dexterity disability is also associated with lower rate awards for children.

Table 8.12 Prevalence of different types of disability by DLA mobility awards

Type of disability	Higher rate mobility (N)	Lower rate mobility (%)	Rejected claims (%)	Not claimed (%)
Behaviour	(1)	90	69	58
Locomotion	(6)	61	67	35
Personal care	(6)	58	51	47
Communication		75	44	21
Intellectual functioning		57	18	12
Continence	(2)	31	36	37
Hearing	(1)	34	29	12
Dexterity	(4)	27	13	2
Consciousness	(1)	19	16	5
Seeing	(1)	15	13	7
Disfigurement	(2)	5	9	7
Reaching and stretching	(2)	2	9	5
Eating, drinking. digesting	(1)	3	4	2
Base (= 100%)	*6*	*98*	*45*	*43*

There is, however, some overlap in the prevalence of different types of disability across mobility outcomes. Two-thirds of rejected claimants have a behaviour problem and two-thirds have a locomotion disability. Over a half of non-claimants of the mobility component have a behaviour problem, and a third have a locomotion disability.

Table 8.13 Severity of different types of disability by DLA mobility awards

Type of **disability***	**Higher rate mobility Mean (SD)**	**Loner rate mobility Mean (SD)**	**Rejected claims Mean (SD)**	Not **claimed Mean (SD)**
Behaviour	5.4	11.6 (2.6)	9.2 (3.5)	9.5 (2.8)
Locomotion	7.0 (3.5)	5.2 (2.1)	5.5 (2.5)	4.5 (2.2)
Personal care	9.0 (3.5)	9.4 (2.5)	9.2 (1.9)	9.7 (1.8)
Communication		9.1 (2.9)	7.9 (2.8)	8.9 (3.0)
Intellectual functioning		5.8 (3.1)	5.5 (3.0)	2.8 (2.5)
Continence	7.9 (2.6)	6.5 (3.4)	5.1 (3.2)	5.2 (3.5)
Hearing	4.7 (-)	6.8 (1.9)	6.5 (1.7)	6.3 (2.3)
Dexterity	6.8 (0.0)	6.2 (1.1)	6.6 (0.7)	6.8 (-)
Consciousness	9.0	8.0 (3.0)	9.1 (2.1)	5.5 (2.1)
Seeing	6.8 (-)	7.5 (2.1)	7.5 (1.4)	4.5 (0.2)
Reaching and stretching	2.8 (2.3)	5.9 (2.0)	5.9 (1.7)	1.2 (0.0)

* Excludes children below the minimum threshold for each disability.
Severity levels for disfigurement and digestion disabilities were not defined.

The severity of each disability by DLA mobility outcome is summarised in Table 8.13. For behaviour and communication problems, there is a severity gradient across the boundary between lower rate recipients and rejections. The association between these disabilities and lower rate awards is thus confirmed.

The analysis of different types of disability for children does not provide such clear evidence as the adult survey that lower rate awards, particularly lower rate care, are being `well targeted' according to the criteria. In the adult sample it was possible to explore the association between DLA outcomes and different types of disability further using multivariate analysis. This was not feasible for children because of the much smaller numbers overall and the very small number of higher rate awards.

8.6.3 Lower rate awards and conditions causing disability

We were able to identify above some specific conditions that were associated with lower rate awards. Here we investigate whether these associations can be specifically related to care outcomes or to mobility outcomes. Table 8.14 shows the conditions causing disability, as defined earlier, across the boundary between lower rate awards and rejected claims for both components.

The earlier analysis indicated an association between lower rate only awards and particular conditions in children. It is clear from the table that these associations are, in fact, separately attributable to the care component or to the mobility component. Conditions that indicate a need for extra levels of personal care - asthma, eczema, diabetes and cystic fibrosis - were associated with lower rate care. For example, 33 per cent of lower rate care recipients had asthma compared with nine per cent of lower rate mobility recipients, and 17 per cent of lower rate care recipients had diabetes compared with none of the lower rate mobility recipients.

Conditions that indicate a need for guidance or supervision when out and about - learning disability, behaviour disorders, epilepsy and sensory disorders - are associated with lower rate mobility. For example, 43 per cent of lower rate mobility recipients had a learning disability, compared with only 12 per cent of lower rate care recipients, and 31 per cent of lower rate mobility recipients had a behaviour disorder compared with only two per cent of lower rate care recipients.

Table 8.14 DLA outcome by conditions causing disability

Classification of complaints	Lower rate care recipients (%)	Lower rate mobility recipients (%)
Learning disabilities	12	43
Asthma	33	9
Behaviour	2	31
Eczema or dermatitis	26	4
Epilepsy	5	15
Digestive & excretory system	5	7
Diabct, s	17	
Dea en & car complaints	–	10
Vino n disorder	5	10
Nlusi i-skeletal system	7	6
Cerebral palsy		(3)
Heart conditions	(2)	(3)
Cystic fibrosis	(4)	
Base (=100%)	*42*	*98*

8.7 Summary and conclusions

Children are an important category of claimants of DLA, and they receive specific consideration in the determination of claims and awards. In this chapter we have examined the outcome of cla in) s on behalf of the children who were included in the targeting sample. The analysis has focused on the distribution of DLA awards in relation to disabling conditions and disabilities but was limited by relatively small numbers, particularly among recipients of the higher rate care component and recipients of the higher rate mobility component. The children in the study were, on the whole. more severely disabled on the overall OPCS severity scale than the adult claimants; the distribution of DLA outcomes among the children was different from that of the adults; and the conditions causing disability in children were on the whole intrinsically different.

Although lower rate recipients were on the whole less severely disabled than middle or higher rate recipients, there was little evidence to indicate that lower rate awards are targeting children with moderate disabilities. This reflects the distribution of awards among adult claimants. There was also little correspondence between DLA outcomes and the disabilities most closely linked with the criteria for DLA awards. This was particularly the case for care awards perhaps because the amount of care that children require varies at different stages of development. When age is taken into account younger children, who might be less able to cope with their own care needs, were more likely to be getting a lower rate care award. By comparison, disabilities reflecting lower rate mobility guidance and supervision criteria were more prevalent and more severe among recipients of the lower rate mobility component. Moreover, older children for whom guidance and supervision needs may increase with age, were more likely to be getting a lower rate mobility award.

For children, the most striking association revealed by the analysis was between lower rate awards and the conditions causing disability. In particular there was an association between lower rate care awards and children with eczema, with diabetes, with cystic fibrosis and with asthma. This shows that lower rate care is helping those families where children need special medical attention or intermittent special care. There was also an association between lower rate mobility and conditions that imply the need to be watched over when out and about such as sensory impairments, epilepsy, behaviour and learning disorders.

The evidence therefore indicates that the new lower rate awards are successfully extending help to specific groups of disabled children who would have failed to qualify for the old style AA and MobA. It seems that the lower rate criteria have identified additional groups of recipients among disabled children. However, it would require a larger sample of children to describe and interpret more precisely the ways in which the lower rate criteria have extended the scope of these former benefits and to evaluate whether the care and mobility needs of disabled children are adequately addressed.

PART TWO
The Quality of Service Study for New Claimants

Chapter 9 Introduction to Quality of Service Study for New Claimants

In Chapter 1 we explained that the aims of introducing DLA and AA were not only to extend help to people with moderate disabilities who have care and mobility needs, but also to provide a better standard of service through a more straightforward and transparent claims process. In Part Two we present the findings of the survey of new DLA and AA claimants which aimed to assess the quality of service provided by the Benefits Agency. (Part Three contains our analysis of claimants' experiences of the new review and appeal mechanisms.)

This chapter defines the main research questions addressed in this part of the project, explains the methods adopted, describes the claiming process for DLA and AA, discusses how the data are used in the chapters presenting our empirical findings, and, finally, sets out the structure of Part Two of the report.

9.1 The research questions

Our main objective in the research was to evaluate whether the objective of a more straightforward and transparent claims process has been achieved by measuring, and exploring what influences the expressed satisfaction of DLA and AA claimants. We set out, therefore to address the following questions.

1. What are people's perceptions of, and satisfaction with:
    a. the new claim forms
    b. the help and advice received form the Benefits Agency in making a claim for DLA or AA
    c. the contacts they have with the Agency after submitting their claim, and after getting their decision
    d. any medical examinations connected with the claim
    e. the time taken to process their claim
    f. the letters setting out the adjudication officer's decision?

2. How do people's expectations about claiming, and the decision on their claim, affect their expressions of satisfaction or dissatisfaction?

3. What aspects of the claiming process most contribute to people's overall satisfaction with the service provided by the Benefits Agency?

9.2 Research design and methods

A large quantitative survey was selected as the most appropriate method for conducting the project. Our survey sample was divided into two different groups, the first comprising people who had recently had their claim for DLA or AA decided by the Benefits Agency (the `decided claims' sample), and the second composed of people still in the process of claiming who had not yet received a decision (the `claims in progress' sample). The rationale for this division was that previous studies have shown that the outcome of people's claims influences their responses to questions about satisfaction. By interviewing people before they knew the result of their claim, we hoped to avoid this *outcome effect and* achieve a more reliable measure of people's satisfaction. The implications of the *outcome effect* are discussed further in Section 9.4.

The survey fieldwork was carried out by SCPR between May and August 1994. Interviews with the `decided claims' sample were conducted face-to-face using a structured questionnaire. The `claims in progress' sample was interviewed by telephone using a shortened version of the `decided claims' questionnaire. Table 9.1 shows the numbers of achieved interviews.

Table 9.1 Structure of samples of DLA and AA claimants

Type of **claimant**	**DLA** (N)	AA (N)
Decided claims	1807	304
Claims in progress	305	272

The large number of DLA claimants in the decided claims sample reflects the requirements of the project investigating the targeting of DLA lower rate awards (see Chapter 2). While such a large sample expands the possibilities for statistical analysis, the peculiar construction of the sample also presented problems for the analysis and interpretation of the data. These difficulties are discussed in Section 9.5 below.

9.3 The claiming procedure for DLA and AA

Under the old AA and MobA schemes all claimants were required to undergo an examination by a medical practitioner. For the new benefits, claimants complete a self-assessment claim form giving details of their illness or disability and the way in which this affects their everyday activities. The intention was that adjudication officers would be able to decide a large number of claims solely on the information given in the claim form. However, they could, if they thought necessary, request either a report from someone involved in the care or the treatment of the disabled person, their GP or from an EMP.[27] A claimant may also ask for a medical examination.

The claim packs for DLA and AA are in two parts. Section 1 is the claim and asks for basic factual information about the claimant, including biographical details, their disabling condition, and preferences about method of payment. Section 2, which is optional, asks a series of questions about care needs and, for DLA only, mobility needs. Section 2 also offers the claimant the opportunity of obtaining up to two *supporting statements,* one from a GP or other health professional, and one from a person who has knowledge of their disabilities and how these affect their everyday life.

The sections are physically separate to allow the claimant to send in one before the other. The rationale for this is that a person's claim is established when the form is received in a Benefits Agency office and any payments due will generally be made from that date. A claimant can therefore register a claim by sending in (usually) Section 1 if time is needed to obtain supporting statements or other evidence. Claim packs received direct from the Benefits Agency are stamped on the date of despatch to a claimant. Provided that the claimant submits the claim within six weeks, the date of claim will be taken as the date of despatch. In this way claimants are not penalised if someone else delays completing part of the form. Also, claimants who request a medical examination or who are terminally ill and are not expected to live more than six months do not have to fill in the rest of the form.

Initial claims are decided by adjudication officers working in one of the 11 DBCs in Great Britain. Adjudication officers decide, in the light of the evidence available, if any clarification or additional evidence is needed and, if so, the best source. They may ask the claimant, their carer, or a person involved in their treatment for additional information. They may seek help and advice from the Benefits Agency

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[27] EMPs are doctors recruited and trained by the Benefits Agency specifically for the purpose of completing reports to assist DLA and AA adjudication officers.

Medical Service. They may request a factual report from a doctor who knows the claimant, usually a GP, or they can request a report from an EMP, or from a hospital.

At the time the research was conducted, the arrangements for notifying claimants of decisions and for making initial payments of awards were slightly different for DLA and AA. This was due to differences in the capabilities of the DLA and AA computer systems. When a decision on a claim for AA was made, the claimant was initially notified by post. However, the first payment of any award was processed separately and would have reached the claimant at some point later. In contrast, DLA claimants received their decision letters and first payment at the same time.

9.4 Preliminary note on satisfaction measurement and the *outcome effect*

The aim of the DSS and Benefits Agency in trying to measure quality of service is to obtain feedback on how they deliver benefits to people. Such information can then be used to improve systems of delivery and to make the experience of claiming benefits as acceptable and trouble-free as possible. People's views and opinions about the benefits themselves or the amount paid to them as individuals is a different issue which ideally would be kept separate in a survey about quality of service. However, in practice many people conflate the *outcome* of their claim with the *process* of filling in a claim and dealing with Agency staff.

The problem this creates for satisfaction surveys is that some people's responses to a range of questions about their experiences in general and about their levels of satisfaction in particular will be influenced by the outcome of their claim. There is always, to some degree, an *outcome effect* which can work in two opposite directions. First, people unhappy with the decision of the Agency can respond negatively to questions which attempt to elicit information on the experience of claiming. In contrast, people who are happy with the result of their claim can have an exaggeratedly positive view of how their claim was handled.

The problem of the *outcome effect* in satisfaction surveys is well known (see for example, Knight, 1994). Some commentators have even questioned whether such surveys can yield any useful information at all; others have argued that people *can* distinguish between process and outcome in their dealings with public bodies and value a positive experience of the process even when they are not successful in getting the outcome they wanted.

Our analysis of the survey data shows sometimes strong correlations between the result of a claim and responses to a number of questions exploring people's subjective experience of claiming. However, particularly for DLA, the relationship is not straightforward but complicated by the complex structure of the benefit. DLA has two components, *mobility* (which has a higher and a lower rate) and care (which has three rates, higher, middle and lower). Claimants can be awarded either or both of these components. There are therefore *eleven* possible combinations of award. When we add *rejection* to these we have 12 possible outcomes to a claim. When we asked respondents if they were happy with the decision on their claims they fell into three groups. First were those people who were happy with whatever award of DLA had been made; second, there were those with an award but not happy with it; and third, there were the rejected claimants, also unhappy. Each group gave distinctive responses to the subjective questions about claiming and about satisfaction levels. Therefore, in the presentation of the survey results we have usually given the responses of each group separately.

While an *outcome effect* is almost certain to be present in the survey data, it is difficult to gauge its strength or to dissociate it from genuine expressions of dissatisfaction from people unhappy with the processing of their claim. For example, the responses to the question about whether the claim form was easy or difficult to fill in (see Chapter 11) may be influenced by the outcome - an unsuccessful claimant may want to express dissatisfaction with the decision of the

Benefits Agency by complaining, among other things, about the form: `I didn't win therefore I'll complain about the form.' However, someone who genuinely has had difficulties with the form is also more likely to have provided information which is incomplete, or not comprehensive, or inaccurate. Information which is deficient in some way may not be identified as such by an adjudication officer, a possible effect of which would be a greater chance of the claim failing.

We have tried to overcome some of the problems of the *outcome effect* in two ways, first by using open-ended questions in the questionnaire to investigate people's responses to closed questions about satisfaction with various aspects of claiming, and second, as explained earlier, through the `claims in progress' survey.

9.5 A note on the effect of the construction of the DLA sample and survey response rates

The sample of DLA claimants with decided claims was designed to reflect the main objectives of the targeting element of the project. Hence, the sample contained higher numbers of claimants who have lower rate components as part of their total awards than those whose award comprises only middle or higher rate components. (The sample of AA claimants is not affected and can be considered representative.)

Had the sample been constructed solely for the purposes of the quality of service study a straightforward random sample would have been drawn. However, the adoption of a biased sample was not expected to create any major difficulties. It is possible to compensate for the effects of a biased sample by weighting the data to replicate the known distribution of the total population (in this case people who had claimed DLA in the first four months of 1994, excluding *special rules* cases and children under five). For our sample we expected weights to fall into the range of around 0.5 to 2. When we analysed the achieved sample, however, we found that in some categories there were far fewer cases than we expected. This meant that the weights for these categories were comparatively high, as shown in Table 9.2, which compares the distribution of the claimants with awards in our DLA `decided claims' sample with the actual distribution of awards made in the period 1.1.94 -- 30.4.94 (the period during which the sample was drawn).

Table 9.2 The distribution of DLA awards compared with the survey sample

DLA awards	**Actual awards'** (%)	**Sample** (%)	**Sample** (N)	**Weight**
Higher Mobility	31.0	13.9	184	2.2
Lower Mobility	3.8	4.8	63	0.8
Higher Care	1.6	0.5	6	3.6
Middle Care	3.6	2.3	30	1.6
Lower Care	11.4	23.4	309	0.5
Higher Mobility/Higher Care	9.4	1.6	21	5.9
Higher Mobility/Middle Care	11.6	4.7	62	2.5
Higher Mobility/Lower Care	11.2	23.4	310	0.5
Lower Mobility/Higher Care	3.2	3.6	48	0.9
Lower Mobility/Middle Care	8.3	13.0	172	0.6
Lower Mobility/Lower Care	4.9	8.9	118	0.6
Total	55400	1323	1323	

Based on five per cent sample of all claims, excluding Special Rules cases and children under five years.

The table shows how each combination which includes a lower rate award is over-represented. In contrast some of the other combinations are very under-represented, for example, higher rate care only awards (six cases), and double higher rate awards (21 cases). The derived weights are shown in the right-hand column of the table. It can be seen that the two most under-represented categories have large weights (3.6 for higher rate care only awards, and 5.9 for double higher rate awards). The effect of having such high weights for small numbers of cases is that analyses using the weighted data may give a distorted picture of the whole population of DLA recipients. The assumption underlying weighting is that the numbers in each category to be weighted are in themselves representative of all cases in that category. This is a reasonable assumption when there are, say, over 50 cases in a category, but less so when we have 21 and six cases in a category as we do in the DLA sample. To suggest that as few as six cases are representative of all cases with a higher rate care only award is clearly untenable.

To investigate the effects of the skewed sample we carried out some preliminary analyses on both the unweighted and the weighted data. Comparing the results showed that when we were dealing with large numbers of cases, for example, when analysing the responses to a question answered by the whole sample, the differences were generally very small. However, the effect of the high weights was more marked when we were analysing the responses to a question which relatively few people had been asked.

We can see that weighting the data is not so straightforward as initially expected. A choice has therefore to be made between using weighted or unweighted data for analysis and for presentation. Both have their drawbacks. The distorting effects of the weighted data have already been mentioned. One response to this would be to explain in the text and accompanying tables where such distortions are present and how they affect the interpretation of the results. One of the purposes of weighting, to generate a representative sample, is also undermined by the unrepresentativeness of categories containing small numbers of cases (also mentioned above). Using unweighted data also has problems, however. We cannot claim that the unweighted sample of DLA claimants with decided claims is representative of all decided claims. Also, as explained earlier, satisfaction levels are influenced by the result of a claim and whether the claimant was happy with that result. In general, people who were rejected were unhappy, but there were also significant numbers of people who were unhappy even though they received an award. This latter group of claimants was concentrated among the lower rate awards. Hence using the unweighted sample will probably provide slightly lower aggregate levels of overall satisfaction with the service provided by the Benefits Agency. However, we can avoid this problem by presenting separately the responses of those happy with their award, those not happy with their award and those rejected to questions about satisfaction, and other questions about people's subjective experiences of claiming. The bias in the sample can therefore be circumvented, at least for these questions.

After consultation with DSS policy customers, the use of unweighted data has been preferred for the analyses in this part of the report. However, where the unweighted data might be expected to affect particular analyses this has been noted in the text. The size of the sample, 1807 cases, should at least allow us to be confident that the results will provide us with a picture sufficiently robust on which to base policy responses.

9.6 A note on the presentation of the data

The service provided by the Benefits Agency is clearly not only to the claimants themselves but also to anyone acting on their behalf. In designing this part of the project, we were aware that because of the nature or severity of their disabilities some DLA and AA claimants would not have been the actual people who filled in the claim form or who had any dealings with the Agency subsequently. The quality of service questionnaire therefore attempted to elicit the experiences of the people who were most directly involved in the claim. In most cases this was the claimant himself or herself, with or without help from someone else. In a few cases it was someone other than the claimant. In the chapters which follow therefore we frequently refer to *respondents* to the survey rather DLA or AA *claimants.*

In our analysis of the responses to open-ended questions about people's satisfaction with the service provided by the Benefits Agency, it became clear that three main types of reason were emerging. First, there were comments about the *substance* of the contact with the Agency, such as the quality of the help or advice received, or the information provided. Second, people commented about their *personal treatment* by the staff of the Agency, for example whether staff had been polite or rude, sympathetic or offhand. The third main group of comments was about the *speed* of response by the Agency to their enquiries. There was also a small group of miscellaneous comments, such as observations about the claim form. In the presentation of findings about people's reasons for their satisfaction or dissatisfaction we have adopted this typology, in order to demonstrate how the balance between the three main groups of reasons changes between different points in the claiming process.

9.7 Structure of Part Two of the report

The report is mainly organised as a chronological journey through the various stages in the claiming process, from finding out about the benefit to deciding what to do when the decision finally arrives.

Chapter 10 describes the actions and experiences of people in the early stages of claiming, before they have decided to submit a claim for either DLA and AA. Data are presented on people's original sources of information about the benefits, who they approached for help and advice at this stage, and their experiences of any contacts they had with the Benefits Agency. Chapter 11 deals with people's experiences of obtaining and of completing the claim form. including again the help they received from the Benefits Agency. Chapter 12 explores claimants' dealings with the Benefits Agency after they had submitted their claim, whether in response to an approach by the Agency for more information or in making enquiries themselves about the progress of their claim. Chapter 13 looks at the types of claimant undergoing EMP examinations, whether people thought they presented an accurate picture of themselves during the examination, and their perceptions of, and levels of satisfaction with, this stage of the claiming process. Chapter 14 completes the chronological sweep through the claiming process. It deals with the stage of the claiming process after a decision has been made by an adjudication officer, covering people's perceptions of the time taken for the claim to be decided, their understanding of the decision, and the action taken (or intended) by those claimants unhappy at the outcome. Chapter 15 examines the data on people's preferences about self-assessment by claim form and about medical examination and assessment. In Chapter 16 we present our findings about people's *overall satisfaction* with the service provided by the Benefits Agency and draw together the evidence from previous chapters to consider the question of what aspects of service make the greatest contribution. The final chapter of Part Two summarises the main findings from this part of the project and identifies a number of lessons that could inform future policy towards improving standards of service and measuring satisfaction.

Chapter 10 Getting the Claim In

This chapter describes the actions and experiences of people in the early stages of claiming, before they have decided to submit a claim for either DLA or AA. Data are presented on people's original sources of information about the benefits, who they approached for help and advice at this stage, and their experiences of any contacts they had with the Benefits Agency.

10.1 Original sources of information about DLA and AA

As Table 10.1 shows, friends and relatives were the most common source of initial information about both DLA and AA. Generally, there was a wider spread of responses from the DLA respondents perhaps reflecting their wider range of social contacts than the older AA sample. If we look at the sources which might be described as a health or related professional (that is, a GP, hospital, social worker or residential home) we can see that over a third of AA respondents (36 per cent) said they first heard of the benefit from one of these sources compared with just over a quarter of DLA respondents. Few people (six per cent for DLA, two per cent for AA) gained their first knowledge from a Citizens' Advice Bureau or other advice agency.

Table 10.1 People's original sources of information about DLA or AA

Source of information	**DLA** (%)	AA (%)
Benefits Agency	11	5
Friends/relatives	36	40
GP/doctor's surgery	9	9
Hospital	9	11
Social worker/home help	8	13
Citizens Advice Bureau	3	1
Post office	3	3
Other advice agency	3	
TV/radio	2	1
Nursing/residential home	1	3
Other	14	10
Don't know	2	3
Total	1807	304

Source: Survey of new claimants.

10.2 Sources and types of advice about whether to claim

10.2.1 Disability Living Allowance

Of the 1807 respondents in the DLA survey, 531 (29 per cent) reported that they had contacted somebody or some organisation for initial help and advice (rather than merely to request a claim pack). Most of the contacts were for general advice or more specifically to check whether there was an entitlement to the benefit. Twenty-one respondents said they made contact with two organisations; the total number of reasons for contact in Table 10.2 is therefore 552.

Table 10.2 Reasons for seeking help prior to claiming by source of help (DLA sample)

Source of help/advice	Reason for contact To check entitlement (N)	General advice (N)	Other reason (N)	Total (N)	(%)
Benefits Agency	122	120	12	254	(46)
GP/doctor's surgery	17	43	6	66	(12)
Citizens Advice Bureau	13	43	4	60	(11)
Social worker	9	33	12	54	(10)
Other advice agency	13	31	2	46	(8)
Friends/relatives	3	34	5	42	(8)
Hospital	1	12	3	16	(3)
Post Office	3	9	2	14	(3)
Total	181	325	46	552	

Source: Survey of new claimants.

When looking for help and advice prior to claiming, 46 per cent of the contacts were to the Benefits Agency, 12 per cent to a GP, and 11 per cent to a Citizens Advice Bureau. Most contacts were for general advice (59 per cent). When people wanted more specific advice on their entitlement to DLA they asked the Benefits Agency in two-thirds of cases. Approaches to the Benefits Agency were split nearly evenly between general advice and questions about entitlement. In contrast people tended to want mainly general advice from the other sources of help.

When asked whether the advice or information they had received helped them in deciding to apply for DLA, over 90 per cent of respondents said yes. These responses were spread evenly across all sources of help and advice.

10.2.2 Attendance Allowance

Of the 304 respondents in the AA survey, 69 (23 per cent) reported that they sought some initial help or advice. As with the DLA sample most of the contacts were for general advice or to check whether there was an entitlement to the benefit.

Table 10.3 Reasons for seeking help prior to claiming by source of help (AA sample)

Source of help/advice	Reason for contact To check entitlement (N)	General advice (N)	Other reason (N)	Total (N)
Benefits Agency	15	9	–	24
Friends/relatives	2	9	1	12
GP/doctor's surgery	1	8	2	12
Social worker		8		8
Advice agency (not CAB)	1	5	1	7
Hospital	2	2		4
Citizens Advice Bureau	1	1		2
Post Office	1	1		2
Total	24	43	4	71

Source: Survey of new claimants.
NB Two respondents gave two answers each.

Although the numbers in this table are small, the same pattern emerges as for DLA. Most contacts were for general advice, and where specific advice about entitlement was required, the Benefits Agency was the favoured source.

10.3 Help from the Benefits Agency

10.3.1 Sources of help and methods of contact

At the pre-claiming stage 12 per cent of the DLA sample contacted the Benefits Agency for help and advice. As Table 10.4 shows, over half of these contacts were made to a local (i.e. District or caller) office. One of the freephone services provided by the Benefits Agency such as the Benefits Enquiry Line (BEL) for disabled people, the freeline at North Fylde, or one of the general social security helplines) was used by nearly a third of those making contact (or four per cent of the total sample). Few people contacted either a DBC or the DLA Unit at North Fylde directly. The majority of all contacts (68 per cent) was made by telephone, although over a quarter of contacts with a local office were made by calling in person.

Twenty-four respondents in the AA sample (eight per cent) contacted the Benefits Agency at this stage. Of these, 14 contacted a local office; only two used one of the Freephone services.

Table 10.4 Source of help from Benefits Agency by method of contact (DLA sample)

	Method of contact					
Source of help	**Telephone** (%)	**Letter** (%)	**Call in person** (%)	**Other** (%)	**Total** (N)	**Total** (%)
Local office	51	3	37	9	145	(56)
Disability Benefits Centre	3 cases	1 case	0	1 case	5	(2)
North Fylde	63*	33*	0*	4*	27	(9)
Freephone	100		–		76	(29)
All contacts	68	6	20	6	2601	

Source: Survey of new claimants.
Total includes seven other contacts made to unspecified DSS or Benefits Agency locations.
* Percentages based on fewer than 50 cases.

10.3.2 Levels of satisfaction

All respondents who had been in contact with the Benefits Agency at this stage of a claim were asked to give an assessment of their satisfaction with the service they received. The results are presented separately for the DLA and AA samples and are broken down by how the respondents felt about the outcome of their claim.

Disability Living Allowance

Table 10.5 presents the satisfaction levels expressed by respondents in the DLA sample with the initial help and advice they received from the Benefits Agency before they had submitted a claim. The pattern of responses will become familiar as further satisfaction analyses are presented throughout this report. The `awarded and happy' category of respondents register the highest proportion of *very satisfied* responses (68 per cent in this case) and the highest proportion of combined *very* and *fairly* satisfied responses (88 per cent). The `awarded but not happy' respondents also have a high combined satisfaction score (85 per cent) but with fewer very satisfied respondents. The proportion of respondents who are very satisfied is lowest for the `rejected' category, who also register the highest level of dissatisfaction.

Though the pattern of responses is clear, in this case the differences between the three categories of respondent are not statistically significant. It seems therefore that if there is an *outcome effect* (as defined in Chapter 9) in the responses to the question about satisfaction, then it is only weak.

Table 10.5 Levels of satisfaction with help received from Benefits Agency by response to award - including comparison with `claims in progress' sample (DLA sample)

	Level of satisfaction					
Level of satisfaction	**Very satisfied** (%)	**Fairly satisfied** (%)	**Fairly dissatisfied** (%)	**Very dissatisfied** (%)	**Don't know** (%)	Total (%)
Happy with award	68	20	4	6	3	163
Not happy with award	60*	25*	10*	0*	5*	20
Not happy with rejection	58	22	10	9	1	69
All decided claims	65	21	6	6	2	252
Claims still in progress	69	24	1	1	4	72

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

Since any outcome effect appears to be weak, we can be confident in concluding that since 86 per cent of the whole decided claims sample and 93 per cent of the claims in progress sample said they were satisfied, the Benefits Agency is performing well in giving help and advice at this stage of the claiming process.

Most contacts to the Benefits Agency for help and advice were either to a local office or to one of the freephone services. In Table 10.6 we compare the satisfaction of respondents with the service provided by each.

Table 10.6 Respondents' satisfaction with help provided by local Benefits Agency offices and the freephone services (DLA sample)

Advisory bodies	**Satisfied respondents** (%)	**Dissatisfied respondents** (%)	Total (%)
Local offices	85	15	142
Freephone services	93	7	73
All contacts[1]	87	13	253

Source: Survey of new claimants.
Includes contacts with DBCs, the DLA Unit in North Fylde and other unspecified offices.

The table shows that the level of satisfaction with the freephone services was higher than with local offices, though the differences are not statistically significant. The satisfaction with local offices was very close to the average for all sources of contact. The reasons behind the high levels of satisfaction and those given by the relatively few dissatisfied respondents are explored after the next section.

Attendance Allowance

Table 10.7 presents the data on satisfaction for the 22 AA respondents who contacted the Benefits Agency prior to claiming (seven per cent of the sample) and compares these with the claims in progress sample. Because there are so few respondents, numbers of responses are presented in the table rather than percentages. There is less complication with the AA sample since virtually everyone who received an award (either higher rate or lower rate) was happy with the outcome. The few respondents who were `awarded but not happy' have therefore been added to the `rejected' category.

Table 10.7 Levels of satisfaction with help received from Benefits Agency by response to award - including comparison with `claims in progress' sample (AA sample)

	Level of satisfaction					
Satisfaction with award	**Very satisfied (N)**	**Fairly satisfied** (N)	**Fairly dissatisfied** (N)	**Very dissatisfied**	**Don't know (N)**	**Total** (N)
Happy with award	9	2	0	0	0	I1
Not happy with award/rejection	6	0	1	3		I I
All decided claims	15			3	0	22
Claims still in progress	31	8	2	0	2	43

Source: Survey of new claimants.

Though the numbers in the table are small the general pattern of satisfaction and dissatisfaction reflects the bigger DLA sample. Also the claims in progress sample shows a very high combined satisfaction level (39 out of 41 respondents).

10.3.3 *Reasons for satisfaction and dissatisfaction*

This section presents data for the DLA sample only. The data from the 22 AA respondents who made contact with the Benefits Agency at this stage are not sufficient for any useful analysis. Table 10.8 below presents the main reasons people gave for saying they were either very or fairly satisfied with their treatment by the Benefits Agency. It gives the percentage of respondents in each of these categories who mentioned a particular reason. So, for example, 88 per cent of the DLA respondents who said they were very satisfied included among their reasons that the advice they received was helpful. The table presents the three main reasons cited by respondents only, no other reason was mentioned by more than five respondents.

Table 10.8 Reasons for satisfaction analysis of responses of satisfied respondents (DLA sample)

	Proportion of respondents mentioning reason	
Reason for satisfaction	**Very satisfied** (%)	**Fairly satisfied** (%)
Advice was helpfullthings were explained	88	53
Staff were politelsympatheticlunderstandinglpleasant	44	20
Staff acted quickly	24	22
No. of respondents	166	55

Source: Survey of new claimants.

Table 10.8 suggests that, at this stage of the claiming process before a decision has been taken whether to make a claim, it is likely that the main requirement of people contacting the Benefits Agency will be for good quality advice. When they feel that they have got this then they are likely to register a high level of satisfaction. The table also suggests that how they are treated by Agency staff is also important to people but not so much as the advice received. The third most common reason for satisfaction cited by respondents was the speed of response of the Agency.

Table 10.9 presents the main reasons why people said they were *not* satisfied with the service of the Benefits Agency. It is interesting that, although the numbers in the table are small, a similar pattern of responses to that in Table 10.8 is evident. The most commonly cited reason for dissatisfaction was that not enough help or advice was offered to them, again reflecting that the main requirement of people is for good quality advice, and that their personal treatment by staff and the speed of response is of less importance at this stage of claiming. Although the numbers in the table are small there is a suggestion that when people feel they have been treated badly by Benefits Agency staff they tend, overall, to be very rather than *fairly* dissatisfied.

Table 10.9 Reasons for dissatisfaction: analysis of responses of dissatisfied respondents (DLA sample)

Reasons for dissatisfaction	**Number of respondents mentioning reason** **Fairly dissatisfied (N)**	**Very dissatisfied (N)**	**Total** (N)
Did not get enough help/information	8	11	19
Staff were rudeloffhand	2	6	8
Staff took too long	4	3	7
No. of respondents	16	16	32

Source: Survey of new claimants.

Tables 10.8 and 10.9 above present the most commonly cited reasons for people's satisfaction or dissatisfaction with the Benefits Agency. As mentioned earlier, no other reason was mentioned by more than five respondents. In Table 10.10 we aggregate all the reasons cited by all respondents into their three main types: (a) the *substance* of the dealings with the Agency; (b) the *personal* treatment of the respondent by benefit staff; and (c) the *speed* of the response (as defined in Chapter 9). This allows us to assess the relative importance of each type of reason at each stage of claiming.

Table 10.10 Reasons for satisfaction and dissatisfaction: analysis by type of reason (DLA sample)

Reasons for satisfaction! dissatisfaction	**Number of respondents mentioning reason** **Fairly dissatisfied (N)**	**Very dissatisfied (N)**	**Total** (N)
Substance	51	57*	201 (51)
Personal treatment	29	19*	108 (28)
Time/speed	15	17*	58 (15)
Others	6	7*	23 (6)
Total	348	42	390

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

Table 10.10 reinforces the picture emerging from the previous tables of the relative importance of *substance* in forming people's opinions. Over half of the comments made, whether they came from satisfied or dissatisfied respondents, were about substance; a quarter were about personal treatment; and one in six about time taken.

10.4 Conclusion

This chapter has examined the pre-claim stage of the claiming process, when potential claimants found out about DLA or AA and possibly sought help and advice from the Benefits Agency or someone else.

People obtained their first information about the benefits from a wide range of sources, the most common being family and friends. Relatively few first learned about them from the Benefits Agency. This finding reinforces the importance of both widespread general advertising and targeting information on places where health and social care are organised and provided.

Having heard about the benefits, around a quarter of potential claimants (29 per cent for DLA and 23 per cent for AA) sought further help or advice. Again, the sources of help were wide though this time the most common source was the Benefits Agency (accounting for 46 per cent of the contacts made by the DLA sample). Most contacts with the Agency were either to a local office or to one of the freephone services, as is perhaps to be expected. At this stage of the claiming process it is unlikely that many people will be aware of either their nearest DBC or the central units at North Fylde. Their previous experience of social security would most probably have been with a local office. Although local office staff do not administer DLA or AA, and hence do not have day-to-day experience of the intricacies of the benefit, levels of satisfaction with the help and advice they provided were only slightly lower than the average for all Benefits Agency sources of help.

Our analysis of the reasons given by people for their expressions of satisfaction or dissatisfaction suggest that it is the *substance* of the contact (that is, the quality of help or advice) that is of greatest importance to respondents, above concerns about how they are treated personally by Benefits Agency staff.

Both the `decided claims' and the `claims in progress' samples registered high levels of satisfaction with the service provided by the Benefits Agency at this early stage in the claiming process. It seems justifiable, therefore, to conclude that the Agency is successfully meeting the requirements of claimants or people acting on their behalf for initial help and advice.

Chapter 11 Completing the Claim Form

This chapter deals with people's experiences in obtaining and completing the claim form, including the help they received from the Benefits Agency. The introduction of self-assessment claim forms to replace an obligatory examination by a medical practitioner is one of the major differences between the old AA and MobA schemes and the new benefits. It was widely welcomed as a move away from possibly intrusive and unnecessary medical intervention and towards greater involvement by disabled people themselves and people who contribute towards their care. To help people complete the forms, the Benefits Agency established a range of services; these included helplines and freephones, and dedicated telephone sections within DBCs whose staff would take a proactive role in making sure that as much information as possible about a person's claim was collected before a decision was made.

A large part of the questionnaire was therefore devoted to gathering information on the ease of use of the claim forms and of people's experiences of dealing with the Benefits Agency in this important stage of the claims process.

11.1 Sources of claim form

Table 11.1 shows where people obtained their DLA or AA claim forms.

Table 11.1 Where people obtained their claim forms for DLA or AA

Source of claim form	**DLA** (%)	AA (%)
Benefits Agency	66	45
Social worker	7	13
Citizens Advice Bureau	4	
Other advice agency	4	3
Friends/relatives	3	10
Hospital	3	4
Post office	3	3
Local authority	2	3
GP/doctor's surgery	1	3
Nursing/residential home		1
Other	4	4
Don't know	4	8
Total	1806	304

Source: Survey of new claimants.
= < 0.5 per cent.

The current practice of the Benefits Agency is to make claim packs available from a restricted number of sources only, mainly from the Agency's own offices and from some welfare rights organisations. In contrast, filter leaflets, which potential claimants can send to the Benefits Agency and receive a claim pack in return, are widely available. The evidence in Table 11.1 that DLA and AA claimants obtain their claim packs from a wide variety of sources is, therefore, perhaps a little surprising. One explanation is that, in answering the question, some respondents have confused leaflets with claim packs. Nevertheless, two-thirds of DLA claimants and about a half of AA claimants said they obtained their packs from the Benefits Agency.

The differences between the numbers of claimants for DLA and AA who said they obtained their claim packs from hospitals and residential accommodation are probably explained by the greater proportion of AA claimants in these kinds of institutional care.

Comparing this table with Table 10.1 shows interesting differences in the number of people who heard about the benefits from their GP's surgery (nine per cent for both DLA and AA) and who said they got their claim packs there (one and three per cent respectively). As mentioned above, information leaflets about benefits are distributed widely but the number of outlets for claim packs is restricted. However, the interests of some claimants might be better served if they could obtain both information and a claim form from their GP's surgery.

11.2 Analysis of who filled in the claim form

As Table 11.2 shows, claimants themselves were more often than not involved in the completion of the claim form. (The analysis excludes children for whom a claim must be made on their behalf by a parent or guardian.) In a relatively large minority of cases (particularly for AA) some person or persons filled in the form without the claimant. If a claimant is unable to manage their affairs another person may apply to act as an *appointee* for them. Such applications are investigated by the Benefits Agency and, if approved, that person will be legally entitled to act for the claimant. Other claimants may have *agents* to act for them, in which case the person has no legal status but may, for example, receive correspondence or payments on behalf of a claimant.

Table 11.2 Analysis *of* who filled in the claim form

Applicant	**DLA** (%)	AA (%)
Claimant alone	28	17
Claimant with someone else	49	40
Person(s) on behalf of claimant	23	43
Total	1627	283

Source: Survey of new claimants.

11.3 Reasons why claimants needed help

Comparable proportions of people completing a claim form (69 per cent for DLA and 76 per cent for AA) needed help in completing the claim form, the reasons for which are presented in Table 11.3.

Table 11.3 Reasons why people sought help in completing the claim form

	Proportions of respondents mentioning each reason'	
Why help was needed	**DLA** (N)	AA (%)
Difficulties with completing claim form	42	29
Help valued *per se*	26	26
Physical difficulty with writing	12	15
Claimant mentally unable to complete form	8	9
Other problems with writing/reading	7	3
Sight problems	7	17
Too ill to complete form	6	9
Other reasons	11	12
Number of respondents	1257	224

Source: Survey of new claimants.

Percentages sum to more than 100 per cent due to multiple responses.

The reasons given by people for needing help to complete the claim form fall into three distinct types. First, there is the `positive' reason of `help valued *per se'* which does not imply any particular problem with completing a benefit claim form.

Second, there is a range of `neutral' reasons which are unconnected to DLA or AA but would affect a person's life generally, such as sight problems, physical difficulty or mental incapacity. Finally, there is the `negative' response from people who needed help because of difficulties in completing the claim form (recorded by 42 per cent of the DLA respondents and 29 per cent of the AA respondents who said that someone other than the claimant was involved in completing the claim). We have called such a response 'negative' only because ideally this would not be a reason for seeking help since the form has been designed to be as simple as practicable to complete. The extent of the difficulties people had with the claim forms is investigated more fully later in the chapter, but they included not understanding some of the questions, finding the instructions or layout confusing, experiencing problems in naming their illness or disability, and difficulties describing the effects of their condition on their everyday lives.

11.4 Analysis of sources of help in completing claim form

As Table 11.4 shows, around two-thirds of people completing either a DLA or AA claim form turned to someone with personal knowledge of the claimant for help (either a family member or friend). Apart from this category the DLA sample used the Benefits Agency for help more often than sources connected with either medical or social care, or from an advice agency. The pattern for the AA sample was different. Twice as many claimants obtained help from someone connected with their social care than used the Benefits Agency for help.

Table 11.4 Sources of help with completing claim form

	Proportion of claimants using source of help[1]	
Source of help	**DLA** (%)	AA (%)
Family or friends	63	65
Benefits Agency	16	10
Social care provider[2]	14	20
Advice agency[3]	12	11
Medical care provider[4]	10	7
Other source	6	7
No. of respondents	1257	230

Source: Survey of new claimants.

[1] Percentages sum to more than 100 per cent due to multiple responses.

[2] Including social work professionals and residential home staff.

[2] Including Citizens Advice Bureaux and other advice agencies.

[4] Including GPs and hospital staff.

11.5 Usefulness of form in describing disabilities and their effects

In Section 1 of the claim forms for DLA and AA, a claimant, or someone on their behalf, is required to answer the question, `What is your disability or illness?' Adjudication officers need this information to be able to assess whether care and mobility needs are commensurate with the most likely effects of that illness or disability. Claimants are encouraged in the form to `just tell us your illnesses or disabilities here' and to wait until Section 2 to describe the effects of their condition.

Because the question is important, survey respondents were asked a series of questions about the usefulness of the form and about the extent of any difficulties they experienced in completing it. In this section we look at people's assessments of whether they found the form helpful in (a) naming or describing their illness or disability, and (b) describing the effects of their condition on their everyday lives. The following section examines the *nature* of the difficulties in more detail.

Tables 11.5 (for DLA) and 11.6 (for AA) analyse respondents' views about how helpful the form was in naming or describing their illness or disability. The responses of the decided claims sample are broken down by the perceived outcome of the claim and the respondent's reaction to it. The responses of the claims in progress sample are included in the table for comparison. (NB Only those survey respondents who said that they had some involvement in filling in the claim form were asked the series of questions about their experiences.)

Table 11.5 Helpfulness of claim form in describing illness or disability by outcome of claim (DLA sample)

		Decided claims		
Helpfulness of claim form	**Award/happy** (N)	**Award/not happy** (%)	**Rejection** (%)	**Claims in progress** (%)
Very helpful	26	10	12	17
Fairly helpful	45	55	40	46
Not helpful	29	34	48	37
Total	767	121	337	276

Source: Survey of new claimants.

NB `Don't know' responses have not been included in this table.

Table 11.6 Helpfulness of claim form in describing illness or disability by outcome of claim (AA sample)

	Decided claims		
Helpfulness of claim form	**Award/not happy** (N)	**Rejection** (%)	**Claims in progress** (%)
Very helpful	31	18	18
Fairly helpful	53	39	53
Not helpful	17	42	29
Total	91	71	233

Source: Survey of new claimants.

NB `Don't know' responses have not been included in this table.

There is a correlation between how people reported the helpfulness of the form and the outcome of a claim, which suggests that some people's responses were influenced by the latter. As we shall see later, this correlation is also present in the responses to questions about whether the claim form was helpful in describing the effects of claimants' conditions on their everyday lives, whether claimants experienced difficulties with the form, and whether they presented an accurate picture of their lives on the form. In Section 11.10 of this chapter we consider the possibility of whether it was *only* people's responses to the outcome of their claim which was influencing their answers to these questions. For example, it is possible that someone who genuinely found the form unhelpful might have provided information which was incomplete, not comprehensive, possibly even contradictory or wrong, which in some circumstances could increase the likelihood of the claim being rejected.

Interpretation of this and subsequent tables about the claim form will, therefore, be made with some caution. Nevertheless, since around a third of the 'claims in progress' respondents (taking the DLA and AA samples together) and 29 per cent of the successfullhappy DLA respondents reported that the form was not helpful, there is probably a case for investigating whether the question on the claim form about disabilities could be improved to help claimants more.

Section 2 of the claim form is mainly concerned with the effects of the claimant's illness or disability on their everyday activities. Survey respondents were therefore asked how helpful they found this section. Tables 11.7 (for DLA) and 11.8 (for AA) show the responses of both the decided claims sample, broken down by the perceived outcome of the claim and the respondent's reaction to it, and the claims in progress sample.

Table 11.7 Helpfulness of claim form in describing effect of illness or disability on everyday life by outcome of claim (DLA sample)

Helpfulness of claim form	Decided claims Award/happy (%)	Award/not happy (%)	Rejection (%)	Claims in progress (%)
Very helpful	29	13	12	17
Fairly helpful	44	45	37	47
Not helpful	27	43	51	36
Total	766	120	340	282

Source: Survey of new claimants.

NB `Don't know' responses have not been included in this table.

Table 11.8 Helpfulness of claim form in describing effect of illness or disability on everyday life by outcome of claim (AA sample)

Helpfulness of claim form	Decided claims Award/happy (%)	Rejection (%)	Claims in progress (%)
Very helpful	38	14	20
Fairly helpful	47	40	50
Not helpful	15	46	30
Total	85	72	220

Source: Survey of new claimants.

NB `Don't know' responses have not been included in this table.

The responses to this question were very similar to the previous question. The same caution is needed in interpreting the tables but again it seems that a sizeable minority of claimants found Section 2 of the form unhelpful in describing the effects of their condition on their everyday activities. The more detailed responses about specific problems with the forms should help thinking about how the forms could be amended.

Comparing the responses of the DLA and AA samples, it appears that overall the AA sample found the forms more helpful than the DLA claimants - half of the *unsuccessful* AA respondents found the form helpful on both questions. Part of the explanation for this may be that Section 2 of the AA form is shorter than its DLA counterpart since it does not include questions on mobility. Another explanation might be that because DLA claimants are generally disabled earlier in life and for longer than AA claimants, some may have lower literacy skills.

11.6 Problems experienced with the claim form

Apart from the specific questions about the helpfulness of the form in naming and describing the effects of disabilities, the survey respondents who had been involved in completing the claim form were also asked about the extent of the difficulties, if any, they had had with the form as a whole. That some people experience *a few difficulties* is not surprising given the length and detail of the claim forms but the proportions recording *lots of difficulties* are possibly a cause for concern. The types of difficulties reported by these two categories of respondent are very similar, the main difference being that those saying they had lots of difficulties simply reported more of them - 2.7 per respondent compared with 1.9 for those who responded `a few difficulties'.

The responses of the DLA and AA samples, including comparisons with the `claims in progress' sample, are presented in Tables 11.9 and 11.10. Claimants for whom someone else completed the claim form were not asked this question.

Table 11.9 Extent of people's difficulties in completing the claim form by outcome of claim (DLA sample)

	Decided claims			
Experience of filling in claim form	**Award/happy** (%)	**Award/not happy** (%)	**Rejection** (%)	**Claims in progress** (%)
Easy to fill in	44	31	31	38
A few difficulties	39	49	39	36
A lot of difficulties	17	20	30	26
Total	804	123	353	296

Source: Survey of new claimants.

Table 11.10 Extent of people's difficulties in completing the claim form by outcome of claim (AA sample)

	Decided claims		
Experience of filling in claim form	**Award**	No **award** ("A)	**Claims in progress** (%)
Easy to fill in	53	58	53
A few difficulties	34	22	32
A lot of difficulties	13	21	15
Total	94	78	251

Source: Survey of new claimants.

The two tables above show the correlation between respondents' feelings about the outcome of their claim and their responses to the question about the extent of any difficulties they had with the benefit claim forms. However, despite this apparent *outcome effect* it appears that fewer than half of the DLA claimants found the claim form easy to complete, and over a quarter experienced a lot of difficulties. The responses of the AA sample were somewhat different. Overall more than half of the respondents found the form easy to complete while around a fifth had a lot of difficulties. Again, these responses may partly reflect the fact that the AA claim form is shorter than the DLA form. Interestingly, more of the unsuccessful AA claimants said the form was easy to complete.

Respondents who said they had a few or a lot of difficulties with the claim form were asked whether their problems were specifically with Section 1 or Section 2, or whether they had problems with both. Table 11.11 shows the responses.

Table 11.11 Source of difficulties with claim form

Part of claim form causing problems	**DLA respondents** (%)	AA **respondents** (%)
Section 1 only	5	4
Section 2 only	32	31
Both sections	62	65
Total	757	72

Source: Survey of new claimants.

This table shows that where DLA and AA respondents had problems with the claim forms, they usually struggled with both parts rather than just one section, although for both sets of respondents their difficulties were more with Section 2 than Section 1.

11.7 Reasons for difficulties with the DLA claim form

Survey respondents who had said that the form had given them difficulties were asked to specify what the problems were. The questionnaire attempted to distinguish between difficulties with each of the two sections of the claim form. A majority of the DLA respondents (58 per cent of the 447 who answered the question) were able to link their difficulties with the relevant section, the rest could only offer comments about the claim form as a whole. Table 11.12 therefore distinguishes between the types of response made.

Because of the small numbers of AA respondents answering the question only the responses of the DLA are presented.

Table 11.12 Types of difficulty with the claim form (DLA sample)

	Percentage of respondents having difficulty with:			
Difficulty	**Section 1** (%)	**Section 2** (%)	**Claim form generally** (%)	**All respondents** (%)
Describing effect of illness or disability	32	49	36	46
Understanding some questions	21	25	43	36
Confusing instructions	31	29	34	*36*
Confusing/complicated language used	19	13	32	25
Confusing layout	24	17	24	24
Naming illness or disability	16	16	13	17
Repetition of questions	10	11	9	11
Insufficient space for answers	10	12	6	10
Claimant with writing difficulties	7	3	8	7
Claimant with reading difficulties	6	3	5	5
Relevance of questions	7	6	1	5
Structure of questions	0	7	1	3
Length of form	0	3	2	3
Difficulties answering some questions	4	5	1	3
Print too small	3	1	3	2
Other	12	5	5	7
No. of respondents	147	344	*359*	757'

Source: Survey of new claimants.

Some claimants appear in the totals for both Section 1 and Section 2. Hence column totals do not sum to 757.

Overall, 61 per cent of the DLA sample reported that they experienced some degree of difficulty with the claim form. The most common problem among the 757 respondents who were able to specify their difficulties (mentioned by 46 per cent) was describing the effect of their illness or disability on their daily life (which takes up most of Section 2 of the form). In addition to this main problem the responses included a wide range of other difficulties. Problems mentioned most often, such as not understanding the questions or finding the instructions or language of the form confusing, could possibly be ameliorated by rewording the relevant parts of the form but, because of the nature of the information needed, the form may still prove difficult for some respondents. The layout of the form, a problem mentioned by nearly a quarter of those finding the claim form difficult, may be improved more easily.

11.8 The relationship between disability and the usefulness of the DLA claim form

Apart from special rules cases, claimants complete the same claim form regardless of the type and severity of their illness or disability. In this section we analyse the helpfulness of the DLA claim form by the main disabling condition of claimants as recorded on the DLA database (for those conditions with 30 or more cases). Although claimants may have multiple disabilities, only one, the main disabling condition as perceived by the adjudication officer, is recorded on the DLA database. The pattern of main disabling conditions for the whole DLA sample is shown in Table 11.13. (There were insufficient data from the AA database to allow a comparable analysis for the AA sample.)

Table 11.13 Analysis of main disabling condition of DLA claimants as recorded on the DLA database

Main disabling condition	**Claimants (N)**	**All claimants (%)**
Arthritis	371	21
Muscle disease	143	8
Learning difficulties	132	7
Heart disease	111	6
Spondylosis	97	5
Psychosis	76	4
Epilepsy	73	4
Back pain	71	4
Blindness	68	4
Psychoneurosis	60	3
Cerebrovascular disease	58	3
Chest disease	57	3
Asthma	52	3
Limb trauma	48	3
Diabetes	47	3
Neurological disease	45	2
All disabilities	1807	100

Source: DLA database.

Tables 11.14 and 11.15 look at the helpfulness of the form in (a) describing the claimant's illness or disability, and (b) describing the effects of their disability on their everyday activities. The disabilities have been ranked according to the overall helpfulness of the form. The division of the *very* and *fairly* helpful responses is also given in the middle column of each table.

Table 11.14 Helpfulness of claim form in describing illness or disability by main disabling condition (DLA sample only)

	Respondents' assessment of claim form			
Disability	**Helpful** (%)	**(Very/fairly helpful)** (%)	**Not helpful** (%)	**Total** (N)
Chest disease'	76	(14/62)	24	37
Cerebrovascular disease'	75	(29/46)	26	35
Arthritis	75	(24/51)	26	286
Epilepsy'	73	(27/46)	27	48
Limb trauma'	72	(18/54)	28	39
Heart disease	69	(20/49)	30	79
Blindness'	67	(40/27)	33	30
Spondylosis	67	(13154)	33	78
Diabetes'	66	(24/42)	33	33
Muscle disease	63	(21/42)	37	122
Neurological disorder'	62	(21/41)	38	34
Asthma'	61	*(22/39)*	39	41
Learning difficulties	56	(24/32)	44	71
Psychosis'	55	(23/32)	45	31
Psychoneurosis'	49	(8/41)	51	39
Back pain	45	(19/26)	56	54
All disabilities	65	(21/44)	35	1262

Sources: Survey of new claimants and the DLA database.

' Percentages based on fewer than 50 cases.

Table 11.15 Helpfulness of claim form in describing effect of illness or disability on everyday life by main disabling condition (DLA only)

	Respondents' assessment of claim form			
Disability	**Helpful** (%)	**(Very/fairly helpful)**	**Not helpful** (%)	**Total** (N)
Limb trauma[1]	81	(24/57)	19	37
Chest disease[1]	75	(17/58)	25	36
Epilepsy[1]	74	(29/45)	27	49
Cerebrovascular disease[1]	72	(36/36)	27	33
Arthritis	71	(28/43)	30	287
Learning difficulties	68	(24/44)	32	72
Spondylosis	68	(15/53)	33	80
Heart disease	67	(20/47)	33	76
Psychosis[1]	64	(18/46)	36	33
Asthma[1]	63	(20/43)	38	40
Muscle disease	62	(23/39)	38	126
Blindness[1]	62	(36/26)	39	31
Neurological disorder[1]	61	(17144)	39	36
Back pain	61	(23/38)	40	53
Diabetes[1]	52	(24/28)	49	33
Psychoneurosis[1]	46	(16/30)	54	37
All disabilities	65	(23/42)	35	1265

Sources: Survey of new claimants and the DLA database.

[1] Percentages based on fewer than 50 cases.

Table 11.14 shows that some types of illness or disability were more difficult to describe on the claim form than others. People with back pain appeared to have the most difficulty in trying to describe their condition, perhaps not surprisingly considering it is notoriously difficult to diagnose back pain precisely. In addition, the table shows that people with mentally disabling conditions such as psychosis, psychoneurosis and neurological disorders, also appeared to have above average problems in describing their condition. (The experiences of this particular group of claimants is considered in more detail later in the chapter.)

The pattern of responses in Table 11.15 shows some interesting differences. People with conditions associated with psychoneurosis found the form most difficult but other mentally disabling conditions (such as psychosis and learning difficulties) were much closer to the average than in Table 11.14. In contrast, diabetes sufferers appeared to find it relatively easy to describe their condition but more difficult to describe how their everyday lives were affected.

In general it appears that people with physical disabilities (limb traumas and arthritis, for example) and those with other conditions which restrict physical movement (chest diseases and strokes, for example) found the DLA form most helpful.

11.9 Respondents' overall assessment of the claim forms

Perhaps more important than whether people had difficulties with the claim form or found parts of it unhelpful, is whether they felt that, despite these problems, they had actually presented a full and accurate picture of how their own illness or disability affects their everyday life. Respondents were therefore asked if what they said on the claim was an accurate picture or whether they thought they presented a better or worse picture of themselves than was actually the case. Tables 11.16 and 11.17 show the responses, again broken down by the outcome of the claim, of the DLA and AA samples respectively.

Table 11.16 Respondents' assessments of whether they presented an accurate picture of their lives on their claim form by outcome of claim (DLA sample)

Picture presented of effect of disability on everyday life	Decided claims Award/ happy (%)	 Award/not happy (%)	 Rejection (%)	Claims in progress (%)
Accurate picture	74	44	46	74
Better than really am	21	54	52	26
Worse than really am	4	2	2	0
Total	756	118	320	263

Source: Survey of new claimants.
NB 'Don't know' responses have not been included in this table.

Table 11.17 Respondents' assessments of whether they presented an accurate picture of their lives on their claim form by outcome of claim (AA sample)

Picture presented of effect of disability on everyday life	Decided claims Award/ happy (%)	 Rejection (%)	Claims in progress (%)
Accurate picture	79	52	83
Better than really am	20	48	16
Worse than really am	1	0	
Total	90	65	233

Source: Survey of new claimants.
NB `Don't know' responses have not been included in this table.

Overall, just under a quarter (24 per cent) of the DLA and AA decided claims samples said they presented a better picture of themselves. However, there appears to be an *outcome effect* in some of the responses to this question. Over a fifth of the successful respondents in each group responded that they presented a better picture of themselves than was actually the case. The proportions for unsuccessful respondents were higher. Indeed it is plausible that unsuccessful claimants, seeking a rational explanation of why their claim was rejected, might identify the information they gave on the form as a possible or likely cause. However, it is equally plausible that they would be right in such an assessment. It is interesting that around a fifth of both DLA and AA respondents who made successful claims still considered that they presented a better picture of themselves. Very few said the picture was worse than they really were. This suggests that there is a tendency that the forms themselves and the way people complete them combine to produce, in a sizeable minority of cases, information which understates the extent of people's mobility and care needs.

In the questionnaire respondents were asked if they could explain why the information given on the claim form did not present an accurate picture of how their condition affects their daily lives. Table 11.18 presents an analysis of the 538 responses given by 448 DLA respondents who answered the question. Fifty AA respondents gave 57 responses. The figures in the table are the proportions of respondents giving particular responses, and so sum to more than 100 per cent.

Table 11.18 Respondents' explanations of why the information given on the claim form did not present an accurate picture of how their condition affects their daily lives

Reason	**DLA** Responses (N)	 **Cases** (%)	AA **Responses** (N)	 **Cases** (%)
Problems hard to describe/put into words	137	31	8	16
Questions did not go far/deep enough	113	25	15	30
Illness/condition varies	68	15	2	4
Not enough space to describe condition/effect	45	10	7	14
Just yes or no answers/ just ticking boxes	34	8	3	6
Did not want to appear disabled/ill	30	7	7	14
Forgot something	20	4	3	6
Other answers	67	15	11	22
Don't know	10	2	1	2
No. of respondents	448		50	

Source: Survey of new claimants.

Over 40 per cent (217 out of 498 for DLA and AA combined) of the reasons explaining why the information given on the form was not an accurate picture were specifically about the claim form (questions not going far enough, not enough space, and yes/no answers). Not being able to describe in words a disability and its effects may also be a reflection on the claim form but may also be due to a more general personal or social difficulty in talking about disability. The adjudication process relies on people giving the fullest and most accurate information possible. It is possible that some people will put themselves at a disadvantage if they understate the extent of their disabilities. However, not wishing to present oneself as disabled was mentioned by relatively few claimants, suggesting that the extent of the problem is not as great as the limitations of the form and the difficulties people have in communicating the effects of their disabilities.

Earlier it was shown that people's assessment of the helpfulness of the form varied according to their main disabling condition (Tables 11.14 and 11.15). Table 11.19 presents a similar analysis of people's overall assessment of the claim form.

Table 11.19 Respondents' assessments of whether they presented an accurate picture of their lives on their claim form by main disabling condition (DLA sample)

Disability	**Respondents' assessment of claim form** **Accurate picture** (%)	 **Better than really am** (%)	 **Worse than really am** (%)	**Total** (N)
Chest disease'	82	16	3	38
Diabetes'	79	21	0	34
Epilepsy	78	20	2	50
Cerebrovascular disease'	77	16	7	31
Blindness'	75	21	4	28
Learning difficulties	69	24	7	70
Limb trauma'	67	33	0	39
Spondylosis	65	33	1	72
Arthritis	63	34	3	280
Heart disease	63	32	4	71
Muscle disease	61	37	2	118
Back pain	61	39	0	54
Neurological disorder'	59	38	3	34
Asthma'	56	40	4	45
Psychosis'	47	44	9	32
Psychoneurosis'	42	47	11	36
All disabilities	64	33	4	1234

Sources: Survey of new claimants and the DLA database.
Percentages based on fewer than 50 cases.

In general people who found the form helpful in describing the effects of their disability on their everyday activities also said they presented an accurate picture of themselves. People with mental health problems appeared to find the form least tailored to their conditions. However, comparing Tables 11.14, 11.15 and 11.19 also throws up some apparent anomalies, although it must be remembered that some of the disability categories contain relatively few people. For ease of reference Table 11.20 summarises the *positive* responses from these three tables.

Table 11.20 Summary table of positive responses about claim form (from Tables 11.14, 11.15 and 11.19) (DLA sample)

	Respondents' assessment of claim form		
Main disabling condition	**Helpful in describing condition** (%)	**Helpful in describing effects of condition** (%)	**Allowed accurate picture** (%)
Arthritis	75	71	63
Muscle disease	63	62	61
Learning difficulties	56	68	69
Heart disease	69	67	63
Spondylosis	67	68	65
Psychosis'	55	64	47
Epilepsy'	73	74	78
Back pain	45	61	61
Blindness'	67	62	75
Psychoneurosis'	49	46	42
Cerebrovascular disease'	75	72	77
Chest disease'	76	75	82
Asthma'	61	*63*	*56*
Limb trauma'	72	81	67
Diabetes'	66	52	79
Neurological disease'	62	61	59
Total responding to question	1262	1265	1234

Sources: Survey of new claimants and DLA database.

' Some percentages for these conditions are based on fewer than 50 cases.

It might be expected that people who found the form helpful (particularly in describing the effects of their illness or disability) would also be more likely to present an accurate picture of themselves. For most conditions, Table 11.20 supports this hypothesis. For example, psychoneurosis has the lowest scores on all three variables in the table, while chest disease has the highest scores on two out of three. The table also shows, however, that the relationship is not always so straightforward. For some conditions, such as diabetes and blindness, the proportions saying they presented an accurate picture of themselves was markedly higher than those who found the form helpful. In contrast, for some other conditions, such as limb trauma and psychosis, the opposite was true.

11.10 Do claimants who have difficulties with the form suffer any disadvantage?

That people have difficulties with the claim form is not unexpected, given its length and the range of information it is trying to collect. The question therefore arises of whether people who have difficulties, or who find the form unhelpful, are disadvantaged in any way. Difficulties with the form may become reduced in importance if the claimant seeks help in completing it or in cases where adjudication officers seek further evidence (such as a GP or EMP report). In this section we look first at what action is taken by the claimant and by the Benefits Agency when there have been difficulties with the form or where it has been found unhelpful. Second, we investigate whether initial problems with the form are associated with the outcome of a claim.

Table 11.21 identifies those DLA claimants who either said they had lots of difficulties with the form or said that the form was unhelpful in some way, and shows what action they took before submitting their claim.

Table 11.21 Action of claimants experiencing some kind of problem with the claim form (DLA sample)

Experience of form	Claimant's action Made contact with BA	 Did not make contact with BA (%)	Total
Lots of difficulties/form unhelpful	13	*87*	*663*
No or few difficulties/form helpful	11	*89*	*592*

Source: Survey of new claimants.

Table 11.21 shows that there is no connection between people experiencing problems with the claim form and seeking help from the Benefits Agency. This is perhaps surprising; it might have been expected that claimants who do not find the form easy would approach the Agency for help more than those who had no or few difficulties. Why this appears not to be the case remains unclear.

Table 11.22 shows the actions of the Benefits Agency on claims where claimants say they had some kind of problem with the form.

Table 11.22 Action of Benefits Agency on claims where claimant experienced some kind of problem with the claim form (DLA sample)

Experience of form	Benefits Agency action Contact with claimant only (%)	 Further evidence only (%)	 Both contact and evidence (%)	 No action (%)	Total
Lots of difficulties/form unhelpful	*7*	41	18	34	*665*
No or few difficulties/form helpful	*7*	*35*	16	41	*590*

Source: Survey of new claimants.

In Table 11.22 the differences in the responses from people who experienced problems with the form and those who did not are not statistically significant. Although those who said they had problems were contacted more often by the Benefits Agency, there is no clear explanation of why the difference is not larger. Indeed there are two explanations which, though equally plausible, appear to conflict with each other. First, the similarities between the two groups might show that however difficult or unhelpful claimants found the form, the quality of the data supplied by each was comparable. Hence the pattern of adjudication officers' responses to the forms was also similar between the groups. This implies that it is largely irrelevant whether people find the form difficult or unhelpful because the quality of the information supplied is unaffected. A second interpretation of the table is that the actions of adjudication officers do not discriminate between claims which are easy to complete and those which are not. In other words, the possible disadvantages borne by those who experienced problems with the form were not offset by the actions of adjudication officers. Although it is possible that both explanations might contribute to the result in Table 11.22, the policy implications of each are very different. If the quality of information is uniform across all claims, then there is an argument for not changing either the claim form or the procedures carried out by adjudication officers. If the latter explanation is a closer reflection of reality, then there is an opposite argument for reassessing whether the claim form is sufficiently helpful (since it would be difficult to make adjudication officers more alert to claim forms which have caused problems for claimants).

In Tables 11.23 and 11.24 we look at the eventual outcome of claims where the claimant reported some problem with the form. In order to explore this fully, we have concentrated on two groups of claimants who either said they had lots of difficulties with the form, or who found the form unhelpful in describing the effects of their condition, *and* who also said they presented a better picture of themselves than was actually the case. Claimants who had problems but nevertheless said they presented an accurate picture of themselves are less of a concern.

In looking at these two groups we have taken into account the possibility that if the Benefits Agency obtained more information about a claim any initial problems that were experienced might have been overcome. Such information might come from the claimant, a medical officer of the Benefits Agency Medical Service, the claimant's doctor or carer, or from an EMP's report. In effect we are making the assumption that additional information is likely to result in a more accurate picture of the claimant's abilities than was presented initially on the form.

Table 11.23 first looks at the outcomes of claims by people who said they had lots of difficulties with the form and who gave a better picture of themselves than was actually the case, broken down by whether the Benefits Agency obtained further information of any kind.

Table 11.23 Outcomes of claims from people who had lots of difficulties with the claim form and who gave a better picture of themselves than was actually the case (DLA sample)

	Outcome		
Further information obtained by **Benefits Agency?**	**Award** (%)	**Rejection** (%)	**Total** (N)
Yes	55	45	73
No	41*	59*	29

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

Table 11.24 looks at the outcomes of claims by people who said that the form did not help them describe the effects of their condition and who gave a better picture of themselves than was actually the case, broken down by whether the Benefits Agency obtained further information of any kind.

Table 11.24 Outcomes of claims from people who found form unhelpful and who gave a better picture of themselves than was actually the case (DLA sample)

	Outcome		
Further information obtained by Benefits Agency?	**Award** (%)	**Rejection** (%)	**Total** (N)
Yes	54	46	145
No	36	64	66

Source: Survey of new claimants.

Tables 11.23 and 11.24 show two interesting features. First, there are over twice as many cases in Table 11.24 as 11.23. This suggests that the likelihood of claimants presenting a better picture of their lives than was actually the case is greater for those who found the form unhelpful than for those who found it difficult. Second, the higher proportion of awards for cases where the Benefits Agency obtains further evidence suggests that action by the Agency can make up for some (though not all) people's tendencies to understate the effects of their condition on their lives.

11.11 Experiences of claimants with mentally disabling conditions

The care and mobility needs of people with mentally disabling conditions (including mental illness and learning difficulties) are likely to be different from those whose disabilities have a physical cause. It may also be more difficult for them to describe on a standardised claim form how their lives are affected. As one respondent noted: `The form mainly covers physical problems, it doesn't cover mental health problems.' In order to investigate this further we used the information on the DLA database about the main disabling condition reported by claimants and re-analysed the responses to the questions on the usefulness of the claim form. The large size of the DLA sample allowed us to distinguish between people with learning difficulties and those with a mental illness. The results are presented in Tables 11.25 to 11.27. As mentioned in Chapter 9 the main disabling condition is missing for a large proportion of the AA sample. The following tables are for the DLA sample only therefore.

Table 11.25 Helpfulness of claim form in describing illness or disability: a comparison of claimants with mentally disabling conditions with other claimants (DLA sample only)

	Respondents' assessment of claim form			
Type of disability	**Very helpful** (%)	**Fairly helpful** (%)	**Not helpful** (%)	**Total** (N)
Learning difficulties	24	32	44	71
Mental illness	16	39	45	98
All other disabling conditions	21	46	34	1093

Sources: Survey of new claimants and the DLA database.

Table 11.26 Helpfulness of claim form in describing effect of illness or disability on everyday life: a comparison of claimants with mentally disabling conditions with other claimants (DLA only)

	Respondents' assessment of claim form			
Type of disability	**Very helpful** (%)	**Fairly helpful** (%)	**Not helpful** (%)	**Total** (N)
Learning difficulties	24	44	32	72
Mental illness	16	37	47	99
All other disabling conditions	24	42	34	1094

Sources: Survey of new claimants and the DLA database.

Table 11.27 Claimants' assessments of whether they presented an accurate picture of their lives on their claim form: a comparison of claimants with mentally disabling conditions with other claimants (DLA sample only)

	Respondents' assessment of picture conveyed in claim form			
Type of disability	**Accurae picture** (%)	**Better than really am** (%)	**Worse than really am** (%)	**Total** (N)
Learning difficulties	69	24	7	70
Mental illness	51	42	8	91
All other disabling conditions	64	33	3	1073

Sources: Survey of new claimants and the DLA database.

The tables above show that the experiences of people completing the claim form for a person with learning difficulties (often the parent of a child rather than the claimant himself or herself) are similar to those for people with non-mentally disabling conditions. The picture for people with mental illnesses is different. Confirming the picture emerging from earlier tables, more of this group found the claim form unhelpful and around half thought that the information they gave made them seem better than they really were.

Constructing a standard claim form which is as helpful to the person with a neurotic or psychotic illness as it is to the person suffering from arthritis is extremely problematic. However, the evidence from the survey respondents does suggest that more thought needs to be given to ways in which people with mental illnesses can be helped to describe the effects of their illness more fully and accurately.

11.12 Claimants' practices in sending Sections 1 and 2 separately

As mentioned in Chapter 9, claimants of both DLA and AA are given the option of sending in the two parts of the claim form separately. Most claimants send both parts together, however: 93 per cent of the DLA sample and 94 per cent of the AA sample.

The intention behind the two-part claim form is to allow claimants to register a claim at the earliest possible time rather than wait until they have collected all the information they want or until others have completed supporting statements. In this way claimants do not lose benefit if there are delays outside their control. While this option should be in the interests of claimants generally, it does seem to cause difficulties for a small minority, although only those who do not send in Section 1 could be financially disadvantaged. Forty-six per cent of the 94 DLA claimants who sent their form in two parts said that they thought it unnecessary to send in the other part or were simply confused about what to do.

11.13 Analysis of time taken to submit claim

Table 11.28 shows how long claimants took to submit their claims (or part of a claim) after first obtaining a form.

Table 11.28 Time taken for people to submit claims (DLA and AA samples)

Time	**DLA** (%)	AA (%)
Less than one week	33	35
Less than two weeks	33	34
Less than four weeks	23	22
Less than six weeks	7	5
Six weeks or more	5	5
Total	1676	253

Source: Survey of new claimants.

The table shows that despite any time taken to obtain supporting statements, the vast majority of people submit their claims within six weeks of getting hold of a claim form. People who had obtained their form from the Benefits Agency would have had the opportunity for any award to be paid from the date the form was issued. Other claimants are relatively disadvantaged because the effective date of their claim will be when the form is received in a DBC.

The small percentage of people who took over six weeks to submit their claim gave a variety of reasons for the delay. Among the DLA respondents the most common reasons were that they were waiting for some kind of assistance or information (mentioned in 37 per cent of cases) and because they were either too unwell to complete the form or were in hospital (mentioned in 29 per cent of cases).

11.14 Use of supporting statements by claimants

11.14.1 Number and sources of supporting statements

In Section 2 of the DLA and AA claim forms claimants have the opportunity of obtaining up to two `*supporting statements*', one from a person who has knowledge of how a claimant's disabilities affect their everyday life, and one from a doctor, health professional, teacher or someone else with knowledge about the claimant's illness or disability. As Table 11.29 shows most claims included at least one such statement.

Table 11.29 Proportion of claims which included statements in support of the claim

Number of supporting statement(s) obtained	**DLA** (%)	AA (%)
None	19	23
One	52	54
Two	26	18
Don't know	4	5
Total	1346	186

Source: Survey of new claimants.

As Table 11.30 shows, over three-quarters of people obtaining statements went to their GP. The second most common group approached for help was relatives and friends. The percentage columns in the table sum to more than 100 per cent because of multiple responses.

Table 11.30 Sources of supporting statements

Source of supporting statement	**DLA** (N)	(%)	AA (N)	(%)
GP	779	75	99	74
Relative or friend	310	30	33	25
Social worker	48	5	5	4
Hospital doctor	51	5	6	5
Paramedical worker	53	5	1	1
Nursing/residential home staff	43	4	11	8
School	37	4	0	0
Other	103	7	11	8
Totals	1387	1056	166	133

Source: Survey of new claimants.

11.14.2 *Time taken to obtain statements*

Obtaining supporting statements is a potential source of delay in submitting a claim which can affect the date on which an award will commence unless Section 1 of the claim pack is returned independently. Table 11.31 shows a comparison between how long people waited for a GP or a relative or friend (the two most common sources) to supply a statement and the times for all sources.

Table 11.31 Times waited for supporting statements to be supplied

	DLA			AA		
Time waited	**All sources** (%)	**GP** (%)	**Relative friend** (%)	**All sources** (%)	**GP** (%)	**Relative friend** (%)
Less than one week	90	88	97	83	74	94*
1-2 weeks	6	7	1	9	13	3*
2-3 weeks	2	2	(.)	5	8	0*
3-4 weeks		1	1	1	1	3*
Longer than 4 weeks	1	1	1	1	3	0*
Total'	1284	701	296	158	77	29

Source: Survey of new claimants.
`Don't know' responses excluded from these totals.
* Percentages based on fewer than 50 cases.
(.) = < 0.5 per cent

Generally, those asked to supply supporting statements appeared to have responded very quickly, the large majority of forms being returned within a week. GPs appear to perform slightly below average, particularly for AA claims. Although the picture presented in the table might appear very satisfactory, it should be remembered that unless a claimant has sent in Section 1 of the claim pack beforehand, any delay caused by waiting for a statement to be completed will effectively result in lost benefit.

11.14.3 *Reasons for* **not** *getting statements*

Where appropriate, people were asked why they did not get any supporting statements. Table 11.32 presents the responses of the 250 DLA respondents who answered the question of whom 20 each gave two responses, and the 43 AA respondents of whom three gave two reasons. The percentage column in the table sums to more than 100 per cent because of multiple responses.

Table 11.32 Reasons for not getting supporting statements

	DLA		AA	
Reason for not getting supporting statement	(N)	(%)	(N)	(%)
Didn't think it was necessary	134	54	25	58*
Didn't want to bother anyone	30	12	4	9*
Didn't notice it on claim form	22	9	2	5*
Thought it would take too long	19	8	–	
Difficult finding an appropriate person	11	4	2	5*
Prefer the DSS to get statements if necessary	11	4	–	–
Didn't want others to know my business	5	2	2	5*
Did not want any help	3	1	4	9*
Other reason	14	6	3	7*
Don't know	15	6	4	9*
Total	270	250	46	43

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

Over half of the respondents did not get supporting statements because they did not think it necessary. This is despite the request on the claim form which reads: `Please get the statements on the next two pages filled in.' However, this seemingly unequivocal message is possibly weakened two paragraphs later by the following sentence: `If you cannot get these statements filled in, do not worry - we will normally write to your doctor or someone else who can tell us about your illness or disability.' Some thought might therefore be given to whether this message could be reworded to encourage more people to get supporting statements. As we will see in the next section, a claim is more likely to be decided on the claim form alone if it contains supporting statements. This will, at least, reduce the time necessary to decide the claim.

11.14.4 The effect of supporting statements on how claims are processed

Table 11.33 shows how the number of supporting statements obtained by claimants appears to have affected later choices by the Benefits Agency adjudication officers about what further evidence was collected. For both DLA and AA there is a greater likelihood that a claim is decided on the fosin only if it includes one or two supporting statements. Where further evidence was sought, however, adjudication officers relied more on GP factual reports than EMP reports to help them decide DLA cases, and vice versa for AA cases.

Table 11.33 Method of assessment by number of supporting statements obtained (DLA and AA samples)

	DLA - number of supporting statements			AA - **number of supporting statements**		
	0	**1**	**2**	**0**	**1**	**2**
Method of assessment	(%)	(%)	(%)	(%)	(%)	(%)
Claim form only	37	44	53	49*	60	63*
GP factual report	34	27	24	10*	13	17*
EMP report	26	25	19	34*	22	10*
Other	3	4	4	7*	5	10*
Total	251	698	346	41	94	30

Sources: Survey of new claimants and the DLA database.
* Percentages based on fewer than 50 cases.

11.14.5 Outcomes of claims with no supporting statements and no further evidence

Of those who answered the question about whether they obtained any supporting statements, 251 DLA respondents (19 per cent) and 43 AA respondents (23 per cent) replied that they had not. The internal policy of the Benefits Agency is that such cases should not be paid without some form of further information being obtained. However, as Table 11.34 above shows, over a third of DLA claims (37 per cent) and nearly half of the AA claims (49 per cent) appear to have been decided on the claim form alone. Table 11.34 below compares the outcomes of these claims with the outcomes of claims (with no supporting statements) for which further evidence was obtained by the Benefits Agency.

Table 11.34 Outcomes of claims with no supporting statements

	DLA		AA	
Method of **assessment**	(N)	**Successful claims** (%)	(N)	**Successful claims** (%)
Claim form only	92	43	20	35*
Claim form plus further evidence	101	64	20	20*

Sources: Survey of new claimants and the DLA database.
* Percentages based on fewer than 50 cases.

Of the 92 DLA claimants whose claims appear to have been decided solely on their own evidence, 43 per cent were successful compared with 64 per cent of other claimants who did not obtain supporting statements. These success rates contrast with the overall success rate of the DLA claimants in the sample (around 75 per cent). The numbers of AA cases in the table are small but also show a relatively low success rate compared with the whole of the AA sample (around 57 per cent).

Table 11.34 raises an interesting issue. Regulations allow adjudication officers to make decisions on claims which have no supporting statements and for which they decide no further information (such as a GP or EMP report) is necessary. If the adjudication officer intends to make an award though, the Secretary of State requires *corroborative evidence* of the claimant's identity and of their disabling condition before a payment can be made. However, as Table 11.34 shows, 43 per cent of DLA claims for which no further evidence was collected were successful (40 cases). If corroborative evidence in the form of a GP or EMP report had been sought in each of these cases the percentage success rate of `claim form only' cases would be zero. We would not expect a zero per cent success rate in practice because corroborative evidence might have legitimately been gathered from a claimant's existing social security record. However, a success rate of 43 per cent does suggest that there are a small number of claims for which the requisite administrative action is not being followed.

11.15 Help from the Benefits Agency in completing form

11.15.1 Sources of help and methods of contact

Ten per cent of the DLA sample contacted the DSS for help with completing the claim form. As Table 11.35 shows, over half of these contacts were made to a freephone service and a third to a local (i.e. District or caller) office of the Benefits Agency. Few people contacted either a DBC or the DLA Unit at North Fylde directly. The majority of all contacts (77 per cent) were made by telephone, although over a third of contacts with a local office were made by calling in person. Only 15 respondents in the AA survey sample (five per cent) contacted the Benefits Agency at this stage. Of these, five contacted a local office and four used a freephone service.

Table 11.35 Source of help from Benefits Agency with completion of claim form by method of contact (DLA sample)

	Proportions of respondents using method of contact				
	Telephone	**Letter**	**Call in person**	**Other**	**Total**
Source of help	(%)	(%)	(%)	(%)	(N)
Local office	46	0	41	13	56
DBC	5 cases	0	1 case	1 case	7
North Fylde	89*	11*	0*	0*	18
Freephone	100	–	–		76
All contacts'	77	1	16	6	159

Source: Survey of new claimants.

* Percentages based on fewer than 50 cases.

Totals include seven other contacts made to unspecified DSS or Benefits Agency offices.

11.15.2 Levels of satisfaction

All respondents who received help from the Benefits Agency with completing their claim form were asked to give an assessment of their satisfaction with the service they received. The results are presented separately for the DLA and AA samples and are broken down by how the respondents felt about the outcome of their claim.

Disability Living Allowance

Table 11.36 shows the levels of satisfaction of the 158 DLA respondents who contacted the Benefits Agency for help with their form.

Table 11.36 Levels of satisfaction with help received from Benefits Agency with completion of claim form by response to award - including comparison with claims in progress sample (DLA sample)

	Level of satisfaction					
	Very satisfied (%)	**Fairly satisfied** (%)	**Fairly dissatisfied** (%)	**Very dissatisfied** (%)	**Don't know** (%)	**Total** (N)
Happy with award	73	16	5	3	3	104
Not happy with award	68*	21*	0*	11*	0*	19
Not happy with rejection	60*	11*	14*	9*	6*	35
All decided claims	70	16	6	5	3	158
Claims still in progress	87*	10*	0*	0*	3*	39

Source: Survey of new claimants.

* Percentages based on fewer than 50 cases.

It is clear that levels of satisfaction with the help given by the Benefits Agency to people trying to complete their DLA claim forms were generally very high (86 per cent of the whole sample). Again, satisfaction levels fall away when people are unhappy with the outcome of their claim, but the responses of the claims in progress sample confirm the overall picture of a successful service. Thirty-nine people in the DLA claims in progress sample (12 per cent of all respondents) made contact with the Benefits Agency at this stage, 38 of whom registered their satisfaction.

The reasons behind the high levels of satisfaction and those given by the relatively few dissatisfied respondents are explored in the next section.

Attendance Allowance

The following table presents the data on satisfaction for the 15 AA respondents who contacted the Benefits Agency prior to claiming (five cent of the sample) and compares these with the claims in progress sample. Because there are so few respondents, numbers of responses are presented in the table rather than percentages. There were no `don't know' responses from the 15 respondents.

Table 11.37 Levels of satisfaction with help received from Benefits Agency with completion of claim form; by response to award - including comparison with claims in progress sample (AA sample)

	Level of satisfaction				
	Very satisfied (N)	**Fairly satisfied** (N)	**Fairly dissatisfied** (N)	**Very dissatisfied** (N)	**Total** (N)
Happy with award	11	1	1		13
Not happy with award/rejection	1			1	2
All decided claims	12	1	1	1	15
Claims still in progress	21	10	5		36

Source: Survey of new claimants.

Though the numbers in the table are small, the satisfaction of the AA respondents in the `decided claims' sample is very high. For this question, the claims in progress sample is almost the same size as the DLA sample (36 and 39 respectively). It is interesting therefore that five of the AA sample said they were dissatisfied with the help they received compared with none of the DLA sample.

11.15.3 Reasons for satisfaction and dissatisfaction

This section presents data for the DLA sample only. Since only 15 AA respondents made contact with the Benefits Agency at this stage there is insufficient data for any feasible analysis.

The table below investigates the reasons why people were either very or fairly satisfied with their treatment by the Benefits Agency. It gives the percentage of respondents in each of these categories who mentioned a particular reason. So, for example, 90 per cent of respondents who said they were very satisfied included among their reasons the actual help they had received.

Table 11.38 Main reasons for satisfaction: analysis of responses of satisfied respondents (DLA sample)

	Proportion of respondents mentioning reason	
Reason	**Very satisfied** (%)	**Fairly satisfied** (%)
Staff were helpful/things were explained	90	81*
Staff were polite/sympathetic/understanding/pleasant	33	15*
Staff acted quickly	9	0*
No_ of respondents	111	26

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

This table shows clearly the extent to which the *substance* of the contact with the Benefits Agency, that is the quality of the help and advice received, contributed to people's satisfaction, compared with their personal treatment by Agency staff. That the speed of response was mentioned by very few respondents probably reflects, paradoxically, the fact that most help would have been given immediately in response to a telephone call. A quick response would perhaps have been taken for granted and therefore may not have been in people's thoughts when answering the question.

Table 11.39 Main reasons for dissatisfaction: analysis of responses of dissatisfied respondents (DLA sample)

Reason	**Number of respondents mentioning reason** **Fairly dissatisfied (N)**	**Very dissatisfied (N)**	**Total** (N)
Did not get enough help/information		6	
Staff were rude/offhand			3
Staff took too long	4	3	7
No. of respondents	11	8	19

Source: Survey of new claimants.

Only 19 respondents said they were dissatisfied with the help they received from the Benefits Agency in completing their claim form. The pattern of responses, however, is slightly different to that in Table 11.38 above. Very few people had complaints about their treatment by Agency staff but slightly more cited the time taken to respond as a reason for dissatisfaction. This reinforces the observation made earlier that a quick response is probably taken for granted, so that when this does not happen people feel they have cause for complaint.

Though the tables above present the most commonly cited reasons for people's satisfaction or dissatisfaction with the Benefits Agency, there were also a number of other reasons given although none was mentioned by more than three respondents. As in Chapter 10 we have grouped these into three main categories: *substance, personal treatment* and *time.* Table 11.40 presents the number of times each type of reason was cited by the level of satisfaction reported. Most of the comments made, whether they came from satisfied or dissatisfied respondents, were about substance, over a quarter were about personal treatment, and fewer than one in ten about time taken.

Table 11.40 Reasons for satisfaction and dissatisfaction: analysis by reasons (DLA sample)

Type of reason	**Level of satisfaction** **Very or fairly satisfied** (%)	**Fairly or very dissatisfied** (%)	**Total** (%)
Substance	64	67*	143 (64)
Personal treatment	27	10*	55 (25)
Time/speed	5	23*	17 (8)
Others	4	0*	8 (4)
Total	193	30	223

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

11.16 Conclusion

The decision to change the claiming and assessment procedures for DLA and AA, away from medical examination and towards self-assessment, required a large investment in designing new claim forms and providing help for people in completing them. In this chapter we have attempted to assess the success of these efforts.

The evidence about where claimants first hear about DLA or AA and about where they obtain a claim pack suggests that some consideration might be given to extending the number of places where packs are available to include GP surgeries (in addition to Benefits Agency offices and specific welfare rights outlets).

The claim forms for both benefits have to serve a number of purposes. They must collect basic information about claimants, details about their illness or disabilities, and a large amount of information about how their everyday lives are affected by disability. They must also be relevant for a vast range and number of medical conditions, the severity of which is also very variable. It would be surprising if everyone found the forms simple and helpful.

In our surveys there was consistent evidence that a substantial minority of people experienced a lot of difficulties with the forms, particularly DLA respondents whose claim form is longer than for AA claimants. Two main types of problem were most often cited. First, there were what might be called technical problems, such as confusing or complicated language or instructions, and lack of space for answers. Second, people had problems putting into words the way in which their lives were affected by disability, or in saying exactly what their illness or disability was. Claimants with certain types of disability, such as mental illness, were particularly affected. One effect of this was that around a quarter of the DLA samples said the picture they presented of themselves in the claim foil' was better than was actually the case.

The problems identified in this survey suggest that the Benefits Agency could make several improvements when the DLA and AA forms are next revised. Action could be taken to address the technical problems identified. Less straightforward is addressing the difficulty that some people have in conveying the true extent of their situations on a standard fowl. One possibility is the creation of forms specifically for people with certain types of disability (although, of course, claim focus also need to cater for people with more than one disability). Alternatively, the Agency could take a more proactive role when they receive such claims, by routinely checking that people are happy they have completed the claim form to their satisfaction. However, targeting certain groups in this way, even though in their interests, can carry the risk of charges of discrimination.

The two-part claim form does appear to confuse and potentially disadvantage some claimants. However, this is not a problem affecting large numbers of people since the vast majority (more than 90 per cent) of claimants send in both parts of the form together. The main alternative to a two-part form is a single, combined form, which might help those who find the current arrangements confusing and who for whatever reason fail ever to submit both parts. However, there might also be some `losers', that is, those who delay submitting their claim while they seek additional information or supporting statements.

Supporting statements make the job of adjudication officers easier but a sizeable minority of claimants do not obtain any. The evidence from our analysis of the evidence used to decide claims is that if more supporting statements were supplied fewer GP factual reports and fewer EMP visits might be required. Making supporting statements mandatory would not be sensible or feasible but more encouragement could be given to claimants, in the claim form and the wider literature, to supply them.

Our finding that some DLA awards were made on claim forms with no supporting statements and no corroborative evidence (in the form of a GP or EMP report) suggests the need for a review of current practices for processing unsupported claims.

The help that claimants and people acting on their behalf obtained from the Benefits Agency in completing claim forms received very high satisfaction scores from our samples of decided claims and claims in progress. This aspect of service therefore appears to be working very well. No specific problems emerged which would suggest that any departures from current practice are required.

Chapter 12 After the Claim: Dealings with the Benefits Agency

Decisions on initial claims for DLA and AA are made in one of the 11 DBCs in Great Britain. When a claim is received in a DBC an acknowledgement is sent to the claimant and the form is initially checked by a clerk. If there are any glaring omissions in the claim, such as a missing signature or a section not completed, then the clerk will either write or arrange for a telephone call to be made to the claimant. Otherwise the claim is entered on the computer system and passed to an adjudication officer for consideration. Adjudication officers can then do one of several things. They can decide the case straightaway on the basis of the information in the claim form alone. They can seek further information from the claimant by telephone, letter or by a visit from a member of the DBC staff. They can refer the case for advice to a medical officer of the Benefits Agency Medical Service or ask for a factual report usually from the claimant's GP (known as a GPFR). Another option is to arrange for a report from a hospital or from an EMP, a doctor other than the claimant's own GP, who will see the claimant personally, usually in their own home.

If they cannot make a decision on the claim form alone adjudication officers' courses of action will be determined primarily by their need to gather sufficient information to make a decision. The most direct, and often the quickest and cheapest method of getting more information is to telephone the claimant. In DBCs there are dedicated telephone sections which will make such enquiries on behalf of adjudication officers and also handle enquiries from the public. A Helpline telephone service in the central office at North Fylde is also available to DLA claimants.

This chapter presents the responses of our survey samples when asked about both contacts they had received *from* the Agency and contacts they made *to* the Agency after they had submitted their claim.

12.1 The acknowledgement letter

Every claimant should receive an acknowledgement of their claim. For DLA claimants the letters are generated automatically by the DLA computer system. Nevertheless, 121 DLA respondents (seven per cent of the whole DLA sample) and 32 AA respondents (11 per cent of the AA sample) said they did not get one, as Table 12.1 shows. Nevertheless, the vast majority of people thought an acknowledgement was important. The differences between those who did and those who did not get an acknowledgement may be evidence of how the provision of a service creates more of a demand for it. In other words, when people get something they value it but those who have never had it do not see it as so important.

Table 12.1 Respondents' assessment of the importance of an acknowledgement by whether they received one

	DLA		AA	
Assessment of importance	**Did receive acknowledgement** (%)	**Did not receive acknowledgement** (%)	**Did receive acknowledgement** (%)	**Did not receive acknowledgment** (%)
Important	97	83	96	78*
Not important	3	17	4	22*
Total	1575	121	230	32

Source: Survey of new claimants.

* Percentages based on fewer than 50 cases.

12.2 Contact from the Benefits Agency after submission of the claim

12.2.1 Methods of contact and difficulties arising

Respondents were asked if the Benefits Agency contacted them for further information or to check something after they had submitted their claim. Excluding those people who did not know, 26 per cent of the DLA sample (460 respondents) and 19 per cent of the AA sample (56 respondents) said they were contacted. Excluding medical examinations (see Chapter 13) this was the highest level of contact between claimants, or people acting on their behalf, and the Benefits Agency throughout the course of applying for either DLA or AA. Table 12.2 shows the method of contact used by the Agency.

Table 12.2 Methods of contact used by the Benefits Agency

Method of contact	**DLA respondents** (%)	AA **respondents** CA)
Telephone	45	42
Letter	52	55
Other	3	4
Total	450	55

Source: Survey of new claimants.

In recent years the Benefits Agency has actively pursued policies which would increase the amount of business conducted with claimants by telephone. The results in Table 12.2, because they are a snapshot only, can therefore be interpreted in different ways. They may reflect one point in a process of change from using letters to communicate with claimants towards more use of the telephone. However, without knowing what the pattern was before the survey we cannot explore this any further. Alternatively, they may demonstrate an under-use of telephone sections by adjudication officers. If this is the case then the cause of adjudication officers' reluctance could be investigated. For example, they may have entrenched attitudes about the reliability of verbal information or they may feel that telephone sections are not providing the service that they need. In contrast, it is also possible that adjudication officers may wish to engage in correspondence in order to have a written record of their enquiries and the claimant's responses.

Other results from the survey suggest that more telephone contacts at this stage would be popular with claimants. Among those respondents who expressed any preference, the telephone was the first choice of 67 per cent of the DLA sample and 60 per cent of the AA sample. Furthermore, as we shall see later in the chapter, when the Benefits Agency contacts them, rather than *vice versa,* people are more concerned with prompt action than at any other stage of the claiming process.

Most people had no difficulty in responding to the Benefits Agency's enquiries. The 71 DLA respondents who said they did have some problems (15 per cent of those contacted) were divided almost equally between those contacted by telephone and those receiving a letter. Only three of the 56 AA respondents contacted had any problems. Among the DLA sample, the most common difficulty (mentioned by just over a third of respondents) was not understanding what the Agency staff actually wanted to know. Other problems mentioned were not knowing the answers to questions and having difficulty explaining the effects of their condition on their everyday activities.

12.2.2 Levels of satisfaction with the contact from the Agency

Disability Living Allowance

All respondents who were contacted by the Agency were asked to give an assessment of their satisfaction with the service they received. The results are presented separately for the DLA and AA samples and are broken down by how the respondents felt about the outcome of their claim.

Table 12.3 Levels of satisfaction with contact from Benefits Agency by response to award -- including comparison with `claims in progress' sample (DLA sample)

	Level of satisfaction					
	Very satisfied (%)	**Fairly satisfied** (%)	**Fairly dissatisfied** (%)	**Very dissatisfied** (%)	**Don't know** (%)	**Total**
Happy with award	58	32	3	2	5	306
Not happy with award	40*	38*	6*	15*	0*	47
Not happy with rejection	26	43	13	12	6	89
All decided claims	49	35	6	5	5	442
Claims still in progress	39	42	2	7	8	84

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

As mentioned above, contact from the Benefits Agency to the claimant after the claim was received was the most frequent type of contact, excluding medical examinations. An *outcome effect* is once again present in the responses, but overall levels of satisfaction were still high (84 per cent for both the `decided claims' and 81 per cent for the `claims in progress' sample). The overall satisfaction of the `decided claims' sample is comparable to that when claimants contacted the Agency for help with filling in the claim form (86 per cent). However, the proportions of *very* satisfied claimants are lower at this stage.

Attendance Allowance

The following table presents the data on satisfaction for AA respondents who were contacted by the Benefits Agency after submitting their claim (18 per cent of the sample) and compares these with the claims in progress sample. Because there are so few respondents, numbers of responses are presented in the table rather than percentages.

Table 12.4 Levels of satisfaction with contact from Benefits Agency by response to award - including comparison with `claims in progress' sample (AA sample)

	Level of satisfaction					
	Very satisfied (N)	**Fairly satisfied (N)**	**Fairly dissatisfied (N)**	**Very dissatisfied** (N)	**Don't know (N)**	**Total**
Happy with award	23	12	1	1	2	39
Not happy with award/rejection	4	7	1	3	1	16
All decided claims	27	19	2	4	3	55
Claims still in progress	22	26	2	1	8	59

Source: Survey of new claimants.

Although the numbers of AA respondents who were contacted by the Benefits Agency are relatively small for a comparable analysis, Table 12.4 does appear to show the same general pattern as the DLA respondents.

12.2.3 Reasons for satisfaction and dissatisfaction

When people have contacted the Benefits Agency for initial advice or for help with the claim form, one of the main reasons given for expressions of satisfaction was the quality of the help or advice received. (For example, this was cited by around 90 per cent of *very* satisfied respondents at both of these stages in the claiming process - see Tables 10.8 and 11.38.) In contrast, very few people mentioned the speed of response of the Agency as contributing to their satisfaction. However, as Table 12.5 shows, when the Agency contacted people after they had submitted their claim, fewer than half of the very satisfied respondents mentioned the substance of the contact as part of the reason for their satisfaction. Nearly a third mentioned that staff acted quickly.

Table 12.5 Reasons for satisfaction: analysis of responses of satisfied respondents (DLA sample)

Reason	Proportion of respondents mentioning reason Very satisfied (%)	Fairly satisfied (%)
Staff were helpful/things were explained	48	28
Staff were polite/sympathetic/understanding/pleasant	38	15
Staff acted quickly	30	13
Contact was straightforward/things went smoothly	12	17
Kept informed	11	8
No. of respondents	222	163

Source: Survey of new claimants.

The shift in emphasis possibly reflects that, by this stage of their claim, people are becoming more aware of the time since they sent in their claim *form'* and are concerned to get a decision as soon as possible. This interpretation is supported by the evidence that some people's satisfaction, unlike earlier stages in claiming, is linked with the *absence of* problems or the straightforward nature *of* the contact.

As Table 12.6 shows, the main reasons for people's dissatisfaction were more to do with the substance of the contact (the help received from Benefits Agency staff, inadequate enquiries, difficulties with the claim form) rather than about the conduct of staff or problems with delays.

Table 12.6 Reasons for dissatisfaction: analysis of responses of dissatisfied respondents (DLA sample)

Reason	Number of respondents mentioning reason Fairly dissatisfied (N)	Very dissatisfied (N)	Total (N)
Did not get enough help/information	3	8	11
BA did not ask for right information	6	3	9
Staff took too long	4	3	7
Problems with the claim form	1	6	7
Staff were rude/offhand	1	4	5
Letter did not explain things well	1	3	4
No. of respondents	25	24	49

Source: Survey of new claimants.

Table 12.7 presents the data used for the previous tables slightly differently and incorporates *all* the reasons given for people's satisfaction or dissatisfaction. The picture given confirms the picture drawn earlier, that the substance of this particular contact features less in people's minds than for other stages in the claiming process and that the speed of the Agency's response is more prominent.

Table 12.7 Reasons for claimant satisfaction and dissatisfaction: analysis by reasons (DLA sample)

Type of reason	Level of satisfaction Very or Fairly dissatisfied (%)	Fairly or very dissatisfied (%)	Total (%)
Substance	38	55	240 (40)
Personal treatment	27	10	151 (25)
Time/speed	16	10	95 (16)
Others'	19	24	117 (19)
Totals	536	67	603

Source: Survey of new claimants.

' Includes mainly `neutral' reasons such as `contact was straightforward' and `no problems'.

12.3 Contact from the claimant to the Benefits Agency after submission of the claim

12.3.1 Respondents' reasons for contacting the Benefits Agency, and where they sought help

Relatively few claimants made contact with the Benefits Agency after they had submitted their claim: 128 DLA respondents (seven per cent of the whole DLA sample) and 15 AA respondents (five per cent of the whole AA sample). The tables that follow present the responses of the DLA sample only. Two-thirds of the contacts made were to check on the progress of a claim and a further quarter were to supply further information.

Table 12.8 Type of Benefits Agency office contacted by method of contact (DLA sample)

	Proportions of respondents using method of contact				
	Telephone	**Letter**	**Call in person**	**Other**	**Total**
Type of office	(%)	(%)	(%)	(%)	(N)
Local office	77	6	13	4	48
DBC	100	0	0	0	20
North Fylde	97	0	0	3	37
Freephone	100		–		10
All contacts	90	2	6	2	124[1]

Source: Survey of new claimants.

[1] Total includes nine other contacts made to unspecified DSS or Benefits Agency locations.

NB Excluding bottom row of table, all percentages are based on fewer than 50 cases.

At this stage a local office was the most common point of contact followed by the central DLA Unit at North Fylde. The level of contact with North Fylde may be partly explained by the fact that the acknowledgement letters sent to claimants when they submit their claim gives the Helpline telephone number there. Fewer than one in six respondents contacted the DBC whose staff perhaps would be better placed to deal with some enquiries. (In practice, queries that cannot be dealt with at North Fylde are transferred immediately to the appropriate DBC.)

12.3.2 Levels of satisfaction

Disability Living Allowance

As Table 12.9 shows, levels of satisfaction of respondents contacting the Benefits Agency, although still around 80 per cent for all the `decided claims' sample, are lower than for earlier stages of claiming. The levels of dissatisfaction among the `claims in progress' sample, although comprising only 38 respondents, is strikingly high at 34 per cent. Again an outcome effect is discernible in the differences between respondents who were happy with the outcome of their claim and those who were not.

Table 12.9 Levels of satisfaction with contact to the Benefits Agency by response to award - including comparison with `claims in progress' sample (DLA sample)

	Level of satisfaction					
	Very satisfied (%)	**Fairly satisfied** (%)	**Fairly dissatisfied** (%)	**Very dissatisfied** (%)	**Don't know** (%)	**Total**
Happy with award	52	35	6	7	0	71
Not happy with award	50*	19*	15*	15*	0*	26
Not happy with rejection	36*	32*	20*	12*	4*	26
All decided claims	48	31	11	10	1	123
Claims still in progress	29*	37*	18*	16*	0*	38

Source: Survey of new claimants.

* Percentages based on fewer than 50 cases.

Attendance Allowance

The following table presents the data on satisfaction for the 15 AA respondents who contacted the Benefits Agency after submitting their claim (five per cent of the sample) and compares these with the `claims in progress' sample. Because there are so few respondents, numbers of responses are presented in the table rather than percentages. There were no `don't know' responses among the 15 respondents.

Table 12.10 Levels of satisfaction with contact to the Benefits Agency by response to award - including comparison with `claims in progress' sample (AA sample)

	Level of satisfaction				
	Very satisfied (N)	**Fairly satisfied** (N)	**Fairly dissatisfied** (N)	**Very dissatisfied** (N)	**Total** (N)
Happy with award	9	0	0	0	9
Not happy with award/rejection	2	2	2	0	6
All decided claims	11	2	2	0	15
Claims still in progress	6	8	2	0	16

Source: Survey of new claimants.

Although the numbers of AA respondents who contacted the Benefits Agency are relatively small for a comparable analysis, Table 12.10 appears to show that AA respondents are less dissatisfied than DLA respondents.

12.3.3 Reasons for satisfaction and dissatisfaction

The pattern of reasons given by DLA respondents expressing some degree of satisfaction is similar to other stages in claiming, where the claimant is responsible for the contact (such as seeking initial help and advice or asking for help in completing the claim form). As Table 12.11 shows, the *substance* of the contact was the most prominent reason cited, mentioned by nearly two-thirds of the respondents. One in five people said that being kept informed contributed to their satisfaction.

Table 12.11 Reasons for satisfaction: analysis of responses of satisfied respondents (DLA sample)

	Proportion of respondents mentioning reason	
Reason	**Very satisfied** (%)	**Fairly satisfied** (%)
Staff were helpful/things were explained	62	48*
Staff were polite/sympathetic/understanding/pleasant	38	20*
Kept informed	18	18*
Staff acted quickly	18	3*
Contact was straightforward/things went smoothly	12	15*
No. of respondents	61	40

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

The pattern of reasons for people's dissatisfaction is also familiar and confirms that when people make the effort of contacting the Benefits Agency, they are not happy when the substance of their enquiry is not addressed adequately.

Table 12.12 Reasons for dissatisfaction: analysis of responses of dissatisfied respondents (DLA sample)

	Number of respondents mentioning reason		
Reason	**Fairly dissatisfied (N)**	**Very dissatisfied (N)**	**Total** (N)
Did not get enough help/information	8	3	11
Staff were rude/offhand	3	0	3
Staff took too long	3	2	5
BA lost paperwork	1	4	5
No. of respondents	13	12	*25*

Source: Survey of new claimants.

Table 12.13 combines all the reasons for satisfaction and dissatisfaction and reaffirms the dominance of the substance as the most important aspect of this contact with the Agency.

Table 12.13 Reasons for claimant satisfaction and dissatisfaction: analysis by reasons (DLA sample)

	Level of satisfaction		
Reason	**Very or** fairly **satisfied** (%)	**Fairly or very dissatisfied** (%)	**Total** (%)
Substance	52	56*	94 (53)
Personal treatment	25	15*	41 (23)
Time/speed	8	15*	17 (9)
Others	15	15*	27 (15)
Total	145	34	179

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

12.4 Conclusion

This chapter has investigated the experiences of claimants and people acting on their behalf in their dealings with the Benefits Agency after they have submitted a claim. Two types of contact were examined: contact *from* the Agency to the claimant, usually for the purpose of either checking something on the claim form or collecting more information; and contact *to* the Agency from people enquiring about the progress of their claim or supplying further information themselves.

Over a quarter of DLA respondents and nearly a fifth of the AA sample said they had been contacted by the Agency. That the Benefits Agency had to make contact with the claimant in a quarter of all cases might imply that the claim form is not eliciting the quality of information required by adjudication officers, or that a sizeable minority of people are not completing the form adequately. These two reasons are not mutually exclusive and there is ample evidence from Chapter 11 that some people do experience considerable difficulties with the form.

We have noted how time assumes a greater importance for people when the Agency contacts them and have suggested that investigating why the telephone is not used more to contact claimants might be worthwhile. Satisfaction with this stage of the process is comparable to the high levels associated with the earlier stages of claiming, although the proportion of *very* satisfied respondents do not reach their levels. The *outcome effect is* still discernible, however.

Contacts *to* the Benefits Agency were less favourably assessed by DLA respondents (though not by the small number of AA respondents who made contact). Nevertheless, the overall satisfaction score was still 79 per cent for the decided claims sample and 81 per cent for the claims in progress sample. One hypothesis to explain this relative dip in satisfaction is that the nature of the contact between the claimant and the Agency is different than for contacts earlier in the claiming process. People who call the Agency (90 per cent of whom used the telephone) enquiring about the progress of their claim may already be a little dissatisfied that their claim has not been dealt with already. We do not know from the survey data exactly what people hoped to get from their call (perhaps some general reassurance that their claim had not been lost, or a filni date by which they would get a decision) but Benefits Agency staff may not always be able to provide a full answer or explanation (especially if the wrong office is contacted).

It is not necessary to be certain what is behind the lower score for satisfaction to be able to suggest that the Agency could examine its procedures for handling enquiries between the submission of a claim and a decision, in an attempt to bring the quality of service provided at this stage of the process up to the high levels achieved elsewhere.

Chapter 13 The EMP Examination

Under the old AA and MobA schemes all claimants were required to undergo an examination by a medical practitioner. For DLA and the new AA a medical examination is no longer obligatory, although adjudication officers have the option of asking for an EMP report if they feel they cannot make a decision without one. Claimants also have the opportunity of requesting an EMP visit rather than complete Section 2 of the claim pack. In this chapter we look briefly at the types of claimant undergoing EMP examinations, whether respondents considered that they presented an accurate picture of themselves during the visit, and their perceptions of, and levels of satisfaction with, this stage of the claiming process.

13.1 EMP referral rates

The Benefits Agency's own statistics show that around a quarter of DLA and AA claimants receive an EMP visit, a similar picture to that presented by our survey samples as Table 13.1 shows.

Table 13.1 Proportions of DLA and AA claimants receiving an EMP visit

	(N)	(%)
DLA	463	26
AA	69	23

Source: Survey of new claimants.

Using information from the DLA database about the main disabling condition of each claimant, Table 13.2 shows which conditions are associated with EMP visits above and below the average figure of 26 per cent for the whole sample.

Table 13.2 EMP visits by main disabling condition (DLA sample)

Conditions with above average number of EMP visits	**Claimants receiving EMP visit** (%)	**Total** (N)
Chronic fatigue	74*	19
Spondylosis	52	97
Back pain	37	71
Conditions with below average number of EMP visits		
Diabetes	19*	47
Asthma	17	53
Psychosis	17	74
Psychoneurosis	17	59
Learning difficulties	13	132
Epilepsy	12	73
All conditions	26	463

Sources: Survey of new claimants and the DLA database.
* Percentages based on fewer than 50 cases.

This is an interesting table which raises questions about the policy and practice of using EMP visits. In order to explain fully the current pattern of use of EMP reports, which would also allow an assessment of whether resources are being used efficiently, further work with adjudication officers would be needed. Nevertheless, Table 13.2 does suggest some possibly fruitful lines of enquiry. For example, although the number of claimants in the survey with a chronic fatigue illness was small, a high percentage received a visit from an EMP. This is not surprising given the advice to adjudication officers about chronic fatigue illnesses in the *Disability Handbook* which reads:

> A report by an Examining Medical Practitioner may greatly assist in helping the affected person identify the level and extent of care and mobility needs.

However, there is no comparable clear-cut advice concerning spondylosis or back pain. Back problems are notoriously difficult to diagnose with the same precision as, say, arthritis or limb trauma, and can vary enormously in their severity and effects on people's lives. The reason why adjudication officers request, relatively, so many EMP reports for claimants with these conditions may reflect their difficulty is assessing whether the effects on the claimant's life is commensurate with their account of their illness.

EMP visits are expensive, and the most efficient use of them is desirable. If reports are being requested because adjudication officers cannot make decisions on the claim form (with or without a GPFR) this could be considered a sensible use although the effectiveness of the claim form for these conditions must therefore be brought into question. Whether this is the case for all conditions is not clear from our survey data. However, the differences in referral rates evident in Table 13.2 (even though the numbers of people in the sample with any particular condition are generally not large) does suggest that it would be worthwhile investigating the practices of adjudication officers in requesting EMP reports.

13.2 Respondents' assessment of the information provided to the EMP

All respondents in the survey were asked whether the information they provided on the original claim form was an accurate reflection of the way their illness or disability affected their everyday activities. The responses were presented in Chapter 11. The same question was also asked of those claimants who had been visited by an EMP. The responses of DLA and AA respondents are presented in Tables 13.3 and 13.4 respectively.

Table 13.3 Respondents' assessments of whether they presented an accurate picture of their lives to the EMP by outcome of claim - including comparison with 'claims in progress' sample (DLA sample)

	Decided claims			
Picture presented of effect of disability on everyday life	**Award/happy**	**Award/not happy** (%)	**Rejection** ***(N)***	**Claims in progress** (N)
Accurate picture	88	58	56	85*
Better than really am	10	42	43	15*
Worse than really am	2	0	1	0*
Total	292	57	80	47

Source: Survey of new claimants.
NB `Don't know' responses have not been included in this table.
* Percentages based on fewer than 50 cases.

Table 13.4 Respondents' assessments *of* whether they presented an accurate picture of their lives to the EMP by outcome of claim, including comparison with `claims in progress' sample (AA sample)

	Decided claims		
Picture presented of effect of disability on everyday life	**Award/ happy** (%)	**Rejection** *(N)*	**Claims in progress** *(N)*
Accurate picture	79	70	91
Better than really am	18	30	9
Worse than really am	4	0	0
Total	28	33	35

Source: Survey *of* new claimants.
NB `Don't know' responses have not been included in this table.
NB All percentages based on fewer than 50 cases.

Comparing these tables with their equivalents in Chapter 11 shows that, in general, more people thought they presented an accurate picture of themselves to the EMP than in the claim form (the differences are mostly in the region of ten percentage points for happy and unhappy claimants alike).

Of the 104 DLA claimants who had said that the information on the claim form had presented a better picture of themselves than was really the case, 61 per cent (63 people) said that, in contrast, the picture presented to the EMP was accurate.

Where appropriate, respondents were asked if they could explain why the information given to the EMP did not present an accurate picture of how their condition affects their daily lives. Table 13.5 presents the responses of the DLA sample only and compares these with the responses to the equivalent question about the claim form. Too few AA respondents answered this question to allow a comparable analysis.

Table 13.5 Respondents' explanations of why the information given to the EMP did not present an accurate picture of how their condition affects their daily lives (DLA sample)

	EMP responses		**Claim form responses**
Reason	**(N)**	**(% of cases)**	**(% of cases)**
Problems hard to describe/put into words	20	23	31
Did not want to appear disabledlill	19	21	7
Questions did not go far/deep enough	11	12	25
Illness/condition varies	8	9	15
Not enough time to describe conditionleffect	8	9	10
Just yes or no answers	5	6	8
Forgot something	6	7	4
Other answers	23	26	15
Don't know	2	2	2
No. of claimants	89		448

Source: Survey of new claimants.

Though the pattern of responses about the EMP visit is similar to that for the claim form the general level of problems associated with the former appears to be lower. The one exception is the percentage of claimants who said that they did not want to appear ill or disabled to an EMP. One of the possible problems with self-reporting of disability is that people will under-represent the extent of their disablement. The evidence in the table above suggests that this is a problem associated less with the claim form than with a personal interview and examination by a medical practitioner.

13.3 Perceptions of the EMP visit

The medical examinations associated with the MobA and old AA schemes attracted criticism for their unnecessarily intrusive nature (see, for example, Buckle, 1988, and National Association of Citizens Advice Bureaux, 1990) although research evidence has also revealed a high level of satisfaction with EMP visits (see, for example, Chilvers, 1990). In order to investigate how claimants perceived the EMP visit, we asked a series of questions about whether people minded being physically examined, being asked to demonstrate their walking ability (applicable to DLA claimants only), and being asked questions by the doctor. The responses are presented in Table 13,6.

Table 13.6 Respondents' perceptions of the EMP visit

	Proportion of respondents who said they did mind specific aspects of EMP visit			
	DLA		AA	
Aspect of EMP visit	(%)	(N)	(%)	(N)
Physical examination	8	405	6	52
Walking demonstration	10	316	–	–
Doctor's questions	5	462	6	69

Source: Survey of new claimants.

Table 13.6 shows that relatively few people objected to being physically examined, demonstrating their walking ability or answering the EMP's questions. However, we do not have data which would allow us to compare this level of acceptability with that prior to the introduction of the new benefits. Nevertheless, the table does provide benchmark figures which could be used in any future monitoring of people's experiences of claiming DLA or AA.

13.4 Levels of satisfaction with EMP visit

13.4.1 Disability Living Allowance

When respondents were asked about their general levels of satisfaction with the EMP's visit, a similar pattern of responses emerged as for equivalent questions about other stages in the claims process. Aggregate levels of satisfaction for both the `claims in progress' sample and for those whose claims had been decided were high (92 and 86 per cent respectively), although the differences between those happy with the outcome of their claim and those unhappy were again marked.

Table 13.7 Levels of satisfaction with EMP visit by response to award - including comparison with `claims in progress' sample (DLA sample)

	Level of satisfaction					
	Very satisfied (%)	**Fairly satisfied** (%)	**Fairly dissatisfied** (%)	**Very dissatisfied** (%)	**Don't know** (%)	**Total**
Happy with award	71	23	3	2	2	306
Not happy with award	43	38	5	5	9	58
Not happy with rejection	31	34	9	23	3	88
All decided claims	59	27	4	7	3	452
Claims still in progress	57	35	4	2	2	51

Source: Survey of new claimants.

13.4.2 Attendance Allowance

Levels of satisfaction among the AA sample were also high, as Table 13.8 shows. Unlike the DLA sample, however, there appears to be very little *outcome effect.* While there were fewer *very* satisfied responses among those who had been rejected compared with successful claimants, dissatisfied respondents were evenly spread between the two groups.

Table 13.8 Levels of satisfaction with EMP visit by response to award - including comparison with `claims in progress' sample (AA sample)

	Level of satisfaction					
	Very satisfied (N)	**Fairly satisfied** (N)	**Fairly dissatisfied** (N)	Very **dissatisfied** (N)	**Don't know** (N)	Total (N)
Happy with award	18	8	2	2	3	33
Not happy with award/rejection	15	15	5	0	1	*36*
All decided claims	33	23	7	2	4	69
Claims still in progress	20	17	1	0	1	39

Source: Survey of new claimants.

13.4.3 *Reasons for satisfaction and dissatisfaction with EMP visit*

The reasons for people's satisfaction with the EMP visit were very different from those given for other contacts between claimants and the Benefits Agency. Eighty-one per cent of the very satisfied respondents mentioned the manner with which the EMP had treated them. Far fewer mentioned anything to do with the substance of the contact.

Table 13.9 Main reasons for satisfaction with EMP visit: analysis of responses of satisfied respondents (DLA sample)

	Proportion of respondents mentioning reason	
Reason	**Very satisfied** (H)	**Fairly satisfied** (%)
Doctor was polite/sympathetic/understanding/pleasant	81	48
Doctor was helpful	16	7
Doctor was knowledgeable about condition	12	6
Visit was straightforward/things went smoothly	4	I1
No. of respondents	272	126

Source: Survey of new claimants.

Aspects of the personal contact between the claimant and the EMP were also the most common reasons for dissatisfaction, as Table 13.10 shows.

Table 13.10 Main reasons for dissatisfaction with EMP visit: analysis of responses of dissatisfied respondents (DLA sample)

	Number of respondents mentioning reason		
Reason	**Fairly dissatisfied (N)**	**Very dissatisfied** (N)	Total (N)
Doctor was rude/offhand	I1	22	33
Doctor was not knowledgeable about condition	0	11	11
Was not treated like an individual	2	8	10
No. of claimants	17	31	48

Source: Survey of new claimants

Table 13.11 combines all the reasons for satisfaction and dissatisfaction and reaffirms the dominance of the personal nature of the contact as the most important aspect of the EMP's visit.

Table 13.11 Reasons for satisfaction and dissatisfaction with EMP visit: analysis by reasons DLA sample)

	Level **of satisfaction**		
Type of reason	**Very or fairly satisfied** (%)	**Fairly or very dissatisfied** (%)	Total (N) (%)
Substance	18	23	108 (18)
Personal treatment	70	67	418 (70)
Time/speed	1	0	4 (1)
Others	11	11	67 (11)
Totals	531	66	597

Source: Survey of new claimants.

13.5 Conclusion

The EMP visit is not only the most common contact between claimants of DLA and AA, it will probably be the only time when a face-to-face encounter takes place during the process of claiming (the other example being when people call in person to a local Benefits Agency office). EMP visits will in most cases also be instigated by the Agency, distinguishing them from most other contacts which are initiated by the claimant or someone acting for them. The EMP visit is, therefore, a highly distinctive stage in the claiming process.

This is reflected in the reasons people gave for their satisfaction or dissatisfaction. We have seen in Chapter 12 that when the Benefits Agency contacted people for further information, the *substance of* the contact became relatively less important for people than when they themselves made the contact (for example, for help, advice or information). The same effect can be seen with the EMP visit, except that in this case the personal nature of the contact became by far the most important aspect of the contact. As a consequence, because most respondents found the EMP polite, friendly, helpful or sympathetic they also reported generally high levels of satisfaction with the visit.

We have mentioned how the previous medical assessments for MobA and the old AA were generally unpopular with claimants. However, there is no evidence from the survey results that the EMP visit attracts a comparable level *of* unpopularity.

One *of* the fundamental aims of DLA and the new AA was to base adjudication on self-assessment by claimants, thereby making the claiming procedures less reliant on medical inputs. That around half of all claims are decided on the claim form alone shows that this aim has been at least partially met. However, it is not clear whether the evidence that over 25 per cent of claims are referred for an EMP report shows that the numbers of medical assessments are still too high. As far as we know there has been no target set for an acceptable rate of EMP referrals. Having said that, the evidence presented in this chapter, that claimants felt they gave a more accurate picture of the effects of their disabilities on their lives to the doctor than on the claim form, suggests that the EMP visit generates the most accurate information on which an adjudication officer can decide the claim. There may, therefore, be a basis for arguing that more EMP reports should be requested in the interests of higher quality decision making.

Whether or not the current rate of EMP referrals is a cause for concern, there is a case for reviewing the practices of adjudication officers to identify any opportunities for a more efficient use of what is an expensive resource.

Chapter 14 Getting the Decision

This chapter deals with the stage of the claiming process after a decision has been made by an adjudication officer. It covers people's perceptions of the time taken for the claim to be decided, their understanding of the decision, and the action taken (or intended) by those claimants unhappy at the outcome.

14.1 People's perceptions of the time taken to process claims

The Benefits Agency calculates the clearance times for claims from the time a claim is registered as having been received in the Agency to the time a decision is despatched to the claimant. For DLA the Agency has a primary target of clearing 65 per cent of new cases (excluding Special Rules claims) in 30 working days, and a secondary target of 85 per cent in 55 working days. The DLA Unit's on-line computer system allows faster processing than the AA Unit's system. The targets for AA are, therefore, slightly different: 60 per cent cleared in 35 days and 90 per cent in 60 days." For both DLA and AA the existing primary and secondary targets have consistently been achieved in the past year or so.

How claimants and others acting on their behalf perceive the time taken to clear claims is likely to be different from the official measure. `Clearance times' for them are more likely to start when they post or hand in their claim and end either when they receive a decision or get their first payment. Asking people in a survey how long their claim took to process therefore produces data which cannot be compared directly with official statistics.

However, in this section it is not the intention to measure clearance times using respondents' recollections of how long the process took. People's perceptions of the passing of time, in some cases in this survey recalled a number of months later, can be unreliable. Of more interest is people's ideas about what constitutes a *reasonable* time to process a claim. Tables 14.1 and 14.2 present respondents' assessments of whether the time they said was taken to process their claim was reasonable or not.

Table 14.1 Respondents' perceptions of time taken to process claims by their assessment of reasonableness (DLA sample)

	Respondent's assessment of reasonableness				
	Very	**Fairly**	**Not very**	**Not at all**	**Total**
No. of weeks	(%)	(%)	(%)	(%)	(N)
1-2	77	20	2	1	193
3-4	60	36	3		526
5-6	42	46	8	4	388
7-8	27	52	15	7	245
9-12	18	43	22	18	143
13 and over	6	29	33	33	52
All cases	47	39	9	5	1547

Source: Survey of new claimants.

" When the AA Unit's new computer system is operational (at the time of writing this was expected to be October 1995) the clearance targets will be the same.

Table 14.2 Respondents' perceptions of time taken to process claims by their assessment of reasonableness (AA sample)

	Respondent's assessment of reasonableness				
No. of weeks	**Very** (%)	**Fairly** ("A)	**Not very** (A)	Not at all (%)	Total (N)
1-2	74*	26*			23
3-4	57	41	3		79
5-6	32	44	18	6	50
7-8	22*	50*	19*	9*	32
9-12	19*	25*	28*	28*	32
13 and over	7*	27*	20*	47*	15
All cases	40	38	13	10	231

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

The information in these tables can be used in two complementary ways. First, we can ask whether the performance of the Benefits Agency in meeting its own internal targets is also satisfactory from the claimants' viewpoint. Secondly, we can use the data to assess whether the targets used by the Agency could be made more useful and effective in promoting the standard of service required by claimants.

In addressing the first of these issues, the tables show that the large majority of DLA respondents (86 per cent) thought that their clearance time was reasonable. The verdict of the AA population was not as good, however. Twenty-three per cent of the AA sample recorded `not very reasonable' or `not at all reasonable' answers. Most respondents (DLA and AA) thought that clearance times of up to eight weeks (40 working days) were either very *or* fairly reasonable. Even clearance times of up to 12 weeks were thought reasonable by over half the DLA respondents.

The Secretary of State's target for claimant satisfaction (across all benefits) has been set at 85 per cent for the past four years. If we take people's assessment of `reasonableness' as an indication of satisfaction we can see from Table 14.1 that for DLA respondents, over 85 per cent of those whose claim took up to six weeks to clear were satisfied but the percentage falls below the 85 per cent threshold at eight weeks. This suggests that setting a primary target based on six or seven weeks (30 to 35 working days) is an appropriate choice. Setting the target at 65 per cent, however, may seem low given that achieved clearance times have been consistently above 80 per cent in recent years.' Tables 14.1 and 14.2 also show that clearance times of no more than four weeks produce a majority of `very satisfied' claimants. If the Agency wanted to `delight' claimants rather than merely satisfy them, then a performance target based on four weeks might be appropriate.

In comparing the responses of the DLA and AA samples it would seem that the AA claiming population is more demanding than its DLA counterparts. The proportion of `very reasonable' responses is consistently lower, and the proportion of not at all reasonable' responses consistently higher, among the AA sample. This suggests that performance targets based on claimant demands would be tougher for AA than for DLA rather than the reverse at present.

14.2 Claimants' levels of understanding about their decision

Lele i lag cliii m.l ,t he outcome of their claim are generated automatically by the eoaln u ter systems. They contain standard explanations for decisions rather fiaa miffed accounts of why a particular award was made or why a claim was rejected. a the survey, respondents were asked how they rated their understanding of their decision. The responses are presented in Tables 14.3 and 14.4 (for the DLA and AA samples respectively) according to people's response to the outcome of the claim. (NB Respondents were given the option of acknowledging that they took little notice of the decision letter.)

" Benefits Agency internal statistics.

Table 14.3 Claimants' levels of understanding of their decision (DLA sample)

Response to award	Level of understanding Very good (%)	Adequate (/o)	Not good (/ii)	None (%)	Total (N)
Happy with award	53	40	2	5	1005
Not happy with award	23	40	18	19	166
Not happy with rejection	12	23	15	50	425
All decided claims'	39	35	7	18	1596

Source: Survey of new claimants.

Excluding 77 respondents who said that they took no notice of the decision letter.

Table 14.4 Claimants' levels of understanding of decision letter (AA sample)

Response to award	Level of understanding Very good (°/o)	Adequate (°/o)	Not good (%)	None (%)	Total (N)
Happy with award	49	40	4	6	146
Not happy with rejection	14	25	21	40	110
All decided claims'	34	34	11	21	256

Source: Survey of new claimants.

' Excluding 20 respondents who said that they took no notice of the decision letter.

The first point to note about the responses is that relatively small numbers of respondents said they did not take much notice of the reasons for the decision (five per cent of the DLA respondents and seven per cent of the AA sample). The majority of claimants, therefore, do read the information in the decision letter although 25 per cent of DLA respondents and 32 per cent of AA respondents said either that their understanding was not good or that they did not understand the letter at all.

Both tables appear to show the familiar *outcome effect,* reported levels of understanding being much lower among those unhappy with outcome of their claim. However, the high proportions of rejected claimants who said their understanding was `not good' or `none at all' (over 60 per cent for both DLA and AA samples) suggest the need for an explanation beyond people's general dissatisfaction with not getting the benefit. Most claimants who are successful possibly do not need a full explanation of how they satisfied the conditions of entitlement; to be told that they fulfilled the necessary criteria is explanation enough. However, rejected claimants and those unhappy with their award may want a clear, comprehensible explanation of why their claim failed or why a certain award was made. This would require an account of why the adjudication officer decided that, based on the information they gave on the claim form together with any other evidence (such as a GPFR or an EMP report), either they did not meet one or more of the eligibility criteria of the benefit or were not eligible for a higher award. At present claimants may not even know what evidence has been used to make the decision. The standard letters sent to rejected claimants state only that the claimant did not fulfil the conditions of either DLA or AA. There is no attempt to identify which conditions were not satisfied or why. A similar level of explanation is also sent to `successful' claimants.

The alternative to standard letters - personalised reasoned decisions - would be time-consuming and therefore expensive to produce. However, at present rejected claimants are frequently left not knowing why they did not meet the eligibility criteria. Furthermore, while the decision letter and the leaflet that accompanies it tell claimants what to do if they think the decision is wrong, they do not invite or encourage them simply to ask for an explanation. If comprehensive, comprehensible decision letters are thought to be prohibitively expensive, then the offer of a verbal or written explanation should perhaps be the least that is made to rejected claimants.

14.3 Contact to the Benefits Agency after getting decision

Relatively few respondents (122 DLA and 13 AA) contacted the Benefits Agency to find out more about their decision. Table 14.5 presents the levels of satisfaction reported by the DLA respondents only.

Table 14.5 Levels of satisfaction with contact to Benefits Agency after receipt of decision by response to award (DLA sample)

	Level of satisfaction					
Response to award	**Very satisfied** (%)	**Fairly satisfied** (%)	**Fairly dissatisfied** (%)	**Very dissatisfied** (%)	**Don't know** (%)	**Total** (N)
Happy with award	62	14	8	14	3	37
Not happy with award	18	29	16	18	18	38
Not happy with rejection	26	26	11	26	13	47
All decided claims	34	23	11	20	11	122

Source: Survey of new claimants.

NB Excluding bottom row of table. all percentages based on fewer than 50 cases.

It is not surprising that the majority of people making contact at this stage were unhappy with the decision on their claim. The relatively low aggregate level of satisfaction (57 per cent) is perhaps to be expected, therefore. However, it would be wrong to attribute the high level of dissatisfaction to the *outcome effect* alone. Giving a clear comprehensible explanation of a decision is not necessarily straightforward and would be difficult for anyone other than the relevant adjudication officer to attempt. It is not surprising that many people would still feel dissatisfied having made the effort of contacting the Agency.

14.4 Appeal intentions of claimants unhappy with initial decision

Any claimant dissatisfied with the result of their claim has a right to a review of the decision by an adjudication officer. Claimants can request a review for any reason within three months of getting the original decision. The review is carried out by the central DLA and AA Units in North Fylde, not by the DBC which made the original decision.

In the survey, respondents who said they were not happy with the result of their claim were asked if they intended to appeal against the decision." As Table 14.6 shows the responses of the DLA and AA samples were broadly similar.

Table 14.6 Appeal intentions of claimants unhappy with initial decision

	DLA		AA
Appeal intentions	**Unhappy with award** (%)	Rejected (%)	**Rejected**
Intend to appeal/seek review	24	29	22
Have appealed	38	35	38
Do not intend to appeal	21	16	22
Undecided	10	11	4
Did not know could appeal	7	10	15
Total	180	445	110

Source: Survey of new claimants.

This information on people's appeal intentions is difficult to interpret. There are, as far as we know, no directly comparable data relating to the `appeal rates' for other benefits. Part of the difficulty is in establishing what the population of eligible appellants might be. Strictly speaking, every decision, since it is made by an independent adjudication officer, can be subject to appeal, but basing an appeal

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[30] The question used the words -intend to appeal against the decision' rather than -seek a review' because experience from previous research has shown that the word 'review' is not widely recognised compared with `appeal'.

rate on all decided cases seems inappropriate. However, basing an appeal rate on rejected cases only is equally inappropriate since, as we have seen, many people with awards do appeal. Using `unhappy' claimants does seem more justified but. outside a special survey, it would be impossible to measure routinely. Nevertheless, one possible definition of an `appeal rate' is the proportion of 'unhappy' claimants who intended to request, or who had already requested, a review. Based on this definition both DLA and AA samples have an appeal rate of over 60 per cent. However, it is not possible from our survey data to calculate a final appeal rate, that is the proportion of those who actually did lodge an appeal, because we do not know how many of those who said they were going to appeal actually did so, and because some of our respondents (ten per cent) were still undecided. Nevertheless, we would estimate that the final appeal rate is likely to be slightly lower than our provisional figure of 60 per cent. Processing appeals (which in the case of DLA and AA means carrying out an internal review in the first instance) is time-consuming and has administrative costs. Our provisional appeal rate may not be surprising given the complexity of the benefits, but at over 60 per cent there would appear at least to be some scope for reduction. For example, if more 'unhappy' claimants were convinced of the correctness of the decisions on their claims, we could expect that fewer appeals would result.

Table 14.7 presents an analysis of the reasons respondents gave for making, or intending to make, an appeal.

Table 14.7 Reasons why people had appealed or intended to appeal

Reason for appealing	**Respondents mentioning reason** **DLA** (N)	 AA (%)
Decision was wrong/unfair	55	33
Need the award/help	22	38
Advised by someone to appeal	9	15
Condition has got worse	9	15
Other, less disabled people get benefit	8	9
Proper assessment not made (including not seen by a doctor)	7	0
Did not give sufficient information/forgot to mention something	6	5
No. of respondents	395	66

Source: Survey of new claimants.

Although claimants do not have to state well-argued grounds for requesting a review, most were able to give some idea of their motives behind appealing. All but two of the most common reasons stated could probably be construed as reasonable and proper grounds for appeal. The exceptions, in the sense that they provide the adjudication officer with no immediate basis for changing the decision, are requesting a review because the claimant needs the money and because other people get the benefit.

In an ideal world it might be hoped that the reason people do not appeal is that even though they do not like the decision on a claim, they nonetheless understand and accept the decision as correct on the basis of the information known to the adjudication officer. Even though 43 per cent of DLA respondents and 50 per cent of AA respondents said they had a very good or adeq- t-te understanding of ti t: decision, no one among respondents who were not Intc ding to appeal gave .- kind of response, as Table 14.8 shows. Even though (.'_lion letters state clef -I what people should do if they are unhappy with the decision, there were still around a quarter of the DLA sample and over a third of the AA respondents who said they did not know they could appeal. Among the others the most commonly stated reasons were all. what we might call, *resigned or fatalistic* in tone, that is they were to do with feeling that an appeal would be a waste of time, or feeling generally downhearted and depressed.

Table 14.8 Main reasons why people do not appeal/intend to appeal

	Percentage **of respondents mentioning reason'**	
Reason for not appealing	DLA (%)	AA (%)
No point a waste of time	29	30*
Did not know could appeal	25	36*
Felt downhearted/depressed	9	16*
Fed up filling in forms	7	5*
Turned down so often already	5	11*
Number of respondents	230	44

Source: Survey of new claimants.

Only the most common reasons appear in the table. Percentages will not sum to 100 per cent as a result.

* Percentages based on fewer than 50 cases.

Although it is probably inappropriate for a government agency actively to encourage appeals it would be equally unacceptable for *it* to discourage potential appellants, even inadvertently. There may be a case, therefore, for reviewing the information on decision letters about appeals to minimise the possibility of people being discouraged from exercising their right to a review.

14.5 Conclusion

This chapter has examined the period after a decision has been made by an adjudication officer. Most respondents considered the time that their claim took to clear was reasonable. Their responses could also be used to inform the definition of performance targets in the future. For example, the data suggest that although clearing claims in six to seven weeks might represent a good service, a clearance time of around four weeks would produce a majority of `very satisfied' claimants and so might represent an excellent service.

The evidence on people's understanding of their decisions is less comforting. At present the standard letters of rejection give claimants very little idea, if any at all, of why their particular claim failed. Successful claimants are no better informed but although some may not want an exact understanding, others will want more information, particularly if they wish to appeal against the rate or duration of an award. Even when people contacted the Agency to find out more about their decision, only just over half said they were satisfied with the contact. Although no one cited deficiencies in the decision letter as their main reason for seeking a review of their decision, it is not unreasonable to suggest that some, perhaps many, would not seek a review if they understood fully the reasons why they were rejected. In this way the current seemingly high `appeal rate' of over 60 per cent in the DLA and AA samples could be reduced. It seems a pity that the time and effort that the Benefits Agency has put in to help prospective and new claimants does not appear to be offered in equal measure to those who emerge at the end of the process as disappointed, rejected claimants.

Chapter 15 Claimant's Preferences of Assessment Method

Claimants' experiences of claiming DLA or AA is limited to filling in a claim form, or, in addition, responding to further enquiries from the Benefits Agency and possibly undergoing an examination by an EMP. They will usually be unaware if the Benefits Agency has asked for a factual report from their GP. From the claimant's viewpoint a claim is either assessed on the basis of information provided on the form, or on the basis of the form plus a medical examination. We asked respondents whether they would prefer, if they were hypothetically claiming for the first time, assessment by claim form only or by medical examination. This chapter presents their responses.

15.1 Preferences of the `decided claims' samples

Tables 15.1 and 15.2 present the preferences of the DLA and AA samples respectively.

Table 15.1 People's preferences of assessment method (DLA `decided claims' sample)

	Claimants assessed on form only			Claimants assessed by medical examination		
Preference	**Award! happy** (%)	**Award! not happy**	**Rejection/ not happy** (%)	**Award! happy** (%)	**Award/ not happy** (%)	**Rejection/ not happy** (%)
Form only	44	41	17	14	27	21
Medical examination	13	38	59	56	48	48
No preference	42	21	24	31	25	31
Total	778	117	356	302	59	83

Source: Survey of new claimants.

Table 15.2 Claimants' preferences of assessment method (AA `decided claims' sample)

	Claimants assessed on form only		Claimants assessed by medical examination	
Preference	**Aware! happy** (%)	**Rejection/ not happy** (%)	**Award/ happy** (%)	**Rejection/ not happy** (%)
Form only	50	21	19*	24*
Medical examination	13	49	41*	35*
No preference	37	30	41*	41*
Total	124	79	32	34

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

The first point to note from these tables is that around a third of both DLA and AA samples expressed no preferences at all about how their claim is assessed. When preferences were expressed it emerged that those claimants who were awarded a benefit and were happy with the outcome tended to prefer the method of assessment that led to the award, whether it was by form or following a medical examination. The picture for claimants unhappy with their decision was slightly different. Those rejected on the form only tended to state a preference for medical assessment. However, relatively few claimants rejected after a medical said they would have preferred to have been assessed on the form only.

The most common reason why people preferred a medical examination, mentioned by around a third of DLA and AA respondents alike, was that they wanted confirmation or verification of the information they had themselves supplied on the claim form. There was a commonly stated concern that their own honesty should not be in question. Around one in ten DLA respondents thought a medical examination would prevent people exaggerating or lying on their claim form. Just under a quarter of the DLA respondents preferred the medical because a doctor would be able to see directly the problems they suffered; and one in six said that the doctor was better able to provide an accurate picture of the effect of their disabilities.

Preference for assessment by claim form centred on three main reasons. First, there was a feeling, expressed by over 40 per cent of both DLA and AA respondents, that when a claim contains information from a GP or hospital doctor (in the supporting statements) there should be no need for a further medical. Second, there was a range of negative comments about doctors generally and about DSS doctors in particular (accounting for around a third of all reasons cited). Third, there were a number of positive responses to the claim form, for example that they were easy to fill in and that they collected sufficient information, mentioned by about one in six DLA and one in three AA respondents.

15.2 Preferences of the `claims in progress' samples

Table 15.3 presents the preferences of the `claims in progress' samples.

Table 15.3 People's preferences of assessment method (claims in progress' samples)

	Experience of assessment so far			
	DLA		AA	
Preference	**Form only** (%)	**EMP visit** (N)	**Form only** (%)	**EMP visit** (%)
Form only	33	19	34	7*
Medical examination	23	52	7	36*
No preference	45	29	59	57*
No.	220	75	212	42

Source: Survey of new claimants.
* Percentages based on fewer than 50 cases.

The picture from this table is similar to that from the decided claims samples. First, there are large proportions of claimants who expressed no preference (which are higher than for the decided claims samples). This suggests that when people get a decision their views become more polarised whether in favour of, or against, the method of assessment used on their claim. The second similarity is that people tended to state a preference for whatever method they had experienced up to the time they were interviewed. Thus we see very few AA respondents who said they preferred the alternative method to the one they had experienced. Seven per cent who had not had a medical said they would have preferred one, while seven per cent who had had a medical examination said they would have preferred assessment by form only. The proportions were higher for the DLA sample: 23 per cent and 19 per cent respectively.

15.3 Conclusion

The introduction of self-assessment forms was a major innovation into the assessment procedures for disability benefits and was widely welcomed at the time. It might have been hoped that the responses of our samples of DLA and AA claimants would have given a clear idea of whether claimants were content with the change. However, the results from the surveys provide neither a ringing endorsement for self-assessment nor suggest that there is widespread discontent. The picture provided by the `decided claims' sample is that people, understandably, are happy wi fiver method of assessment is necessary for them to get an award of benefit. That unsu ties- I claimants who had undergone an EMP examination did not state a preference for assessment by form is probably explained by a feeling that if one is going to lose then at least it is better to have had one's claim investigated through face-to-face contact. The responses of the `claims in progress' sample similarly shows that people's preferences are limited by their experiences. Most people were happy with what had happened to them so far.

If these results are a little frustrating in not giving a clear indication of where claimant preferences lie, then at least we can say that there is no overwhelming evidence against either self-assessment or medical examination.

Chapter 16 Analysis of Overall Satisfaction

The Secretary of State sets performance targets each year for different aspects of the administration of the social security system. Since these targets were introduced the Benefits Agency has had a target for °customer satisfaction' of 85 per cent across all benefits. Though equivalent targets have not been set for individual benefits, one of the main aims of this project was to measure the overall satisfaction of DLA and AA claimants with the service provided by the Agency, and to investigate how the different aspects of service contribute. In this chapter we draw on all the data concerning satisfaction from the surveys based on decided claims and on claims in progress in an attempt to address these issues.

Respondents were asked a single question about their overall satisfaction with the way in which the Benefits Agency had dealt with their claim. The first section of this chapter explores and compares the responses from the 'decided claims' samples and the `claims in progress' samples. The next section presents a summary and comparison of respondents' levels of satisfaction at the various stages of the claiming process when they come into contact with the Benefits Agency. Section 16.3 summarises the reasons given by respondents to explain their satisfaction or dissatisfaction. The fourth section attempts to shed light on the interaction between people's expectations of claiming and their experiences. Section 16.5 presents the results of a statistical analysis of the contribution of different aspects of claiming (including contact with the agency, letters and documents, and time taken) to expressed levels of overall satisfaction. In the penultimate section we reflect on the lessons of this part of the project for the future measurement of the satisfaction of DLA and AA claimants. The final section gives our concluding thoughts on claimants' overall satisfaction with the quality of service provided by the Benefits Agency.

16.1 Overall satisfaction of DLA and AA respondents

In Tables 16.1 and 16.2, we look at people's expressed levels of satisfaction with the whole claiming process. Table 16.1 compares the satisfaction of the DLA `decided claims' sample (broken down by whether respondents were happy with the result of their claim) with the responses of the claims in progress sample. The AA responses are in Table 16.2. Two statistical correlation tests, Kendall's Tau-c and Goodman and Kruskal's Gamma were carried out on the `decided claims' responses.[31] The reason for the shaded areas of the table will be explained below.

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[31] These two statistical tests were chosen because they are suitable for ordinal variables; that is, those having classified categories which fall iknto a natural *order* (for example, satisfaction, and happiness with award). Kendall's Tau-c and Goodman and Kruskal's Gamma are both tests of association for a contingency table using categorical variables rather than continuous data. Tau-c takes account of the rectangular nature of the tables (that is unequal numbers of rows and columns) while Gamma can be used for any configuration of table. Both vary between +1 and -1 which allows us to identify both the strength of association and its direction. A value of zero indicates no association. Gamma is particularly useful because high values (which indicate a strong association) are produced for associations which are not necessarily linear. For example, an association which concentrated all the values in a table along, say, the left-hand column and bottom row (i.e. around one corner of the table) would produce a value of 1.0 for Gamma (see Mueller *et al.,* 1970, pp. *288-90).*

Table 16.1 Analysis of overall satisfaction: comparing `decided claims' sample with `claims in progress' sample (DLA sample)

	Level of **overall satisfaction**					
	Very **satisfied** (%)	**Fairly satisfied** *(N)*	**Fairly dissatisfied** *(%)*	Very **dissatisfied** *(%)*	**Don't know** *(N)*	Total (N)
Happy with award		0				1085
Not happy with award			10		1	179
Not happy with rejection					4	453
All decided claims	51		7	7	2	1775
Claims still in progress	22	50	12	4	12	303

Source: Survey of new claimants.
(.) = < 0.5 per cent.
Kendall's Tau-C coefficient of correlation (for decided claims only) = 0.44.
Gamma value (for decided claims only) = 0.78.

Table 16? Analysis of overall satisfaction: comparing 'decided claims' sample with `claims in progress' sample (AA sample)

	Level of **overall satisfaction**					
	Very satisfied (%)	Fairly satisfied (%)	Fairly dissatisfied (%)	Very **dissatisfied** (~'))	**Don't know** (N)	Total (N)
Happy with award	1		2	1	5	168
Not happy with rejection					5	116
All decided claims	43	30	12	10	5	299
Claims still in progress	24	46	7	1	22	270

Source: Survey of new claimants.
Kendall's Tau-C coefficient of correlation (for decided claims only) = 0.46.
Gamma value (for decided claims only) = 0.80.

These tables, and their associated values for Tau-c and Gamma, give a clear picture of the *outcome effect,* described in Chapter 9, influences people's views of their overall satisfaction. The values of Tau-c can be interpreted as showing a moderate, rather than strong, linear correlation between people's feelings about the decision on their claim and their overall satisfaction. However, the high values of Gamma show that there is a stronger `corner effect' in the data. In other words, the correlation is not so much a simple linear one but more complicated, that is, the interaction between outcome of a claim and satisfaction tends to concentrate people's responses around one corner of a cross-tabulation (the shaded areas in the tables) rather than along a diagonal. This correlation does not directly explain the nature of the association between outcome and satisfaction but does allow us to offer a more detailed interpretation of the *outcome effect.* In practice, there appear to be two effects rather than a single one. First, among those claimants happy with their result there is a strong tendency to record `very satisfied' responses, and second, among the rejected claimants there is a tendency for responses to be spread, though not entirely evenly, among the range of possible options from `very satisfied' to 'very dissatisfied'. It appears that happy claimants will find very little to be dissatisfied with about the process of claiming. Being satisfied with the result means being satisfied with everything. In contrast, unhappy claimants are more likely to be able to untangle their feelings about their result and their views about the process. There *are* claimants who will be dissatisfied with the process because they are dissatisfied with the result but there is also a sizeable proportion who will put aside their disappointment and give a detached view of how the Agency dealt with their claim.

The impact of the *outcome effect* and the shortcomings of simplistic attempts to measure overall satisfaction have been recognised in other studies of consumer satisfaction (see, for example, Knight, 1994, Russell and Whitworth, 1992, Sainsbury, 1992). The results from this part of the project now lead us to challenge whether measuring overall satisfaction from a sample drawn from decided claims is a valid enterprise at all. We discuss this issue further in the section on the lessons that our research has for assessing satisfaction.

For the `claims in progress' samples there cannot be a *direct outcome effect* simply because there has been no decision on the claim. However, the pattern of responses from the DLA and AA samples does suggest that there is what we might call a *quasi-outcome effect.* This means that the *absence* of any outcome of the claim has influenced how people responded to the question about overall satisfaction. This *quasi-outcome effect* is manifested in two ways. First, the proportions of `don't know' responses are much higher in the `claims in progress' samples (12 per cent compared with one per cent in the decided claims sample for DLA, and 22 and five per cent respectively for AA). The effect of the `don't know' responses on the figure for overall satisfaction for the DLA sample is dramatic. Though the dissatisfaction scores are comparable, 14 per cent for the `decided claims' sample, 16 per cent for claims in progress, the combined satisfaction scores are, respectively, 84 per cent and 72 per cent. Excluding the `don't knows' from the calculation produces satisfaction scores of 86 per cent for `decided claims' and 82 per cent for the `claims in progress' sample. In contrast, the main difference in the AA samples is that dissatisfaction is much lower for the `claims in progress' sample (eight per cent) compared with `decided claims' (22 per cent). Unlike the DLA samples, the satisfaction scores are similar (70 and 73 per cent).

The second manifestation of the *quasi-outcome effect* is that relatively few respondents gave an emphatic `very satisfied' or `very dissatisfied' answer, around a quarter in each `claims in progress' sample compared with over a half in each of the `decided claims' samples. This suggests that knowing the outcome of a claim polarises opinion, and that until the outcome is known people tend to be more conservative in their assessments.

An alternative way of looking at the `claims in progress' results is to focus on the dissatisfaction scores. If we know that X per cent of respondents registered their dissatisfaction, then we are justified in saying that (100 - X) per cent *did not* register any dissatisfaction, at least at the time the survey was carried out. Using this perspective we can argue that since 16 per cent of the DLA sample and eight per cent of the AA sample said they *were* dissatisfied, 84 and 92 per cent of respondents respectively apparently had not had cause to be dissatisfied. It is not suggested that measuring a lack of dissatisfaction is an adequate or publicly acceptable substitute for measuring satisfaction directly. Neither measure is adequate on its own for describing the responses of all claimants, particularly when many of them are `don't know'. The important point is to recognise the limitation of apparently simple performance measures which in practice are trying to capture a complex concept such as `overall satisfaction'. We will return to the problem of measuring overall satisfaction in section six of this chapter.

16.2 Comparison of satisfaction at different stages of the claiming process

As we have seen in earlier chapters, the *outcome effect* is present in the responses of people to questions about satisfaction at specific stages of the claiming process. If we wish to make a valid comparison of satisfaction levels between each stage, therefore, we need the success rates of the subgroups of claimants making contact at each stage to be roughly comparable. In fact, the success rates for all stages *except* the EMP visit do not vary significantly around an average of 76 per cent. The success rate of respondents seeing an EMP is lower at 59 per cent. In the interpretation of Table 16.3 therefore it should be remembered that, due to the *outcome effect,* the satisfaction level at the EMP stage is probably slightly depressed compared with the other stages.

Table 16.3 presents a summary of satisfaction levels with each stage of the claiming process for the large DLA sample only; the numbers of AA claimants making contact with the Benefits Agency were insufficient for a comparable analysis.

Table 16.3 Summary of satisfaction levels at each stage of the claiming process (D sample)

Stage (see key)	Level of satisfaction Very **satisfied** (%)	Fairly satisfied (%)	Fairly dissatisfied (%)	Very dissatisfied (%)	**Don't** know (Yo)	Total (N)
	65	21	6	6	2	252
ll	70	16	6	5	3	158
III	49	35	6	5	5	442
IV	48	31	11	10	1	123
V	59	27	4	7	3	452
VI	34	23	11	20	11	122
Overall satisfaction	51	33	7	7		1807

Source: Survey of new claimants.
Key to stages:
I = Pre-claim. deciding whether to claim.
II = Help with completing claim form.
III = Contact from the Benefits Agency after claim submitted.
IV = Contact *to* the Benefits Agency after claim submitted.
V EMP visit.
VI = Contact *to* the Benefits Agency after decision received.

From this table we can see that the Benefits Agency appears to be delivering its highest quality service in giving initial advice, helping people complete the claim form, and carrying out EMP visits. Each of these stages attracts a combined (that is, `very' plus `fairly') satisfaction rate of 86 per cent, though help with the claim form had the highest proportion of `very satisfied' respondents (70 per cent). The contact from the Benefits Agency after the form has been submitted also gained a high combined satisfaction score (84 per cent). In contrast, the other two stages, responding to claimants' enquiries before and after the decision has been made, had relatively high dissatisfaction scores (21 and 31 per cent respectively).

This pattern of responses could reflect the priority placed on different aspects of service by the Benefits Agency since the initial troubled period following the introduction of the new benefits in 1992. Providing initial help and advice and help with completing the form, and ensuring the acceptability of the EMP visit, would have been understandable priorities given that the form and the changed nature of the doctor's visit were two of the main innovations in the processing of the benefits. The Benefits Agency would naturally have wanted these aspects of claiming to be working well. In contrast, responding to claimants' enquiries before and after the decision may not have attracted the same level of attention. Hence, there may not be a full appreciation of what people want when they contact the Agency and, however inadvertently, insufficient time or attention may be paid to their needs.

Another possible explanation is that when people contact the Agency with enquiries it may be very difficult for the staff to resolve the issue easily or quickly. A Benefits Agency officer may simply not have the information to be able to answer a person's enquiry about the progress being made with a claim, or to explain the reason why a particular decision was made. In contrast, when claimants contact the Agency for help and advice or for help in completing a form the person responding will probably be able to deal fully with any questions.

163 Summary of reasons for respondents' sa ction or dissatisfaction with each stage of the claiming process

In earlier chapters we have presented information summarising the reasons given by respondents for their satisfaction or dissatisfaction. Table 16.4 brings this information together and allows us to identify what appear to be the most important aspects of each contact between claimants or people acting for them and the Benefits Agency. As we described in Chapter 9 the reasons have been grouped into their three main types. First, there were reasons concerning the *substance* of the contact with the Agency, such as the quality of the help or advice received, or the information provided. Second, people commented about their *personal treatment* by the staff of the Agency: whether staff had been polite or rude, sympathetic or offhand. The third main group of reasons concerned the speed of response by the Agency to their enquiries.

Table 16.4 Types of reason given for satisfaction/dissatisfaction at each stage of the claiming process

	Stage of claiming process						
		H	III	IV	V	VI	All
Type of reason	(%)		(%)		(%)	(%)	(%)
Substance	51	62	40	53	18	45	40
Personal treatment	28	26	25	23	70	22	38
Time/speed	15	8	16	9	1	8	10
Others	6	4	19	15	11	26	13
Total number of reasons	388	213	603	179	597	167	2147

Source: Survey of new claimants.
Key to stages:
I = Pre-claim, deciding whether to claim.
II = Help with completing claim form.
III = Contact from the Benefits Agency after claim submitted.
IV = Contact to the Benefits Agency after claim submitted.
V = EMP visit.
VI = Contact to the Benefits Agency after decision received.

This table shows that, with the exception of the EMP visit, the substance of the contact with the Benefits Agency is cited most often as a reason for someone's satisfaction or dissatisfaction. From this it is reasonable to infer that the substance of the contact (for example, the quality of the information, help or advice received) is usually also the most important aspect of people's contacts with the Agency. The personal treatment of people is also clearly important but only becomes the dominant concern during an EMP visit. This is perhaps not surprising given the personal and possibly intimate nature of the doctor's questions and the fact that for most claimants this will be the only occasion when there is any face-to-face contact with someone from the Benefits Agency.

The patterns in the reasons for people's satisfaction and dissatisfaction appear to reflect the different types of contact that are possible between claimants and the Benefits Agency. The substance of the contact scores most highly when the claimant makes contact with the Agency. This is probably because people will only make contact themselves if they have a purpose in doing so. Primarily they will be looking for help, advice and information, they are not making contact in order to be treated nicely. When the Agency contacts the claimant (Stage III) *substance* still scores highly but there is also an above average score for *time.* This suggests that people value a quick response from the Agency after they have submitted their claim. If there is delay at this stage the impression could be created of an organisation unable to process claims efficiently.

16.4 Satisfaction and expectations

How people assess their level of satisfaction with a service is likely to be influenced by their expectations of that service. The interaction between satisfaction, expectations and actual standards of service can be complex, however, and difficult to untangle. Someone who says they are `very satisfied' with the service may have had high expectations which were met in practice. Alternatively they may have had low expectations, received a slightly better service than expected but nonetheless felt `very satisfied' as a result.

The relationship between satisfaction and expectations is a particular problem if one is trying to measure changes in satisfaction, say from year to year, at a time when efforts are also being made to improve a service. It is one of the frustrations of service providers that improvements in service will inevitably lead to higher, possibly unrealistic, expectations which may actually result in people expressing a lower level of satisfaction compared with the previous, inferior service if their new expectations are not met.

In this one-off survey it was not possible to investigate the effect of changing expectations on satisfaction levels. However, we did attempt to gather information on whether people's experiences were different from their expectations. We did this by asking respondents whether their expressed satisfaction or dissatisfaction with each stage of the claiming process was due to the Benefits Agency acting differently from how they expected. Respondents could place themselves in one of three groups: (a) experience was different than expected; (b) experience was as expected; and (c) respondent did not have any expectations. In Table 16.5 we present a summary of people's responses for each stage in the claiming process where they may have been in contact with the Benefits Agency. The data are for the large DLA sample only.

Thble *16.5* Comparison of people's experiences of claiming and their expectations (DLA sample)

	Respondents' comparisons of experience with expectations			
Stage **in claiming process (see key below)**	**Different than** expected (%)	As expected (%)	No **expectations** (%)	Total (N)
	48	15	37	239
	48	21	31	150
III	39	18	43	423
IV	38	24	38	123
V	32	17	51	436
VI	45	21	34	106
All stages	40	18	42	1477

Source: Survey of new claimants.
Key to stages:
I = Pre-claim, deciding whether to claim.
II = Help with completing claim form.
III = Contact *from* the Benefits Agency after claim submitted.
IV = Contact *to* the Benefits Agency after claim submitted.
V = EMP visit.
VI = Contact *to* the Benefits Agency after decision received.

This table has two interesting features. First, a large minority of respondents overall (42 per cent) said that they had no expectations before their contact with the Benefits Agency. The two stages with the highest scores for `no expectations' were the EMP visit (Stage V) and the contact *from* the Agency after the claim had been submitted (Stage III). This may reflect the possibility that the experience of an EMP visit will be new for many people, and that being contacted by the Benefits Agency, particularly directly by telephone, may be outside their normal expectations of dealing with a large organisation. Second, it appears that the stages where experiences differ most from expectations (I, II and VI) are also the stages with the highest proportions of respondents saying they were `very satisfied' (Stages I and II) or `very dissatisfied' (Stage VI) (see Table 16.3 above

In Table 16.6 we present an aggregation of respondents' satisfaction compared with their expectations for all aspects of the claiming process.

Table 16.6 Comparison of respondents' satisfaction with their experiences and expectations (DLA sample)

	Respondents' assessment of own satisfaction				
Comparison of experience	**Satisfied**		**Dissatisfied**		Total
with expectations	(N)	(%)	(N)	(%)	(N)
Different than expected	460	79	124	21	584
As expected	253	93	18	7	271
No expectations	560	90	62	10	622
All respondents	1273	86	204	14	1477

Source: Survey of new claimants.

From this table it is possible to infer that people who received the service they expected and those who had no expectations tended to be satisfied. Dissatisfied claimants, on the other hand, were concentrated among those whose experience was different than expected. Only a small percentage of people said they were dissatisfied but that the service was as they had expected. While this group can be thought of as having poor expectations of service, they were a small percentage of all dissatisfied claimants (actually 18 in number, or nine per cent of the 204 respondents in this category).

The Benefits Agency will clearly want to satisfy as many claimants as possible. However, the group of 253 claimants who said the service was as they as expected and that they were satisfied is particularly interesting. They could be considered the sort of claimants that the Benefits Agency might like to create, that is. people with high expectations of the service they receive (reflecting a positive view of the Agency) and whose expectations are presumably met since they register themselves as satisfied. The 253 responses in this category represent 17 per cent of all 1477 responses, or 30 per cent when the 'no expectations' category is excluded.

16.5 Statistical analysis of factors contributing to overall satisfaction

One of the aims of the whole project was to measure, if possible, how different aspects of quality of service contribute most to people's overall levels of satisfaction. We hypothesised that the aspects of claiming that might contribute to overall satisfaction were people's satisfaction with any contacts they might have had with the Benefits Agency, their experiences of official forms and letters, the time taken to process the claim, and the result of the claim. We then identified the following questions in the questionnaire which we could use as appropriate indicators of these aspects:

a. satisfaction with initial help and advice

b. extent of difficulties with the claim form

c. satisfaction with help in completing the claim form

d. satisfaction with the contact fi-om the Benefits Agency after submitting a claim

e. satisfaction with contact to the Benefits Agency after submitting a claim

f. satisfaction with the visit from an EMP

g. time taken to process claim

h. the result of the claim

understanding of decision letter sent by the Benefits Agency

j. satisfaction with contact to the Benefits Agency after receiving decision.

We then applied a CHAID analysis to these factors for the samples of DLA and AA decided claims. A CHAID analysis allows us to find those factors or variables, or combinations of factors or variables, which best predict satisfaction levels. The result of the analysis was that the outcome of a claim was such a dominant predictor of satisfaction that no other factors emerged as additional predictors. While this was not unexpected given the findings reported in earlier chapters, it does raise serious doubts about whether it is possible at all to measure levels of satisfaction with quality of service alone. We will return to this issue later in the chapter.

Notwithstanding the finding from the CHAID analysis that the outcome of a person's claim overwhelms all the other aspects of claiming as an influence on overall satisfaction, we can use logistic regression techniques to identify whether, and to what extent, each aspect makes any contribution at all. We can then rank these factors in order of greatest influence.

We therefore examined in turn all the factors listed above excluding the result of the claim. In Table 16.7 we present the `OR' statistic from the logistic regression. This allows us to estimate the strength of the influence of each factor on overall satisfaction. How to interpret the OR is best explained by using an example. In Table 16.7 the OR for satisfaction with the initial help and advice received from the Benefits Agency is 3.0. This means that people who were satisfied overall with the Agency's quality of service were three times as likely to be satisfied with the initial help than respondents who were dissatisfied overall.

Table 16.7 `OR' values from logistic regression to test contributions of different aspects of claiming process to overall satisfaction

Aspect of claiming		OR values' **DLA**	 AA
a.	Initial help and advice	3.0	16.6
b.	Experience of claim form	1.6	1.0
c.	Help with completing form	3.6	3.7
d.	Contact *from* BA after submitting claim	4.9	7.8
e.	Contact *to* BA after submitting claim	11.4	3.7
f.	EMP visit	3.3	4.9
g.	Time taken to process claim	5.2	5.1
i.	Understanding decision letter	5.9	8.1
j.	Contact *to* BA after receiving decision	3.7	11.5
Number of claimants		1807	304

Source: Survey of new claimants.
All OR values are statistically significant.

The research question we are attempting to address in this analysis is which aspects of service contribute most to people's overall satisfaction. In Table 16.8 therefore we have placed the different aspects of claiming in order of their OR values.

Table 16.8 Rank order of `OR' values for different aspects of claiming process ('decided claims' samples)

Aspect of claiming		Rank order of OR values' **DLA**	 AA
e.	Contact *to* BA after submitting claim	1	8=
i.	Understanding decision letter	2	3
g.	Time taken to process claim	3	5
d.	Contact *from* BA after submitting claim	4	4
j.	Contact to BA after receiving decision	5	2
c.	Help with completing form	6	8=
f.	EMP visit	7	6
a.	Initial help and advice	8	1
b.	Experience of claim form	9	9
Number of claimants		1807	304

Source: Survey of new claimants.
All ORs are statistically significant.

This table has a number of interesting features which have possible implications for the way in which the Benefits Agency might think about its strategy to improve quality of service further. Looking at the DLA sample initially, it can be seen that the aspects of the claiming process after submitting a claim occupy the higher places in the table (the exception being the EMP visit which comes lower down). What happens in the initial stages of claiming would appear to contribute less to overall satisfaction. It seems surprising that initial help and advice and help with completing the claim form (Stages a. and c. in the table) appear to make less of a contribution to overall satisfaction than other aspects of claiming. The Benefits Agency has made particular efforts in these areas and as we can see from Table 16.3 earlier, they attracted the highest proportions of `very satisfied' responses compared with other stages in the claiming process.

Interpreting the ranking of OR values for the AA sample is more difficult. In contrast to the DLA sample, the initial help and advice received (the earliest contact anyone can have with the Agency) appears to have contributed most to overall satisfaction. Conversely, contact to the Agency after submission of the claim had much less of an influence than for DLA respondents. Apart from these main differences, however, we find similar ranking places for the other aspects of claiming.

If we return to the DLA sample there are two observations we can make which might explain the apparent paradox that areas of high satisfaction seem to influence overall satisfaction least. First, the result in Table 16.8 may be an effect of the way in which the questionnaire was structured. The questionnaire took the respondent through a chronological sequence starting with questions about deciding to claim and ending with their actions after receiving the decision. The question about overall satisfaction came afterwards at the end of the questionnaire. It is possible that, when people were thinking about their responses to this question, earlier experiences of the claiming process were not uppermost in their minds and this was reflected in their assessment of overall satisfaction.

The second explanation is that the information in the table is actually a reflection of people's relative dissatisfaction with some stages of claiming compared with others. In Table 16.9 we compare two sets of rankings of the six stages at which claimants might come into contact with the Benefits Agency. The left-hand column ranks the stages in order of the scores of `very satisfied' respondents from the highest score to the lowest (using Table 16.3). The right-hand column ranks the stages according to the contribution each makes to overall satisfaction, but this time from the stage contributing least to the stage contributing *most.*

Table *16.9* Comparison of rankings of each stage in claiming process according to (a) very satisfied scores, and (b) contribution to overall satisfaction (DLA sample)

	Rankings of each stage in claiming process according to:	
Rank	**Very satisfied scores (high to low)**	**Contribution to overall satisfaction (least to most)**
1st	II - Help with form	- Initial help/advice
2nd	I -- Initial help/advice	V EMP visit
3rd	V EMP visit	II - Help with form
4th	VI - Contact after decision	VII - Contact after decision
5th	III - Contact *from* BA after submission of claim	III - Contact *from* BA after submission of claim
6th	IV - Contact *to* BA after submission of claim	IV - Contact to BA after submission of claim

Although the rankings do not match precisely, Stages I, II and V occupy the top three places, and Stages III, IV and VI occupy the last three places in both sets of rankings. This suggests that satisfaction with Stages I, II and V is less important than dissatisfaction with Stages II, IV and VI in contributing to overall satisfaction. Another way of looking at these results is to suggest a probably familiar picture to providers of any service. The amount of approval an organisation gets when things are going well is not as great as the criticism received when they are not.

16.6 Lessons for the measurement of satisfaction

The results from this part of the project raise serious questions about the usefulness of overall satisfaction measures applied to samples of people whose claims have been decided. The strong influence of the outcome of a claim on satisfaction scores of individual respondents has been repeatedly demonstrated in this and earlier chapters. The overall satisfaction score of our DLA sample of 84 per cent (see Table 16.1 above) compares with a success rate of 74 per cent. In contrast, the AA sample recorded a lower overall satisfaction rate of 73 per cent (Table 16.2) and a lower success rate of 58 per cent. Our conclusion is that a score for overall satisfaction is primarily an indication of people's satisfaction with the result of their claim, rather than with the quality of service provided by the Benefits Agency.

In spite of this conclusion it is likely that a performance target based on overall satisfaction will remain part of the Benefits Agency's Business Plan in the near future. The Secretary of State's target figure of 85 per cent satisfaction across all social security benefits is, at present, still in place. In many ways such a target is a hostage to fortune. For example, it would be hard to argue that satisfaction targets for individual benefits should be anything other than 85 per cent. The evidence of this project is that such a target is unlikely ever to be achieved for attendance allowance while the proportion of successful claims remains at the relatively low level of between 55 and 60 per cent. Yet to suggest that, because of this, the target for AA should be lower than for other benefits, say 75 per cent, would possibly give the Agency and the DSS enormous presentational difficulties. Also there is the general problem of all satisfaction surveys of how to treat neutral or `don't know' responses in the calculation of overall satisfaction. This problem was demonstrated in the second National Customer Survey carried out by the Agency in 1992. An increase in the proportion of neutral responses over the previous year contributed to the achieved overall satisfaction score falling below the 85 per cent target, when in practice there had not been an increase in the proportion of dissatisfied claimants. What was partly a statistical effect also proved to be a Departmental embarrassment. Coincidentally the same effect is present in the measure of overall satisfaction for the DLA sample. Including the `don't know' responses in the calculation gives the satisfaction rate of 84 per cent mentioned above. If we exclude them, however, the rate rises to 86 per cent.

The attempt to circumvent the problems of the outcome effect, in the `claims in progress' survey, has only been partially successful. We have already commented how there appears to be a *quasi-outcome effect* present in the responses of our `claims in progress' samples. As explained earlier, there was a large number of `don't know' responses and a greater tendency of other respondents to choose one of the `fairly' responses. In comparison the `decided claims' samples were more likely to opt for more clear-cut (that is, `very') responses. Our interpretation of this pattern of responses is that many people are unwilling to commit themselves to definite responses, or any response at all, until they know the result of their claim. Alternatively, people may not wish to give negative responses for fear (however unfounded) of the Benefits Agency retaliating in some way (an effect noted in the literature on satisfaction surveys).

We also saw, for the DLA `claims in progress' sample, the dramatic effect of relatively high numbers of `don't know' responses on the figures obtained for overall satisfaction. While the proportion of people who said they were satisfied was 82 per cent of those giving a definite response, this figure falls to 72 per cent when the `don't knows' are included in the calculation. This difference raises difficulties in the calculation, interpretation and presentation of a satisfaction score derived from a `claims in progress' sample.

It is also unclear exactly what a `claims in progress' survey is measuring in the responses to a question about overall satisfaction since, by definition, respondents will not have completed the whole of the claims process. Our sample comprised roughly equal numbers of claimants three, five and seven weeks after submitting their claims. Although the differences are not large, there is a tendency for the satisfaction levels of claimants to fall the longer the claim takes. This is not surprising, both intuitively, and because our logistic regression analysis showed that, excluding the result itself, the time taken to process a claim made the second largest contribution to overall satisfaction among all the aspects of the claims process.

16.7 Conclusion

In this chapter we have presented data on the overall satisfaction of DLA and AA claimants and people acting for them from the `decided claims' and the `claims in progress' surveys. We have also attempted to identify which aspects of claiming contribute most to overall satisfaction and how people's expectations affect their experiences.

Asking people to assess their overall satisfaction with a service and presenting their responses is easy. Only a single, simple question is necessary. However, interpreting the responses is less straightforward. The strong correlation (the *outcome effect)* between the outcome of claims and people's reported levels of satisfaction in the `decided claims' sample indicates that our question was producing more a measure of people's reaction to their result than of the quality of service they received. Furthermore, basing an overall satisfaction measure on a `claims in progress' sample does not completely overcome the outcome effect.

The outcome effect is also evident at all stages of the claiming process. However, it is not possible always to attribute negative answers to questions about experience or satisfaction to a *causal outcome effect.* For example, the form may genuinely be less helpful for some groups of claimants who then have more rejections. Their expressions of dissatisfaction with the form are likely to be as much rooted in genuine grievance as a reflex response to an adverse decision.

Our conclusion is that the value of *overall satisfaction* as a performance target or measure must be seriously doubted. Asking about people's satisfaction with separate aspects of the claiming process is more useful. An *outcome effect* is still there, but by comparing satisfaction levels across different stages of claiming, valuable lessons can be learned about where efforts to improve service might best be placed.

The functional, operational value of satisfaction measures will only be established if practical use *is* made of them. Their use as instruments of public accountability, as a way of demonstrating to the public and other interested parties, that the service is performing well is much more limited and probably unwarranted. An indicator which does not measure what it is supposed to and is also sensitive to external factors or statistical effects is probably best avoided altogether. For the Benefits Agency, an overall measure of satisfaction serves very little, if any, functional purpose. For those charged with presenting and explaining such a measure publicly, it is potentially a liability.

Chapter 17 Summary, Discussion and Conclusion

Part Two of this report has presented the findings of our investigation into the quality of service provided by the Benefits Agency to people claiming DLA or AA for the first time. We set out to evaluate whether the objective of a more straightforward and transparent claims process has been achieved by measuring, and exploring what influences, the expressed satisfaction of DLA and AA claimants. In Chapters 10 to 16 we have presented an analysis of people's experiences of completing the new claim forms, their views on the time taken to process their claims and their perceptions of, and satisfaction with, their dealings with the Benefits Agency.

In this chapter we summarise the main findings of the surveys of new claimants and draw together the main lessons for the future delivery of the two benefits.

17.1 Main findings: contacts between claimants and the Benefits Agency

In our structured questionnaires we explored six stages at which claimants or people acting on their behalf might come into contact with the Benefits Agency. These contacts fell into two different types. First, there were the occasions when the claimant contacted the Agency: to get initial help and advice before claiming; to get help with completing the claim form; to make enquiries or supply more information after the claim had been submitted; and to find out about the decision once it had been received. Second, there were times when the Agency was responsible for the contact, either to collect more information for the claim form or when an EMP visited the claimant.

In the first type of contact we found that the *substance* of the contact, that is the help, advice or information received, was the most important aspect of the contact for the claimant. The substance of the contact was mentioned more often in people's explanations of what made them either satisfied or dissatisfied than either their personal treatment by Agency staff or the time involved in the contact (the two other main reasons cited by respondents). The implication of this finding for the Agency is that when people contact them they are doing so with a purpose, either to obtain some form of help or to get information. Most satisfaction is created if people's questions or enquiries are answered adequately. The evidence from this project is that the Agency performs better in giving help and advice to people than it does in keeping people informed about their claim or in explaining the outcome of their claims.

When the Agency gets in touch with the claimant for further information or to check something in the claim form the nature of the contact is different. Here it is the Agency which has a purpose, not the claimant. In consequence the relative importance of the substance of the contact and the speed with which the Agency acts changes. The lesson for the Agency is simply to emphasise the importance of dealing quickly with any initial deficiencies or discrepancies in the information supplied by the claimant on the claim form. The contact between the EMP and the claimant is the most distinctive of all the stages in the claiming process. It is face-to-face, involves a medical professional, and will potentially involve questions of an intimate, personal or embarrassing nature. The EMP visit, though different from its equivalent under the old MobA and AA schemes, nevertheless is the one element of the new arrangements that might be seen as an unwelcome inheritance from former days. The evidence, however, is that for most claimants who are required to undergo an EMP examination (around 25 per cent of both DLA and AA samples) the encounter was largely unproblematic. The satisfaction levels reported by respondents matched the high levels achieved for the early stages of claiming.

Whether *the* levels *of* satisfaction achieved *at each stage of* the claiming process represent acceptable standards *of service,* notwithstanding *the outcome effect,* cannot be resolved by logical argument. What *is* acceptable or *not is a* subjective, and increasingly *in* relation to public *services, a* political *choice.* The Secretary *of* State *has* introduced the figure *of* 85 *per cent as the target* for customer satisfaction *across* all social security benefits. Whatever *the* merits or demerits *of this* figure might be, *it is* possible to adopt *it as* representing one indicator *of the* dividing line between acceptable *and* unacceptable standards *of service.*

For each of the six *stages of* the claiming process *we* asked *our survey* respondents *to assess their* own satisfaction *with* the *service of the* Benefits Agency. Ignoring for *the* moment *the outcome effect,* the levels *of* satisfaction reported by *the* DLA `decided claims' sample were *mainly* around *the* 85 *per cent* level, dropping below for only *the* two contacts involving claimants asking *for* information *about* their claim, or for information about *their* decision.

17.2 Main findings: other aspects of the claiming process

The *claiming process* does *not* only involve direct contact between claimants and *the* Benefits Agency. *We* also investigated other aspects *of* claiming: *the* new claim *forms, the* information provided *about decisions,* and *the* time taken to complete *the* whole claiming process. *The aim here was not* primarily to measure *satisfaction* but *to assess the* usefulness *of the form,* people's levels *of* understanding about *decisions,* and their *notions of* what constitutes *a reasonable* time to allow *the* Agency *to* process claims.

The claim forms clearly have a difficult job to do. They must collect basic information about claimants, details about their illness or disabilities, and a large amount of information about how their everyday lives are affected by disability. They must also be relevant for people with any type or severity of illness or disability. The majority of respondents found the forms helpful but it was not surprising that we found a range of difficulties and shortcomings with the claim forms.

At present the form is long and, in places, repetitive. Many claimants found difficulty, not always because of the form, in conveying the extent to which their illness or disability affected their everyday activities; a sizeable minority said that they presented a better picture of themselves than was really the case. The evidence that around a quarter of the DLA claimants in our `decided claims' sample had been contacted by the Benefits Agency after they had submitted their forms suggests that many claims are not completed or are completed inadequately. In a project based on a quantitative survey it is not possible to identify precisely where the claim forms could be improved. However, the responses from people experiencing difficulties (presented in Chapter 11), and the evidence that people with certain types of medical condition (such as mental illness) find the form less helpful than others, will provide policy makers with indications of the types of improvement that would most assist future claimants.

In Chapter 14 we analysed people's perceptions of how long their claim took to clear and their views about whether this constituted a reasonable wait. Most DLA and AA respondents considered their own clearance time reasonable although nearly a quarter of the AA sample thought the opposite. The data presented could inform a review of performance targets for internal clearance times and provide a basis for targets predicated on claimant expectations and demands.

The one area of service where the Benefits Agency seems to be performing significantly below the standards achieved in other areas is in the information given to claimants about the decision on their claim. One aim of the more `transparent' claiming process that accompanied the introduction of the new benefits was to facilitate people's understanding of adjudication officers' decisions. However, letters to claimants do not explain decisions beyond standard phrases about meeting or not meeting the conditions for entitlement. Furthermore, there is no offer of an explanation of the decision in the letter or in leaflets accompanying the decision. It is not surprising, therefore, to find low levels of understanding among people whose claims were rejected - over 60 per cent for both DLA and AA samples. Our findings suggest that fewer successful claimants require as much detail about the decision although those unhappy with an award might welcome a fuller explanation, particularly if they are contemplating an appeal.

We have seen that the quality of service offered to people in the process of claiming has generally met with their satisfaction. However, the `after-care' service offered to rejected claimants does not meet with the same approval. As we concluded at the end of Chapter 14 it seems a pity that the attention paid to people when they are prospective and new claimants does not appear to extend to them if their claims are ultimately rejected.

17.3 Improving quality of service in the future

In addressing the main research questions of assessing the impact of the new assessment procedures and measuring claimant satisfaction, we have also been able to identify aspects of service where there is possible scope for development and improvement. While these have already been discussed in the relevant chapters, this section presents them in summary form. The suggestions listed below are mainly in the form of ideas that would warrant further investigation. It was not the aim of the research to evaluate such ideas.

Ideas from Chapter 11 - Completing the Claim Form

- Allow GP surgeries to hold and distribute claim packs.
- Reassess layout and wording of Section 1 of the claim pack to assist claimants more in *naming* their disabilities or illness.
- Reassess layout and wording of Section 2 to assist claimants more in describing the effects of their condition on their everyday lives.
- Consider how claim forms could be made more relevant to people with mental illnesses.
- Consider whether and how to reduce the number of people disadvantaged by two-part claim form.
- Encourage more claimants to provide *supporting statements* as part of their claims.
- Investigate why claims are awarded on the basis of forms which contain no supporting statements and where no further evidence has been collected.

Ideas from Chapter 12 - After the Claim

- Investigate use of telephone sections by adjudication officers.
- Reassess procedures for handling enquiries from claimants after claim has been submitted.

Ideas from Chapter 13 - The EMP Examination

- Investigate adjudication officers' practices in ordering EMP reports.

Ideas from Chapter 14 - Getting the decision

- Reassess clearance targets using data on claimant experiences and expectations.
- Improve quality of information about decisions provided in decision letters.
- At least offer claimants the opportunity of receiving a full explanation if required.
- Review content of decision letters to reduce the possibility that people might be discouraged from seeking a review.

These ideas reflect the need for consolidation and incremental improvement rather than for radical change. That most people in our surveys expressed satisfaction with most aspects of service provision indicate that radical change is not required.

17.4 Overall satisfaction: *outcome* and *quasi outcome effects*

Satisfaction surveys of all kinds are dogged by the *outcome effect.* In our 'decided claims' survey the effect is so strong in influencing people's reported levels of satisfaction that, in practice, our overall score is more a measure of people's reaction to their result than with the quality of service they received. The conclusion, therefore, from our analysis in Chapter 16 was that a measure of overall satisfaction was neither valid *per se* nor served much, if any, useful purpose for the Benefits Agency.

The attempt to overcome the *outcome effect* by measuring the satisfaction of people whose claims had not been decided was only partially successful. Our 'claims in progress' survey was always intended to be something of an experiment. A relatively small sample of claimants was interviewed and a very abridged version of the `claims' questionnaire was used. We were therefore unable to gather a comparable level of detail (through the use of open-ended questions, for example) about people's experiences of claiming. The main lessons coming out of the experiment are twofold. First, the `claims in progress' survey did not escape altogether the influence of the *outcome effect* but was subject to its own variant which we have called the *quasi-outcome effect.* This produced a tendency for people to be more conservative in their responses when they gave one, and a large number of respondents unwilling to give any assessment of their own satisfaction at all. Second, any future attempts at conducting such a survey must pay attention to sampling issues. In our survey, we hypothesised that people's satisfaction might change the longer their claim was taking. We therefore constructed our sample to include claimants whose claims were submitted three, five and seven weeks before the date of interview. While this approach produced some interesting results, the sample cannot be considered as representative of all claims in progress. A truly representative sample would comprise a random selection of claimants immediately before they received their decision.

The `claims in progress' experiment has, in the manner of experiments, generated a number of ideas for testing in the future. Certainly, if the experiment is to be extended to other areas of social security then it is recommended that a full questionnaire (comparable to our `decided claims' version) is used and that more representative sampling is attempted.

17.5 Disaggregating satisfaction

While the results of trying to measure overall satisfaction must be treated with the utmost caution, the findings from looking at the individual aspects of claiming can be viewed with more confidence. In general, the *outcome effect,* though still present, was not so strong when people were responding to questions about specific experiences, whether about forms and letters or about contacts with Benefits Agency staff. Furthermore, the reasons for people's satisfaction are useful indicators of where improvements in service could be attempted.

When we used regression analysis to identify which aspects of service most influenced overall satisfaction, apart from the decision on the claim we found, apparently paradoxically, that those contacts with claimants which attracted the highest satisfaction scores contributed least. However, as we explained in Chapter 16 it is possible to construct a plausible explanation for this result based on the idea that people are less influenced in their opinions about services by what is done well compared with what is not.

This result is useful in reinforcing the lesson emerging from the analysis of the separate stages in the claiming process. It is in the areas where claimants want information about their claim and decision from the Benefits Agency that efforts to improve quality of service could increase levels of overall satisfaction.

Our analysis also suggests, however, that we have found a temporary phenomenon. What we have identified as making the largest contributions to overall satisfaction is possibly a reflection of the standards of service currently provided at different points in the claiming process. If some other aspect of service, such as the initial advice given to claimants, had attracted the lowest satisfaction score we would have expected it to have contributed most to overall satisfaction. The set of priorities that is suggested from this survey could therefore be expected to change if such an exercise were repeated in the future.

17.6 Final comments

Two of the aims of DLA and AA were to introduce a more straightforward and transparent claims process and to improve the quality of service provided to claimants. These are both *relative* aims, inviting comparison with procedures and standards associated with benefits which no longer exist. Attempting such a comparison, of unlike systems, is probably of doubtful validity even if a comparable survey of satisfaction had been carried out for the old benefits. What we have attempted, therefore, is to obtain measures of people's experiences of the new procedures and to interpret them in ways which provide an idea of how well the Benefits Agency is performing, not in relation to obsolete systems, but according to standards derived from the claimants themselves. In doing so, we also get indications of where improvements in service are most needed.

What we have discovered is a generally healthy picture. The standards of help and advice provided from all arms of the Benefits Agency to potential and new claimants were well regarded. The policy of being more proactive in obtaining good information on which adjudication officers can make their decisions similarly attracted high levels of satisfaction. The role of medical practitioners, much criticised under the old MobA and AA schemes, has been reduced considerably and again produced high levels of satisfaction. Where improvements are most needed is in the format and content of the claim forms, in the provision of information to claimants when the claim is being processed, and especially after the decision has been made. In particular, the content of decision letters must be considered as the main failure in what is intended to be a *transparent* claims process.

After the traumas of 1992, following the introduction of the new benefits, it is clear that the Benefits Agency is now in a period of relative stability. While we have shown where improvements in service could be made and how the claims process could become more transparent, we have not identified any major areas of lingering discontent. Rather, the levels of satisfaction reported by claimants with nearly every aspect of the claiming process provide, two years after they were introduced, an endorsement of both the new procedures and of their implementation by the Benefits Agency.

PART THREE

The Quality of Service Studies for Claimants Pursuing Reviews and Appeals

Chapter 18 Introduction to the Reviews and Appeals Study

In Part Two of this report we examined the experiences of people making initial claims for either DLA or AA. In Part Three we now concentrate on claimants who, unhappy with their original decisions, take advantage of the opportunity to have their decision reconsidered. In this chapter we explain the background to the review and appeal arrangements open to claimants and describe how the internal review of decisions and the new DAT operate. In subsequent sections we explain the methods adopted for this part of the project and discuss the sampling strategy for the DLA survey samples.

18.1 Background and aims of the reviews and appeals study

The eligibility criteria for the old attendance allowance and mobility allowance benefits were mainly medical in nature. The remaining, `lay' conditions mainly concerned the age of the claimant and how long he or she had lived in this country. Any claimant, for either benefit, whose claim was rejected on one of the lay conditions had a right of appeal to a Social Security Appeal Tribunal (SSAT). However, the arrangements for dealing with appeals against rejections based on the medical criteria were different for the two benefits.

Attendance allowance claimants dissatisfied with the outcome of their initial claim had no right of appeal to an external body such as an independent tribunal, but could apply to the Attendance Allowance Board for a *review* of the original decision. This was usually carried out on the basis of the casepapers only by a doctor employed by the Board. In contrast, dissatisfied mobility allowance claimants had an initial right of appeal to a *medical board* comprising two doctors appointed by the Department of Social Security; and a further right of appeal to an independent Medical Appeal Tribunal (MAT).

The inconsistencies between these two sets of appeal arrangements were removed with the introduction of Disability Living Allowance and the new Attendance Allowance. Now, both benefits share a common, two-tier appeal structure. At the first tier, a claimant dissatisfied with the outcome of an initial claim may request a review of the decision carried out by a different adjudication officer to the one who made the original decision. If the claimant is still dissatisfied there is a right of appeal to a new independent tribunal, the Disability Appeal Tribunal (DAT).

18.1.1 The internal review stage

In the past there has been a relatively clear distinction between appeals and reviews for most social security benefits. Generally, an appeal can be made on any grounds by a claimant dissatisfied with an initial decision, but has to be made within a specified time, usually three months. In contrast, the purpose of a review has been to alter a decision where fresh evidence has been provided on a claim or where there has been a relevant change in a claimant's circumstances, and to correct mistakes (in the facts or the law) in the original decision. There is no time limit to requesting or making reviews. This distinction between the purposes and conditions of appeals and reviews applies to most social security benefits, such as income support, retirement pensions, child benefit and family credit.

Under the DLA and AA regulations the internal review has a dual purpose. It retains its traditional role as an administrative means of changing decisions easily, but it also serves as a first tier appeal. This is achieved by having separate rules for reviews *within three months* and *outside three months.*

A request for a review within three months of the initial decision can be made on any grounds. Requests made after three months are only valid on a limited range of grounds, including when there is a change in the claimant's circumstances (such as a deterioration in their medical condition), or when the original decision was wrong in law or based on a mistake or ignorance of some material fact. The *within three months* review shares the essential characteristics of the traditional appeal. After three months the review reverts to its traditional role of dealing with changes in circumstances and correcting mistakes.

Initial decisions on claims are made at one of the 11 Disability Benefit Centres in Britain. Reviews are handled at either the DLA Unit or AA Unit as appropriate in the North Fylde Central Office. The adjudication officers who carry out reviews can, like their DBC counterparts, request further information from the claimant or someone involved in their care, including their doctor, or arrange for a visit by an EMP.

18.1.2 Disability Appeal Tribunals

Claimants who have applied for a review *within three months* and are still unhappy with the review decision have a right of appeal, on any grounds, to a Disability Appeal Tribunal (DAT). The appeal must be lodged within three months of the review decision. Decisions made on *outside three month* reviews are treated as having the same status as initial decisions. This means that a claimant will need to request a further review in the first instance (that is, *a within three months* review) rather than appeal directly to a DAT.

The DAT has some distinctive characteristics, in its structure and practices, compared with Medical Appeal Tribunals and Social Security Appeal Tribunals. For example, its membership differs from both, comprising a legally-qualified Chair, a doctor (usually a GP) and a person who has experience of disability or working with disabled people. Also, unlike MATs, DATs *cannot* require an appellant to undergo a medical examination or to demonstrate their walking ability, although they can ask for additional medical evidence to be obtained.

DATs, like other tribunals dealing with social security issues, are intended to be *inquisitorial* in nature, rather than *adversarial,* with the members actively participating in gathering the information they need to make a decision. Appellants have the opportunity of appearing before the tribunal in person and of being represented or accompanied by another person, or of providing more information about their claim.

18.1.3 Aims of the research

Reviews and appeals are dealt with by very different procedures. The aims of the research therefore fall naturally into two groups, though some of the areas of interest are common.

The principal aims of the study concerning *reviews* were:

- to understand the reasons why people apply for a review
- to investigate their expectations of, and knowledge about, the review process
- to investigate people's views about the time taken to process reviews
- to assess people's satisfaction with the review process.

The principal aims of the study concerning *appeals* were:

- to understand the reasons why people appeal beyond the internal review to investigate their expectations of, and knowledge about, the tribunal hearing

- to investigate people's views about the time taken to hear appeals
- to investigate appellants' experiences of the tribunal hearing
- to assess people's satisfaction with the tribunal, and with the whole process of claiming.

18.1.4 Methods

The review and appeals studies were conducted using a single research method, a quantitative survey carried out by Social and Community Planning Research (SCPR) in the spring of 1994. Separate questionnaires were developed by SPRU for the sample of claimants whose claim had been subject to review, and for the sample whose appeals had been decided by a Disability Appeal Tribunal.

The DSS was interested in the experiences of people who had applied for a review primarily because they wished to challenge the initial decision rather than as a consequence of their condition worsening. The sample of review applicants was therefore limited to those requesting *within three months* reviews only. It was drawn in March 1994 from reviews registered within the previous three months. The target sample size was 300 each for DLA and AA. Successful interviews were carried out for 278 DLA claimants and 322 AA claimants. The appeals sample was drawn at the same time from recently lodged appeals. The target for achieved interviews was 200 each for DLA and AA, but at the end of fieldwork successful interviews had been carried out with 188 DLA appellants and 174 AA appellants.

18.1.5 A note on the DLA samples

The samples were not stratified in any further way. In particular there was no attempt to obtain predetermined proportions of successful or unsuccessful claimants. At the time of drawing the sample the success rates were 56 per cent for all review claimants and around 50 per cent for tribunal appellants. It was surprising, therefore, to find that the success rates reported by the respondents in both the DLA review and the DLA appeals samples were comparatively very high. Eighty-five per cent of the review sample said that decision on their original claim changed on review. In the appeals sample, 91 per cent of the 163 respondents who had heard the result of their hearing at the time of their interview, said they were successful.

The samples of DLA review and appeal claimants must therefore be considered to be biased in favour of successful claimants. Making generalisations about the total population of review and appeal claimants is therefore not possible where we expect that the outcome of the review or appeal would have influenced people's responses. As the study of new claimants has shown, this *outcome effect is* particularly strong for questions about satisfaction and about subjective experiences of various aspects of claiming. There was no outcome effect for factual questions such as where people obtained either information about benefits or their claim form.

As in Part Two of this report, we have presented the responses of the successful and unsuccessful review and appeal claimants separately in order to avoid the distorting influence of the *outcome effect.* However, there were only 33 people in the DLA review sample and 15 people in the appeals sample who were unsuccessful. The commentary on the tables presenting the responses of these claimants will necessarily be tentative only.

18.1.6 Structure of Part Three of the report

Chapter Nineteen presents the main empirical findings on people's experiences of, and views about, the internal review process. Chapter Twenty analyses the experiences of the sample of claimants whose cases had been decided at a Disability

Appeal Tribunal. The final chapter draws together the main lessons for the new review and appeal arrangements.

Where appropriate, comparisons have been made with the findings from a comparable survey of Medical Appeal Tribunal appellants conducted in 1991 (Sainsbury, 1992).

Chapter 19 The Internal Review

This chapter presents the main empirical findings on people's experiences of, and views about, the internal review process. The first section examines the reasons why people request a review. All the claimants in the sample had requested reviews within three months of receiving their original decision. Though some requests were linked to a change in the claimant's condition (see Table 19.1) we can assume that most were the responses of claimants unhappy with the decision on their original claim. In other words they were treating the review stage like an appeal. The next section considers whether the sample of review claimants differs significantly, in terms of their experience of the original claim, from the sample of decided claims used in Part Two of the project. The third section reports on people's knowledge of what would happen after requesting a review. The following section presents data on the additional information supplied by claimants with their review request. The fifth section looks at people's perceptions of the time taken to process their review and their assessment of whether this was reasonable. Section 6 presents the data on overall satisfaction with the review process. In Section 7 we examine the extent to which claimants dissatisfied with their review decision exercise their right to a tribunal hearing.

19.1 Why people request reviews

Knowing why people decide to request a review or lodge an appeal allows us to assess whether an appeal system is being used appropriately. It is largely an inefficient use of resources if an appeal system is dealing with large numbers of frivolous or hopeless cases. Review applicants were asked why they wanted the Benefits Agency to look at their claim again; the responses are presented in Table 19.1. Respondents could give more than one answer, therefore the percentage column sums to more than 100 per cent.

Table 19.1 Reasons why people request a review

	of **total number of reasons given**[1]	
Reason for request	**DLA**	AA
Perception of something wrong with decision or decision making	58	40
Need the award/help	12	20
Advised by someone to appeal	12	22
Condition has got worse	6	6
Speculative/hopeful attempt	2	4
Reaction against decision/process	2	3
Other, less disabled people get benefit	2	4
No. of respondents	273	304

Source: Survey of claimants who had requested an internal review.

[1] Percentages sum to more than 100 per cent due to multiple responses.

The largest category of responses for both DLA and AA respondents was the perception that something was wrong with the decision or decision making process. Included in this category are responses such as 'the decision was unfair', 'I was not seen by a doctor', 'my condition justified an award' and 'I do not understand why I was turned down'. Often it would be difficult to translate these reasons into any sort of *grounds* that would be recognised by a lawyer, but at the same time they cannot be considered as irrelevant reasons for requesting a review. Respondents who said they wanted a review because they needed the money, if that was their only reason, might be thought of as having a less relevant basis for a review. The proportions of respondents mentioning reasons which might be thought of as largely irrelevant or, at least, of doubtful relevance (such as `1 was angry' or `other people get the benefit so why not me?') were very small.

Relatively few people mentioned their condition worsening as the reason for review. This suggests that the *within three months* review is actually serving its intended function as primarily an appeal mechanism rather than a means of responding to changes in circumstances.

We also tried to distinguish between claimants who appeared to have, among their responses, at least one *relevant* reason for their review request (as defined above), and those whose reason or reasons were of doubtful relevance. Some responses, such as `I was advised to appeal', are ambiguous and are included in Table 19.2 in the category labelled *unknown relevance.*

Table 19.2 Proportions of claimants with `relevant' reasons for requesting a review

Relevance of reasons	**DLA** (%)	AA (%)
Relevant	72	53
Doubtful relevance	12	24
Unknown relevance	16	23
Total	273	303

Source: Survey of claimants who had requested an internal review.

The analysis is somewhat speculative given the limitations of a questionnaire for eliciting qualitative data about motivations. Nevertheless, the picture that emerges is that, for DLA, there appears to be a small minority of people whose main reason for requesting a review was of doubtful relevance. For AA, the size of the minority increases to nearly a quarter. At first sight, it might appear that the review procedures were being used by people other than to challenge what they saw as a wrong decision. If this was the case then the review procedures might be considered as being used inappropriately, for example, to let off steam, or to voice a complaint about AA or the benefit system more generally. However, when we looked at the reported success rate of review claimants, we found no significant differences between people appealing on supposedly relevant grounds and those whose grounds appeared to be of doubtful relevance. That both sets of claimants have an equal chance of success suggests that the reasons why they appeal in the first place are largely irrelevant to the outcome. Those people who said there was something wrong with the original decision are no more likely to have had a wrong decision on their original claim than those people who appealed because they were angry or because they needed the money.

19.2 Are review applicants different from other claimants?

In this section we consider whether the sample of review claimants differs significantly, in terms of their experience of the original claim, from the sample of new claimants. The intention in carrying out the analysis was to examine the notion that people were more likely to request a review if they were dissatisfied with something about the initial claiming process. In particular we looked at people's assessments of the usefulness of the claim form in describing their illness or disability and its effect on their daily lives, at whether they thought they provided an accurate picture of themselves on the form, and at their understanding of the decision on their claim. Overall, the responses of the review claimants were very similar to those of the unhappy first-time claimants.

In both samples a strong association was found between respondents' experiences of claiming and their subjective feelings about the result of their claim. In other words, people who were unhappy with the result (which included a large number of people who had actually been made an award as well as those rejected) tended to give more negative responses to questions about claim forms and official letters.

If the experience of claiming was significant in people's decisions about requesting a review (rather than the decision itself) we would have expected the responses of the review claimants to differ from unsuccessful first-time claimants. However, because the responses were similar, we can infer that people's experiences of the form and the decision letter were *not* significant factors. The analysis of the reasons why people requested a review presented above tends to support this inference. Very few respondents said anything about the forms or decision letter when describing their reasons for wanting a review. Changes to claim forms or procedures for deciding new claims are therefore unlikely to reduce the volume of review requests.

19.3 Knowledge and expectations of the review process

Though not essential, it is useful for review applicants to have some basic knowledge about how their case will be dealt with. If they do, they are more likely to feel comfortable about the process and, perhaps more importantly, to take the most appropriate action in support of their review request. Respondents' expectations of the review process are presented in Table 19.3.

Table 19.3 Expectations of what happens after a review request has been submitted

Expectations	DLA[1] **(% of respondents)**	AA[1] **(% of respondents)**
Just to get a decision from the Benefits Agency	34	36
Did not know what to expect	25	36
A (further) medical examination	23	15
More questions from the Benefits Agency	10	8
A visit from a Benefits Agency official	10	9
A tribunal hearing	9	4
Other	6	7
No. of respondents	276	311

Source: Survey of claimants who had requested an internal review.
Percentages sum to more than 100 per cent due to multiple responses.

Apart from a tribunal hearing, all of the outcomes in the table above are possible. Adjudication officers dealing with reviews can decide the case on the papers alone or gather further information in the most appropriate way. Most people's expectations, therefore, reflect these options. However, the most likely actual outcome, that the claimant will simply receive a decision, was expected by just over a third of respondents. Despite the information provided by the Benefits Agency and available elsewhere, there were sizeable minorities who said they did not know what to expect (a quarter of DLA respondents and over a third of AA respondents).

People obtain their knowledge about the review process from a variety of sources but as Table 19.4 shows, the most common source was the initial decision letter or other official source (posters, leaflets or Benefits Agency staff).

Table 19.4 Sources of knowledge about the review process

Source of knowledge	**DLA[1]** (% of **respondents)**	AA[1] (% of **respondents)**
Decision letter from Benefits Agency	61	50
Benefits Agency poster/leaflet	7	5
Benefits Agency staff	7	4
Advice agency (other than CAB)	7	8
Friends/relatives	5	14
Citizens Advice Bureau	4	3
GP	(.)	5
Other	9	16
No. of respondents	276	311

Source: Survey of claimants who had requested an internal review.
(.) = < 0.5 per cent.
[1] Percentages sum to more than 100 per cent due to multiple responses.

The table shows that AA claimants made greater use of friends and relatives, and their doctors, for information than DLA claimants, who mostly obtained their information from official sources.

If we compare people's expectations with their source of knowledge, we find that those claimants with expectations beyond merely receiving a decision were more likely to have obtained that information from the initial decision letter. Interestingly, claimants who went to people with probably the least initial knowledge of review procedures (friends, relatives and GPs) were least likely to be misled into thinking a tribunal would be involved. One explanation could be that these people had a clearer understanding of the information sent by the Benefits Agency than the claimant.

There might be a case for reviewing the information provided in official letters and other documents to make clear the range of possible responses available to the adjudication officer. These include requesting a GP's or EMP's report or other information, and making a decision on the review papers only. Letters could, therefore, indicate that an adjudication officer would normally adopt the last of these options. As a result, it may be possible to avoid raising, and to prevent any anxiety for people who would not welcome further contact from the Agency or an EMP. It would also reassure claimants who are not contacted between submitting a review request and receiving the decision of the adjudication officer. People might also be encouraged to supply as much information as they could when they submit their review request.

19.4 Claimants' submissions of further information

In general, the task of the adjudication officer in carrying out a review is made easier by claimants providing the fullest possible information. Table 19.5 shows the proportions of claimants who supplied additional information with their review request.

Table 19.5 Proportions of claimants supplying extra information for the review

Extra information supplied?	**DLA** (%)	AA (%)
Yes	51	47
No	49	53
Total'	261	253

Source: Survey of claimants who had requested an internal review.
= 'Don't know' responses not included in the table.

As Table 19.6 shows, the most common means of providing additional information was in a letter from the claimant himself or herself. Further information from a GP was supplied by 30 per cent of the DLA claimants and 38 per cent of the AA sample. DLA claimants were almost three times more likely to supply a report from a hospital than AA claimants.

Table 19.6 Types of extra information supplied at review

Type of information	**DLA** (%)'	AA
Letter from claimant	45	39
GP letter/report	30	38
Hospital letter/report	20	7
Letter from welfare agency	8	3
Letter from health professional (other than doctor)	7	11
Other	5	8
No. of respondents	134	118

Source: Survey of claimants who had requested an internal review.
Percentages sum to more than 100 per cent due to multiple responses.

In general, claimants who did provide further information were slightly more likely to be successful though the differences were not statistically significant. However, the differences were greatest for DLA claimants who supplied further *medical* evidence (95 per cent successful compared with 83 per cent for those providing no extra information). AA claimants who supplied information, either themselves or from a doctor, were also more likely to be successful than those not sending anything more (success rates of 79 and 76 per cent respectively compared with 67 per cent).

In Chapter 11 it was noted that the use of EMP visits by adjudication officers was least for claims which had included one or two supporting statements. The inference was made that EMP visits might be reduced if more claimants could be encouraged to obtain supporting statements on their original claim forms. We carried out a comparable analysis on the reviews sample to investigate whether the supply of further medical information accompanying the review request had a similar effect on the use of EMPs by adjudication officers. However, we found no statistical relationship between additional medical information and the frequency of EMP visits.

We were also interested in whether adjudication officers were requesting most EMP reports often for claimants who had not been visited in connection with their original claim. If this was the case then we might infer that adjudication officers were in some way *compensating* for something which could have been done in the first place, and that, therefore, initial decision making in DBCs was deficient. However, claimants who had received an EMP visit after their original claim were at least as likely to be visited again as those who had not already had a visit. There is no evidence therefore to suggest that DBC adjudication officers should perhaps have been ordering more EMP reports, and that if they had, some reviews would not have been necessary.

19.5 People's perceptions of time taken to process reviews

In the survey, respondents were asked how long their review took to process and their assessment of whether this was reasonable. The responses of the DLA and AA samples are presented in Tables 19.7 and 19.8 respectively. A similar analysis was carried out for the sample of new claimants (see Chapter 14).

It is not the intention here (nor was it in relation to new claims) to attempt to measure clearance times using respondents' recollections of how long the process took. People's perceptions of the passing of time, recalled a number of months later in this survey in some cases, are potentially too unreliable. However, by comparing people's perceptions of how long the process took with their ideas about reasonableness we can assess the relevance for DLA and AA claimants of the Benefits Agency's internal targets.

Table 19.7 Respondents' perceptions of time taken to process claims by their assessment of reasonableness (DLA sample)

	Respondent's assessment of reasonableness				
No. of weeks	**Very** (%)	**Fairly** (%)	**Not very**	**Not at all** (%)	**Total** (N)
1-2	77*	23*			30
3-4	32	56	9	3	75
5-6	19*	66*	13*	2*	47
7-8	10*	52*	19*	19*	31
9-12		41*	41*	19*	27
13 and over		18*	36*	46*	11
All cases	27	49	15	9	221

Source: Survey of claimants who had requested an internal review.

* Percentages based on fewer than 50 cases.

Table 19.8 Respondents' perceptions of time taken to process claims by their assessment of reasonableness (AA sample)

	Respondent's assessment of reasonableness				
No. of weeks	**Very** (%)	Fairly (%)	**Not very** (%)	Not at all ('4')	Total (N)
1-2	78*	22*			18
3-4	29	57	12	2	68
5-6	17	61	17	5	59
7-8	9*	68*	18*	5*	22
9-12	6*	47*	35*	12*	17
13 and over		1 case	1 case	5 cases	7
All cases	25	54	15	6	191

Source: Survey of claimants who had requested an internal review.
* Percentages based on fewer than 50 cases.

The tables show that similar proportions of DLA and AA respondents (76 per cent and 79 per cent respectively) thought that their clearance times were reasonable. Most people also thought that clearance times of up to eight weeks (40 working days) were either very or fairly reasonable. Clearance times of up to 12 weeks were thought reasonable by over half the AA respondents.

While such overall results are similar to those produced by the sample of new claimants, the proportions of people recording 'very reasonable' responses is much lower in the reviews sample. This suggests that the population of review applicants is more demanding than first-time claimants. Perhaps, having been through the initial claiming process only to be rejected (the experience of most claimants wanting a review), people are less prepared to wait long periods for a fresh decision on their claim.

The current targets for processing DLA reviews are 60 per cent cleared in 55 working days (11 weeks), and 80 per cent in 75 days (15 weeks). Although it has already been mentioned that people's own assessments of how long reviews took to clear may not be accurate, it is noteworthy that 87 per cent reported a clearance time of 11 weeks or shorter, and 94 per cent said their review took 15 weeks or less. (These figures are very close to the most recent official clearance rates made available to the research team: 81 per cent in 55 days and 91 per cent in 75 days *(DLA and AA Quarterly Evaluation Report,* February 1994).) The targets for AA reviews are 60 per cent clearance in 61 working days (just over 12 weeks), and 85 per cent in 81 days (just over 16 weeks). Our survey data suggests achieved clearance rates of 94 per cent in 12 weeks and 95 per cent in 16 weeks (the comparable figures from the February 1994 *Quarterly Evaluation Report* are 87 and 97 per cent respectively).

The views of our respondents on clearance times suggest that the official targets for DLA and AA reviews bear little relation either to people's experiences or their ideas about what is reasonable. Looking at Table 19.7 we can estimate that the 60 per cent level for clearing DLA reviews was achieved between five and six weeks after reviews were requested. The 80 per cent mark was reached between nine and ten weeks. In the light of this there is a case for changing the existing targets and, based on recent performances, there also appears to be a case for aligning review targets with those for initial claims, currently 65 per cent in 30 days, and 85 per cent in 55 days. The AA target of 60 per cent was also achieved between five and six weeks following the submission of a review request, and 85 per cent were cleared in eight weeks. Again there is evidence here for constructing targets for AA reviews which reflect both actual performance and the views of claimants about what is reasonable.

19.6 Satisfaction with the review process

19.6.1 Levels of satisfaction

In the questionnaire we attempted to measure people's satisfaction with the review process in two ways. First, we asked people to assess their satisfaction at each of four points in the process when they might have had contact with the Benefits Agency. These four points were (a) contact *from* the Agency after the submission of the review request, (b) contact *to* the Agency after the submission of the review request. (e) a visit from an EMP, and (d) contact after the decision had been received. Second, we asked all respondents for their assessment of their overall satisfaction with the review process.

It will be remembered that the review process is intended to be primarily a paper exercise in order to keep it as simple and as quick as possible. It is not surprising therefore to find that relatively few claimants had any contact with the Benefits Agency between submitting their request and getting a decision. Roughly a third of the DLA sample and only a quarter of the AA sample had any contact at all, though some did have more than one contact. Table 19.9 shows the contact rates of the DLA and AA samples at the various stages in the review process.

Table 19.9 Proportions of claimants having contact with the Benefits Agency during the review process

	DLA claimants making contact		**AA claimants making contact**	
Type of contact	(N)	(%)	(N)	(%)
From BA after review request submitted	31	11	30	9
To BA after review request submitted	47	17	14	4
EMP visit	30	11	40	12
To BA after decision had been received	17	6	11	3
Total no. of respondents	278		322	

Source: Survey of claimants who had requested an internal review.

The low numbers of claimants making contact at each stage poses problems for the analysis of the responses to questions about satisfaction. With such small numbers it is not feasible to present an analysis of satisfaction levels compared with the outcome of the review (that is, the sort of analysis that was possible in Chapter 16 for new claims) and which demonstrated the importance of the *outcome effect)* Instead, in the analysis that follows we have aggregated the responses to the range of questions about satisfaction for all the stages in the review process. Where appropriate we have compared the results of this analysis with people's reported levels of *overall* satisfaction.

In the following tables respondents' satisfaction levels with each stage of the review are presented. The figures in the table refer to the *numbers* of respondents rather than percentages. In the column labelled `aggregate scores', percentages as well as numbers are given to allow a comparison with the *overall* satisfaction levels of the whole sample (given in the right-hand column). The analyses of the DLA and AA samples are presented separately.

Table 19.10 Analysis of satisfaction with each stage of the review process and overall (DLA sample)

	Point of contact (see key below) (no. of claimants)				**Aggregate scores'**		**Overall satisfaction scores**
Satisfaction	**(a)**	**(b)**	**(c)**	**(d)**	(N)	(%)	(%)
Very satisfied	5	17	15	8	45	(38)	(31)
Fairly satisfied	17	14	10	2	43	(37)	(53)
Fairly dissatisfied	3	5	2	1		(9)	(7)
Very dissatisfied	2	10	2	4	18	(15)	(9)
No. of respondents	27	46	29	15	117		258

Source: Survey of claimants who had requested an internal review.

' Aggregate scores are the sum of columns (a) - (d).

Key:

(a) contact *from* the Agency after the submission of the review request

(b) contact *to* the Agency after the submission of the review request

(c) a visit from an EMP

(d) contact after the decision had been received.

Table 19.11 Analysis of satisfaction with each stage of the review process and overall (AA sample)

	Point of contact (see key below) (no. of claimants)				**Aggregate scores'**		**Overall satisfaction scores**
Satisfaction	**(a)**	**(b)**	**(c)**	**(d)**	(N)	(%)	(%)
Very satisfied	9	3	22	1	35	(41)	(32)
Fairly satisfied	13	4	8	6	31	(36)	(46)
Fairly dissatisfied	3	2	3	2	10	(12)	(13)
Very dissatisfied	3	3	4	0	10	(12)	(9)
No. of respondents	28	12	37	9	86		282

Source: Survey of claimants who had requested an internal review.

Aggregate scores are the sum of columns (a) - (d).

Key:

(a) contact *from* the Agency after the submission of the review request

(b) contact *to* the Agency after the submission of the review request

(c) a visit from an EMP

(d) contact after the decision had been received.

If we compare the aggregate scores of satisfaction with the overall levels of satisfaction we can make some observations. For the DLA sample 84 per cent of respondents said they were very or fairly satisfied with the review process as a whole. The combined satisfaction score derived from the aggregate analysis was lower at 75 per cent. The equivalent scores for the AA sample were 78 and 77 per cent respectively. The lower overall satisfaction level of the AA sample is probably partly explained by the different success rates of each (88 per cent for DLA, 69 per cent for AA). In other words the impact of the *outcome effect* is different for the two samples.

A comparison of overall satisfaction with the outcomes of reviews is presented in Table 19.12. Unlike the claims sample, there were virtually no respondents who were successful (that is, had the original decision changed in their favour) but were not happy with this result. In the table below, therefore, we present a simplified analysis of the *outcome effect* (compared with the analysis of new claims) based solely on the success or failure of the review.

Table 19.12 Comparison of overall satisfaction with success of review request

	Outcome of DLA **review**		**outcome of** AA review	
Satisfaction	**Success** (❩	**Fail** (%)	**Success** (%)	**Fail** (%)
Very satisfied	32	17*	39	14
Fairly satisfied	56	31*	48	43
Fairly dissatisfied	7	14*	10	22
Very dissatisfied	5	38*	3	21
Total	229	29	196	86

Source: Survey of claimants who had requested an internal review.
* Percentages based on fewer than 50 cases.

As with the samples of new claimants, there are statistically significant differences between the responses of the successful and unsuccessful claimants in both the DLA and AA review samples (chi-sq test, $p < 0.0000$ at the one per cent level of confidence). The satisfaction levels of the successful claimants was high: 88 per cent and 87 per cent respectively for the DLA and AA samples. The number of unsuccessful DLA claimants in the sample was very small but of those who gave a response, 48 per cent reported themselves satisfied with the review process. compared with 57 per cent of the AA sample.

19.6.2 Reasons for satisfaction and dissatisfaction

In Part Two it was possible to present a detailed analysis of the reasons why people said they were satisfied or dissatisfied with their contact with the Benefits Agency at the various points in the claiming process. However, because of the small numbers making any contact during the review process it is not possible to perform a similar analysis for reviews. Instead, an aggregate analysis, along the lines used for the analysis of satisfaction levels above, is presented.

Respondents were asked to explain, in their own words, why they were satisfied or dissatisfied when they had had some form of contact with the Agency. Their reasons were divided into four main groups, those relating to (a) the *substance* of their dealings with the Agency, such as the quality of the help, advice or information received, (b) the *personal treatment* of the respondent by benefit staff, including whether staff had been polite or rude, sympathetic or offhand, (c) the *speed* of the response from the Agency, and (d) references to the *decision* itself. There was also a small group of other, miscellaneous reasons.

In Tables 19.13 and 19.14 we present the results of this aggregate analysis for the DLA and AA samples respectively. The reasons for people's satisfaction with the EMP visit are not included in the aggregate scores but given separately, because the pattern of responses is different to that for contacts with administrative staff of the Benefits Agency.

Table 19.13 Analysis of reasons for people's satisfaction and dissatisfaction at the various stages of the review process (DLA sample)

Satisfaction	Point of contact (see key below) (no. of claimants) (a)	(b)	(d)	Aggregate scores' (N)	(%)	EMP visit stage (c)
Substance	16	30	16	62	(46)	14
Personal treatment	8	18	3	29	(22)	21
Time/speed	7	11	1	19	(14)	1
Decision	1	3	4	8	(6)	
Other	7	6	3	16	(12)	6
Total no. of reasons	39	68	27	134		43
(No. of respondents)	(27)	(46)	(15)	(88)		(29)

Source: Survey of claimants who had requested an internal review.
' Aggregate scores are the sum of columns (a), (b) and (d).
Key:
(a) contact *from* the Agency after the submission of the review request
(b) contact to the Agency after the submission of the review request
(c) a visit from an EMP
(d) contact after the decision had been received.

Table 19.14 Analysis *of reasons for* people's satisfaction and dissatisfaction *at* the various stages *of* the review process (AA sample)

Satisfaction	Point of contact (see key below) (no. of claimants) (a)	(b)	(d)	Aggregate scores' (N)	(%)	EMP visit stage (c)
Substance	13	4	8	25	(37)	2
Personal treatment	8	7	0	15	(22)	33
Time/speed	4	3	0	7	(10)	0
Decision	6	0	2	8	(12)	0
Other	9	1	2	12	(18)	3
Total no. of reasons	40	15	12	67		38
(No. of respondents)	(28)	(12)	(9)	(49)		(36)

Source: Survey of claimants who had requested an internal review.
' Aggregate scores are the sum of columns (a), (b) and (d).
Key:
(a) contact *from* the Agency after the submission of the review request
(b) contact to the Agency after the submission of the review request
(c) a visit from an EMP
(d) contact after the decision had been received.

These two tables, although based on relatively small numbers, do show a similar pattern to results from the analysis of the samples of new claimants. In their contact with officers of the Benefits Agency, people appeared to be more concerned with the substance of their contact (the help, advice and information received, for example) than with the way they were dealt with as individuals or the time taken to deal with the matter in hand. In contrast, when an EMP saw a claimant, the quality of the personal treatment given by the doctor became the most important aspect of the contact. The same finding was made in the analysis of the *claims* data.

Interestingly, however, the actual outcome of the review was cited as a reason for satisfaction or dissatisfaction with the process by more of the review sample than the claims sample (although the numbers were still small). This provides confirmation that the *outcome effect* can, in some cases, be interpreted as a causal relationship between outcome and responses to questions about subjective experiences of claiming.

19.7 Appeal intentions of claimants unhappy at the outcome of their review

For many social security benefits a dissatisfied claimant has an immediate right of appeal to an independent tribunal. As we explained in Chapter 1, DLA and AA claimants must first complete the internal review process before they can appeal to a DAT. The question arises, therefore, of whether people are discouraged from exercising their further right of appeal because of their experience of the internal review. We therefore asked those claimants who said they were dissatisfied with the outcome of their review whether they intended to appeal further. Table 19.15 presents their responses.

Table 19.15 Appeal intentions of claimants unhappy at outcome of review

Appeal intentions	**DLA** *(N)*	*AA* *(N)*
Already appealed	24	16
Intend to appeal	34	31
Will not appeal	30	32
Undecided	6	16
Unaware could appeal	6	6
Total	50	84

Source: Survey of claimants who had requested an internal review.

We do not know from our survey whether the existence of the internal review as the first-tier appeal had any effect on people's decision whether or not to appeal in the first instance. It is possible that the opportunity of an internal review, compared with a tribunal hearing, might have encouraged people to appeal who would not have done so under the mainstream arrangements. It is also possible that people would have been discouraged from appealing {for example, if they thought that they would not receive an independent review of their case). With these provisos in mind, let us assume that under the appeal structures of other benefits, all 134 of the claimants in Table 19.15 would have had their case heard by a tribunal, there would have been no need for them to request a hearing. If we combine the categories `will not appeal' and 'unaware could appeal' we can estimate of the number of claimants who have been disadvantaged by the new review and appeal arrangements, in the sense that they have not had their case heard by a tribunal whereas they probably would have done under the appeal structures for other benefits. On this basis our initial estimate is 37 per cent. The final figure is likely to be higher, given that not all of the claimants who responded `intend to appeal' or `undecided' will have actually appealed. Table 19.16 looks at the reasons given by people for *not* appealing further.

Table 19.16 Reasons why dissatisfied review applicants do not appeal further (DLA and AA claimants combined)

Reason for not appealing further	(N)
No point/waste of time	19
Downhearted/discouraged/depressed	8
Fed up filling in forms	3
Turned down so often already	2
Too busy	2
Advised not to	2
Other answers	11
Total	47

Source: Survey of claimants who had requested an internal review.
NB The table above combines the responses of the 15 DLA and 28 AA claimants who responded to this question. Multiple responses were allowed.

This table shows that the reasons people gave for not appealing further generally reflect negative feelings about the claiming process up to this point. Some reasons are more ambiguous (such as `too busy' or `advised not to') but what is absent from the table is anyone saying, for example, that they were satisfied with the explanation provided by the Benefits Agency of why their review was unsuccessful.

One argument in favour of the two-tier appeal structures of DLA and AA is that internal reviews provide what some people actually want when they make a request, that is, a comprehensible explanation of the original decision. If this was the case then we would have expected some people to cited 'receiving a full explanation' as a reason for not appealing further. However, as the table shows, our survey uncovered no such evidence.

19.8 Discussion and conclusion

In this chapter we have examined people's experiences of, and satisfaction with, the internal review process for DLA and AA. While the results from the survey of AA claimants have presented no problems, the unusually high success rate of the DLA sample means that we must be cautious in our interpretation of some analyses based on the outcome of the review.

For most people the review of their original decision is a paper exercise. They will have no contact with the Benefits Agency between submitting their request and receiving a decision some time later. This reflects the policy objective of providing a quick and simple means of dealing with claimants unhappy with their original decision. Furthermore, the implication for measuring satisfaction is that for most people their assessment will not be based on any contact with the Agency. It is not surprising to find therefore, that people's responses to the question about overall satisfaction with the review process were strongly associated with the outcome of the review. The *outcome effect* presents problems in interpreting measures of overall satisfaction which were discussed in detail in Chapter 16 in relation to the survey of new claimants. The same problems arise for the review sample but with a possible added complication.

The distribution of responses about overall satisfaction from the claimants who were unsuccessful at review is similar to that for the sample of new claimants, with around 50 per cent satisfied. The combined satisfaction scores (that is, `very' plus `fairly' satisfied) of the successful review claimants are also similar to, though slightly lower than, the sample of new claimants (around 88 per cent compared with 95 per cent). However, the proportions of review claimants who said they were 'very' satisfied were much lower (32 per cent compared with 71 per cent for the DLA samples, and 39 per cent compared with 61 per cent for the AA samples). A hypothesis that might explain these differences is that, in responding to the question about overall satisfaction, the review claimants are not only taking into account the process and outcome of the review but also their feelings about the outcome of (and possibly the process associated with) their initial claim.

From our analysis of the survey of new claimants, we concluded that a simple measure of overall satisfaction was in effect more a measure of how people felt about the decision on their original claim. It is possible that the equivalent measure for review claimants is more a composite measure of how people feel about the *two* decisions on their claim, at the initial claim stage and at the review. If this is the case then the validity of attempting to measure overall satisfaction using a single, simple question must again be questioned.

By looking at separate aspects of the review process, we begin to get a clearer picture of claimants' experiences although the *outcome effect* is still present in responses to individual questions. As with the initial claiming process, when review claimants had contact with officials of the Benefits Agency, rather than an EMP, the most important aspect of the contact was its *substance* followed by the quality of the *personal treatment* provided by the Agency staff. The order was reversed for the EMP visit when personal treatment by the doctor was the principal concern of claimants.

In Section 4 we noted that there was no statistical relationship between additional medical information supplied by claimants and the frequency of EMP visits. This contrasts with the sample of new claimants: where the supply of supporting statements (on the claim form) increased the likelihood that a decision would be made on the form only and reduced the likelihood of an EMP visit. If there is something wrong in the type, quality or relevance of the additional medical information sent in by review applicants, then perhaps it would be better if claimants were asked to supply such information on a review request form in a similar format to that used in the original claim form. If claimants are making the effort of getting more information, it would be more efficient if they obtained it in a form most useful to adjudication officers.

The time taken for the Agency to process reviews was thought reasonable by over three-quarters of both DLA and AA samples. Although the Benefits Agency can claim to be reaching its internal performance targets on clearing reviews, our analysis has suggested how the views of claimants and the actual performance achieved by the Agency could be used to produce revised targets more grounded in people's experiences and expectations.

The internal review is a straightforward procedure which is part of the administrative and adjudicative arrangements of all social security benefits. When it becomes the first-tier of an appeal structure rather than solely a means of dealing with changes in circumstances or of correcting mistakes, it is inevitable that some people who previously would have had their case heard by a tribunal will not pursue their appeal beyond the review. Among our samples we provisionally estimated that over a third of those who were unhappy at their review outcome would not be making a further appeal. The answer to the question of whether the internal review acts as a barrier to the DAT is therefore that it does, and that as a result, the number of DATs which would have ensued under mainstream appeal structures is reduced.

Chapter 20 Appealing to a DAT

The purpose of this chapter is to explore people's experiences of appealing to a DAT. In it we draw on the survey of people whose appeal had been lodged during the three months prior to the sample being drawn in March 1994. A separate questionnaire was administered to this group covering all aspects of their appeal.

The next section of this chapter looks at the reasons why, having been dissatisfied with their original decision and their review decision, people chose to appeal once more. Sections 2-7 cover aspects of the appeal prior to the tribunal hearing, such as people's knowledge and expectations of their appeal, the types of additional information they submitted, the tribunal documents, travelling to a tribunal centre, access to the tribunal premises, and the time taken for the appeal to reach a hearing. Sections 8-13 deal with the tribunal hearing itself, including attendance rates, appellants' treatment by the tribunal members and the extent of participation by appellants. Section 14 presents the data on overall satisfaction with the appeal and with the claiming process as a whole.

As we explained in Chapter 18, the success rate of the 188 people in the DLA sample was remarkably high (91 per cent of those who knew their decision). We therefore have very few people in the *unsuccessful* category of appellants (a maximum of 15) with whom we can compare the responses of the successful appellants. This limitation should be kept in mind when considering the analysis of the DLA sample. There are no comparable difficulties with the AA sample of 174 people for whom the success rate was around 50 per cent, close to the actual success rate at the time of the survey. Unlike the administration of initial claims and the processing of reviews, which are carried out by separate arms of the Benefits Agency, all DLA and AA appeals are handled by the Independent Tribunal Service (ITS). We would not expect, therefore, any significant differences in the experiences of DLA and AA appellants since their appeals will all be processed in the same way. Consequently, in the presentation of some of our findings, we have aggregated the responses of our samples of DLA and AA appellants. One advantage of this is that when we have analysed data according to the outcome of the appeal, the limitation of the small numbers of unsuccessful DLA appellants is minimised.

20.1 Why people make appeals

In Chapter 19 we examined the reasons why people applied for a review of their original decision. Table 20.1 presents the equivalent responses for the appeals samples.

Table 20.1 Reasons why people make an appeal

	Percentage of total number of reasons given	
Reason for appeal	**DLA** (%)	AA (%)
Identification of something wrong with review decision or decision making	55	46
Need the award/help	10	12
Advised by someone to appeal	16	23
Condition has got worse	5	6
Speculative/hopeful attempt	3	1
Reaction against decision/process	3	4
Other, less disabled people get benefit	3	5
No. of respondents	182	166

Source: Survey of tribunal appellants.

The pattern of responses in the table is similar to that for the review sample responses (Table 2.1). However, although the differences are not large, the proportion of AA appellants citing something wrong with the earlier decision is higher than the review sample (46 and 40 per cent respectively), and fewer people appealed for the reason that they needed the money (12 per cent and 20 per cent respectively). As in Chapter 19, we have also recoded the reasons why people appeal fall into categories reflecting whether, based on their own responses, they appeared to have relevant grounds for doing so. Table 20.2 presents the results of this analysis.

Table 20.2 Proportions of appellants with `relevant' reasons for appealing

Type of reason	**DLA** (%)	AA (%)
Relevant	66	60
Doubtful relevance	18	19
Unknown relevance	16	21
Total	174	163

Source: Survey of tribunal appellants.

If we compare this table with its equivalent in Chapter 19 (Table 19.2), it appears that there is a slight shift in the DLA population towards more appeals of doubtful relevance (12 to 18 per cent), and an opposite move in the AA population towards more relevant appeals (53 to 60 per cent). These changes are relatively small, however. Also, if we look at the outcomes of the tribunal hearing we find, as we did for the reviews sample, that success rates are very similar among appellants with `relevant' grounds and those whose grounds appear to be of less relevance. That both sets of claimants have an equal chance of success suggests that their reasons for appealing in the first place are largely irrelevant to the outcome.

These findings suggest where further research into the reasons for tribunal and review decisions might be useful. If we assume that people's responses to the question about why they make an appeal are an accurate reflection of what they said to the Benefits Agency in a letter or on an appeal form, then we might expect that those with grounds of doubtful relevance would be less successful than those with relevant grounds. However, this was not the case. In these cases the DAT must be identifying for themselves a relevant reason for the appeal *or* identifying a change in circumstances (most likely a deterioration in the claimant's condition). If DATs are making a large number of decisions based on changing circumstances, they are in practice carrying out a task that *could* be done by an adjudication officer on review. This is a question that could be resolved by further research. However, in the meantime it does raise the question of whether, in some cases, DATs are performing a role that is not an effective use of the expertise and resources, a question we return to in Chapter 21.

20.2 Knowledge and expectations of the appeal process

There is evidence from other studies of tribunals (for example, Genn and Genn, 1989) that people have little idea of what will ensue when they lodge an appeal against the decision of an adjudication officer. Furthermore, for some, the realisation that a tribunal will be held is something of an unwelcome surprise. Others, having accepted the idea of a tribunal, often have little knowledge about how it will operate and consequently are badly prepared for the hearing or do not appear at all.

Most people obtained their information about the appeal process from an official source, usually the review decision letter but also from other literature or from Benefits Agency staff. Relatively few heard from a Citizens Advices Bureau or other advice agency, as Table 20.3 shows.

Table 20.3 Sources of knowledge about the appeal process

Source of knowledge	**DLA** (% **of respondents)**	AA (% **of respondents)**
Decision letter from Benefits Agency	59	55
Benefits Agency poster/leaflet	9	4
Benefits Agency staff	6	5
Advice agency (other than CAB)	6	7
Friends/relatives	4	8
Citizens Advice Bureau	7	4
Other	11	13
No. of respondents	182	166

Source: Survey of tribunal appellants.

We asked appellants what they had expected to happen next after they had submitted their appeal. Table 20.4 presents their responses.

Table 20.4 Expectations of what happens after an appeal has been lodged

Expectations	**DLA** (% **of respondents)**	AA. (% **of respondents)**
To appear at a tribunal hearing	40	36
Just to get a decision from the Benefits Agency	27	24
Did not know what to expect	16	22
A (further) medical examination	13	12
To get a decision from a tribunal only	8	8
More questions from the Benefits Agency	5	5
A visit from a Benefits Agency official	4	5
To receive further information about the appeal	3	5
Other	5	8
No. of respondents	179	166

Source: Survey of tribunal appellants.

Although the information leaflet that accompanies review decision letters states that an appeal tribunal is the next stage of adjudication beyond the internal review, fewer than half our DLA and AA samples said they expected either to attend a tribunal or get a decision from one. Among the DLA and AA samples, similar proportions expected just to get a decision from the Benefits Agency (around a qUatter) to have some further contact from the Agency (over a third), despite the fact that once an appeal has been made it effectively leaves the control of the Benefits Agency and becomes the responsibility of the Independent Tribunal Service.

It seems desirable that potential appellants should have a good knowledge of what a tribunal is, what its powers are, and how it conducts its business. Informed appellants are not only more likely to prepare themselves adequately (by supplying more information for the tribunal or by recruiting the help of a competent representative) but possibly would be less intimated by the prospect of a hearing and therefore more likely to attend in person. In Chapter 19 we suggested that there was probably a case for reassessing the information produced about reviews for claimants unhappy with the adjudication officer's decision. Although the information in leaflets about appeals is clearly stated, it might avoid confusion if it is emphasised further that the Benefits Agency has no responsibility at all for administering the appeals process.

20.3 Appellants' submissions of further information

Appellants do not only have the opportunity of appearing in person before a tribunal they can, beforehand, supply further information they wish tribunal members to consider. Table 20.5 shows the proportions of DLA and AA appellants who took this opportunity.

Table 20.5 Proportions of appellants supplying extra information for the tribunal

Extra information supplied?	**DLA** (%)	AA
Yes	64	51
No	36	48
Total	170	148

Source: Survey of tribunal appellants.
= `Don't know' responses not included in the table.

Of those who could remember, nearly two-thirds of the DLA and over half the AA appellants said they sent some kind of further information. These proportions are higher than for the internal review stage (see Table 19.5). Among AA appellants, the success rate for those who supplied more information was 54 per cent, compared with 35 per cent for those who did not. This suggests that supplying more information might increase the chances of success for AA appellants. There is no comparable effect in the DLA appellants, although, as we explained in Chapter 18, this sample is less reliable for analyses based on success rates.

In Table 20.6 we compare the types of information sent to the tribunal with that sent to the Benefits Agency for the internal review.

Table 20.6 Types *of* extra information supplied on appeal, compared with internal review (percentage *of* appellants)

	DLA'		AA[1]	
Type of **information**	**Tribunal** (%)	**Review** (%)	**Tribunal** (%)	**Review** (%)
GP letter/report	48	30	54	38
Hospital letter/report	36	20	25	7
Letter from claimant	26	45	25	39
Letter from welfare agency	7	8	10	3
Letter from health professional (other than doctor)	7	7	9	11
Other	1	5	4	8
No. of respondents	109	134	76	118

Source: Survey of tribunal appellants.
[1] Percentages sum to more than 100 per cent due to multiple responses.

This table shows how tribunal appellants used medical evidence more than review claimants and relied less on their own information. Around a half of both DLA and AA appellants obtained further information from their GP. One-third of the AA appellants who obtained a GP's report also said that they had *not* previously obtained a supporting statement from him or her on their original claim form. This suggests the hypothesis, which unfortunately we cannot explore further with our data. that had these appellants obtained some support from their GP earlier in the process their original claims might have been successful. The picture is different for the DLA sample of whom 85 per cent had already obtained a supporting statement from their GP.

Even though the chances of success for AA appellants appear to be increased by supplying further information, as we noted above, this did not appear to be strongly associated with any particular type of information. The success rate of those supplying GP reports was 59 per cent, for hospital reports, 53 per cent, and for claimants' own letters, 47 per cent. Although the success rates of appeals supported by medical evidence were slightly higher they did not vary significantly from the average rate of 54 per cent.

20.4 Views about tribunal documentation

Tribunal appellants should receive a set of papers which will contain the same documents as are made available to the tribunal members. Eighty-six per cent of the combined sample of DLA and AA appellants said they did receive the papers. One of the difficulties for adjudication officers in preparing tribunal papers is that they are necessarily addressing different audiences. The papers must give the tribunal members a full account of the case, including the internal review, making clear which parts of the legislation have been used in reaching the original decision. This may not be easy for appellants, unused to legal terminology, to understand. Table 20.7 presents an analysis of how helpful appellants (DLA and AA combined) found the papers in understanding their case, broken down by whether the appellant won or lost their appeal.

Table 20.7 Appellants' assessment of helpfulness of tribunal documents by outcome of appeal (combined DLA and AA samples)

	Outcome of appeal for appellant	
Extent of help	**Win**	**Lose** (%)
A lot of help	38	19
A little help	31	37
No help	31	44
Total	169	63

Source: Survey of tribunal appellants.

As with many of the tables presenting the responses of appellants to questions designed to elicit their subjective assessment of their experiences, we find a strong *outcome effect,* with successful appellants making far more positive responses than unsuccessful appellants. Although this makes it difficult to generalise about the population of appellants, useful lessons can still emerge. For example, the proportions of respondents who said that the documents were no help (for example, nearly a third of the successful appellants) suggest that there is scope for possibly considerable improvement in their content and presentation to make them accessible to people with little or no medical or legal knowledge.

20.5 Travelling to the tribunal centre

For some claimants of DLA or AA travelling can be difficult and possibly cause discomfort or pain. One of the advantages of excluding medical examinations from tribunal proceedings has been that hearings can take place in all tribunal centres and not only those with special examination facilities. Increasing the number of tribunal locations should therefore mean shorter travelling distances and times than have been associated with Medical Appeal Tribunals (MATs) in the past. Table 20.8 shows how far our sample of appellants travelled to their hearing. The median distance was between six and seven miles.

Table 20.8 Distances travelled to DAT hearings (combined DLA and AA samples)

Distance (miles)	**Number of appellants**	**Percentage**
0-5	79	37
6-10	68	32
11-15	25	12
16-20	14	7
21 and over	24	11
Total	213	

Source: Survey of tribunal appellants.

In the survey of MAT appellants (Sainsbury, 1992), mentioned in Chapter 18) 19 per cent of journeys were reported to be of five miles or less, compared with 37 per cent of our DAT sample. Also whereas 41 of journeys to MATs were sixteen miles or more, only 18 per cent of DAT appellants had to travel such distances.

For people with physical disabilities the time a journey takes is often of more importance to their experience than the actual distance travelled. Table 20.9 presents people's assessments of their journey times.

Table 20.9 Appellants' journey times (combined DLA and AA samples)

Time for journey	**Number of appellants**	**Percentage**
0-29 minutes	97	46
30-59 minutes	81	38
1 hour or more	33	16
Total	211	

Source: Survey of tribunal appellants.

This table shows that nearly half of all journeys took less than 30 minutes. However, one in six appellants was travelling for an hour or more. Table 20.10 compares travelling times with respondents' assessments of the amount of discomfort or pain they experienced on the journey.

Table 20.10 Amount of discomfort or pain experienced by appellants compared with journey times (combined DLA and AA samples)

	Amount of discomfort or pain			
Time for journey	A **lot** (%)	A **little** (%)	**None** (%)	**Total** (N)
0-29 minutes	11	26	63	97
30-59 minutes	14	31	56	81
1 hour or more	24*	27*	48*	33
All	14	28	58	211

Source: Survey of tribunal appellants.

* Percentages based on fewer than 50 cases.

The table suggests that the longer a journey takes, the more likelihood there is that the appellant will experience some degree of discomfort or pain, although the differences in the table are not statistically significant. The implication is that appellants' interests would be better served if more locations were used for tribunal hearings in order to reduce travelling times.

20.6 Access into and around tribunal premises

Table 20.11 shows the extent to which people had problems with access into and around tribunal premises.

Table 20.11 Appellants' experiences of access into and around tribunal premises (combined DLA and AA samples)

Access problems	**Percentage of appellant&**
Getting into tribunal premises	18
Getting around tribunal premises	13
No problems	79
Total	213

Source: Survey of tribunal appellants.

[1] Percentages do not sum to 100 per cent due to multiple responses.

In total, 44 people reported a problem with access either into or around the tribunal premises. The nature and the degree of these difficulties are not known but the fact that one in five appellants reported some problem does suggest that access for disabled people could be improved.

20.7 People's perceptions of the time taken to reach a tribunal hearing

In the survey, respondents were asked how long their appeal took to process and for their assessment of whether this was reasonable. The responses of the DLA and AA samples are presented in Tables 20.12 and 20.13 respectively. The point was made in Chapter 19, in relation to clearance times for reviews, that we are not trying to obtain an objective measure of how long claims, reviews or appeals take to process. Rather, we are drawing on people's perceptions of what is a reasonable time to wait for a hearing, to suggest the type of performance target that the ITS and the Benefits Agency should perhaps be aiming to meet.

Table 20.12 Respondents' perceptions of time taken to process appeals by their assessment of reasonableness (DLA sample)

	Respondent's assessment of reasonableness					
No. of months	**Very (N)**	**Fairly (N)**	**Not very** (N)	**Not** at all (N)	**Total** (N)	(%)
Up to 1	3	2			5	(4)
> 1 to 2	5	15	6	2	28	(23)
> 2 to 3	5	15	6	9	35	(29)
> 3 to 6	1	10	9	17	37	(30)
>6 to 12		3	2	12	17	(14)
Over 1 year				1	1	
All cases (%)	11	37	19	33	122	

Source: Survey of tribunal appellants.

Table 20.13 Respondents' perceptions of time taken to process appeals by their assessment of reasonableness (AA sample)

	Respondent's assessment of reasonableness					
No. of months	**Very (N)**	**Fairly (N)**	**Not very** (N)	Not at all (N)	**Total** (N)	(%)
Up to 1	5	2	1		8	(6)
> 1 to 2	5	21	3	2	31	(25)
> 2 to 3	4	12	6	5	27	(22)
> 3 to 6		7	9	15	32	(26)
> 6 to 12		2	3	12	17	(14)
Over 12				9	9	(7)
All cases (U)	12	35	18	35	124	

Source: Survey of tribunal appellants.

The numbers in these tables are relatively small but the pattern they display does confirm the commonsense notion that people's ideas about what is a reasonable clearance time change, the longer it takes for their appeal to reach a tribunal. It is important to note that fewer than half the appellants in both DLA and AA samples thought that the time they waited was reasonable. The tables also show that the majority of appellants thought periods up to three months were reasonable. By the time people have waited six months the general view of what is reasonable changes, with over half the respondents considering such a length of time unreasonable. Unfortunately the data do not allow us to identify the number of months (between three and six) at which the turning point between reasonable and unreasonable occurs. However, it is not surprising to find a large number of people seemingly dissatisfied with waiting over three months. In Chapter 19, according to the perceptions of our DLA and AA survey respondents, over 95 per cent of their reviews were processed within three months. Similarly, 94 per cent of claimants said their initial claim was cleared in this time (see Chapter 14). Very few people, therefore, are likely to have had to wait for more than three months at either the initial claim or review stages of claiming.

Long delays in arranging tribunal hearings are clearly undesirable. However, as previous studies of tribunals have shown (see, for example, Sainsbury, 1992), the business of getting a case to a hearing is complicated by the number of people who can become involved. Delays cannot simply be attributed to the ITS. Appellants contribute by needing time to collect further information, representatives need time to prepare for the hearing, and the Benefits Agency needs time to put together the adjudication officer's submission. In tackling the problem of tribunal clearance times, therefore, there are opportunities for working on different fronts simultaneously. Because delays can be due to a number of causes, performance targets, which apply to ITS only, may also be problematic by effectively putting responsibility on ITS for delays which are essentially outside its control.

20.8 Tribunal attendance rates

For a tribunal to operate most effectively it is essential that the appellant appears in person at the hearing. For many tribunals, such as Social Security Appeal Tribunals (SSATs), attendance rates are relatively low, below 50 per cent. In contrast the attendance rates for MATs, where a medical examination may be needed, are high. For example, in 1990 the MAT attendance rate was over 90 per cent (Sainsbury, 1992). Table 20.14 shows the proportions of appellants who attended their DAT hearings or had someone represent them.

Table 20.14 Appellants' attendance rates at DATs

	DLA		AA	
Who attended tribunal?	(N)	(%)	(N)	(%
Appellant	107	(72)	108	(63)
Someone on appellant's behalf	19	(13)	27	(16)
Total number of tribunals at which appellant was represented	126	(85)	135	(79)
Total	149		171	

Source: Survey of tribunal appellants.

When we asked respondents why they did *not* attend their tribunal a diverse range of reasons emerged, from people being generally fed up to those who explained that according to official information they had read, attendance was not necessary. However, for the AA sample the most common reasons were that appellants were too ill to attend (but not in hospital at the time) or that, for a number of reasons, they could not get of the house. None of these appellants had requested the tribunal to be held in their home although it seems as though they could have been justified in doing so. Domiciliary tribunals are time-consuming and expensive. It is therefore sensible to hold them only when necessary. However, it is equally undesirable that appellants might want to attend their hearing but are unable to, and do not know about domiciliary tribunals.

Previous studies of tribunals (Baldwin, Wikeley and Young, 1992; Genn and *Genn,* 1989; Sainsbury, 1992) have consistently shown that success rates for appellants are higher when they attend the hearing in person and when they are represented by someone. In Table 20.15, which presents data for AA only', we see a similar association between tribunal attendance and outcome.

Table 20.15 Comparison of success rates with tribunal attendance AA appellants}

Who attended tribunal	Outcome of tribunal for appellant Success	Failure	Total
Appellant and/or representative	53	47	133
No-one	24*	76*	29

Source: Survey of tribunal appellants.

* Percentages based on fewer than 50 cases.

People who attend their hearings are not guaranteed success. However, their chances are increased because the tribunal will be able to base its decision on more than documentary information. Clearly many appellants heed the advice in official documents to attend their tribunal hearing. Nevertheless, if by amending the information currently available, more could be encouraged to do so, then the job of the tribunal would be made easier, and more appellants would be more likely to have their cases decided on the fullest possible evidence.

20.9 Appellants' views about the introductions by the tribunal Chair

The importance of the Chair's role in tribunal proceedings is recognised in the training they receive from the ITS. Putting people at their ease and ensuring that they are aware of how the hearing will be conducted are not only important *per se* but serve a functional purpose also. Appellants who are relaxed and confident about what will happen may be more likely to participate more effectively in presenting their evidence and in responding to the questions from the tribunal members. Although Chairs would be expected, in every case, to introduce the members of the tribunal and to explain its way of working, three per cent of the 215 appellants who attended their hearing said that the tribunal was not introduced, and nine per cent said that the proceedings were not explained to them. In the study of MATs (Sainsbury, 1992) it was found that some people, usually due to high levels of nervousness, did not take in what was being said to them in the early minutes of the hearing and, in an interview later, forgot that introductions had been made. Some of our DLA and AA appellants may have been similarly affected.

Appellants who said that proceedings were explained to them were asked if the explanation was helpful. Table 20.16 presents their responses.

Table 20.16 Appellants' views about the helpfulness of the Chair's introductory remarks (combined DLA and AA samples)

Extent of helpfulness of Chair's remarks	Percentage of appellants
Helped a lot	65
Helped a little	27
Did not help	5
Don't know	3
Total	186

Source: Survey of tribunal appellants.

That five per cent of appellants said that the Chair's explanatory remarks were not helpful suggests that Chairs are generally fulfilling this aspect of their role adequately.

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[1] As we explained in Chapter 18. the bias in the DLA sample does not allow analysis of the date of the outcome of the tribunal.

20.10 Appellants' views about the conduct of the hearing

As mentioned earlier, proceedings during the hearing are intended to be *inquisitorial* rather than adversarial. The task of the tribunal members is to gather as much of the relevant evidence as possible. The role of the Secretary of State's representative is to assist the tribunal by acting as *milieus curiae.* Appellants were asked if they felt the questions from the tribunal helped them present their case or made it more difficult, and about whether they said everything during the hearing that they wanted to.

Table 20.17 first presents the responses to the question about the helpfulness of the tribunal members' questions, broken down by whether the appellant's appeal was successful or unsuccessful.

Table 20.17 Appellants' assessment of tribunal members' questions by outcome of appeal (combined DLA and AA samples)

	Outcome of appeal for appellant	
Assessment of questions	**Win** (%)	**Lose** (%)
A lot of help	63	22
A little help	22	34
Made things difficult	6	26
Neither helped nor made it difficult	8	17
Total	147	58

Source: Survey of tribunal appellants.

Interpretation of this table is difficult because people's assessments of the helpfulness of the tribunal's questions are correlated with the outcome of their appeal. Nevertheless, even among the unsuccessful appellants over half said that the tribunal's questions were helpful to varying degrees.

Table 20.18 presents the responses to the question about whether appellants said everything during the hearing that they wanted to.

Table 20.18 Appellants' assessment of whether they said all they wanted to during the hearing by outcome of appeal (combined DLA and AA samples)

	Outcome of appeal for appellant	
Appellant said all he or she wanted?	**Win** (%)	**Lose** (%)
Yes	86	55
No	14	45
Total	147	60

Source: Survey of tribunal appellants.

Although the tribunal will want to make the most efficient use of its time and therefore restrict the scope of discussions to what it considers relevant, it is also important that appellants feel that they have been able to have their say during a tribunal hearing (some of which may not be relevant at all). If people do not feel this, they are likely to be less convinced that they have had a fair hearing. In Table 20.18 the *outcome* effect is once again clear. However, it is interesting to note that the proportions of successful and unsuccessful appellants who did say all they wanted are higher than the equivalent proportions from the study of MAT appellants (Sainsbury, 1992) - respectively 86 per cent compared with 80 per cent for successful appellants, and 55 per cent compared with 33 per cent for unsuccessful appellants. The figures for unsuccessful appellants are particularly striking and suggest that the task of allowing appellants to have their say is being seriously addressed by most DAT members.

When we asked the appropriate appellants why they did not say all they wanted to, the three most common reasons (each mentioned by around a fifth of respondents) were that:

- they felt inhibited, either through nervousness, or because they felt they were being prevented from speaking
- they felt bombarded by questions from the tribunal
- they simply forgot to mention something.

While the first two problems are within the tribunal's capabilities to affect, it would be difficult for the tribunal to address the third. However, appellants could be encouraged more to prepare fully for the hearing, by simply making notes of points to be made for example, in the documentation sent to them beforehand. In this way the risk of the appellant forgetting something would be reduced.

As mentioned earlier, DATs are not permitted to carry out a physical examination of appellants, nor require them to demonstrate their walking ability either within the hearing room or outside, both of which were standard practice for MATs. As a way of assessing whether DATs were complying with these restrictions, we asked the 215 appellants who attended a hearing whether they were physically examined. Only one said he was. In contrast, six of the 94 DLA appellants whose claim included the mobility component, said they were asked to demonstrate their walking ability. While this is a small percentage, it does appear that some tribunal members were either unaware of the restrictions placed upon them or ignored them.

20.11 Appellants' perceptions of the competence of the tribunal

One aspect of tribunal hearings which emerged as important from the study of MATs was whether appellants felt that the tribunal displayed a good knowledge of their medical condition. They were reassured if they felt the members appreciated and understood the extent of their disability. Our samples of DLA and AA appellants were asked two related questions, first whether they felt the DAT members had a good knowledge of their medical condition, and secondly, whether they had a good knowledge of how their everyday lives were affected by their disability. Table 20.19 presents their responses broken down by the outcome of the appeal.

Table 20.19 Appellants' view of whether tribunal members had a good knowledge of (a) their medical condition, and (b) how their everyday life was affected by outcome of appeal (combined DLA and AA samples)

	(a) Medical condition		**(b) Effect on everyday life**	
Tribunal have a good knowledge?	**Successful appellants** (%)	**Unsuccessful appellants** (%)	**Successful appellants** (%)	**Unsuccessful appellants** (%)
Yes	75	50	72	29
No	25	50	28	71
Total	142	54	141	55

Source: Survey of tribunal appellants.

Again an *outcome effect* is evident in the responses presented in this table. What is interesting, however, is that the responses of the unsuccessful appellants to the two separate questions are very different, unlike those of the successful appellants which are similar. The implication is that unsuccessful appellants are less convinced that the tribunal knows about the effects of disability than about the medical condition which is causing it. This is perhaps disappointing in view of the policy decision to include in the membership of each tribunal a person who is either disabled themselves or has experience of caring for or working with people with disabilities. In the research report on MATs the point was made that although tribunal members may have an expert knowledge of an appellant's condition and therefore do not need to ask questions about it during the hearing, this may be perceived as a *lack* of knowledge by the appellant. The conclusion was drawn that it was important not only that tribunal members were knowledgeable but it was also important to convey this competence to appellants. It seems that the same conclusion could be made about DATs and their knowledge about the effects of disability.

It is also possible that, although the ITS has a policy of `matching' the expertise of tribunal members to the appellants who are scheduled to appear before them, the members might *not* be expert in the effects of some conditions that appellants suffer from. It is not possible to pursue this further using the data from this part of the project. However, there does appear to be a case for investigating in more detail the implementation of the `matching' policy.

20.12 Appellants' perceptions of the `atmosphere' of the tribunal

Earlier in the chapter it was noted that putting appellants at their ease served the functional purpose of increasing the likelihood that they would participate more effectively in proceedings. Establishing a conducive atmosphere serves the same function. Respondents were asked to describe the atmosphere during the hearing. Table 20.20 presents their responses, broken down by the outcome of the appeal.

Table 20.20 Appellants' assessment of the `atmosphere' during the hearing by outcome of appeal (combined DLA and AA samples)

	Outcome of appeal for appellant	
Description of atmosphere	**Win** (%)	**Lose** (%)
Informal and friendly	33	12
Formal and friendly	61	60
Formal and unfriendly	5	13
Other description	2	15
Total	148	60

Source: Survey of tribunal appellants.

Although DATs have an element of formality in the tasks that they have to accomplish during the course of a hearing, they are usually conducted with a large degree of informality at a personal level. Also there are none of the trappings and formal procedures that are common in the ordinary courts. Although the *outcome effect* has affected appellants' responses, there were still over 70 per cent of unsuccessful appellants who thought that, at least, the atmosphere was friendly. In order to pursue this issue further, we asked appellants to assess the extent of their nervousness *before* and *during* the hearing. Table 20.21 compares their responses.

Table 20.21 Appellants' levels of nervousness before and during the tribunal hearing (combined DLA and AA sample)

	Feeling during hearing				**Total**	
Feeling before hearing	**Ye!. new** nu,	**A bit nervous**	**Quite relaxed**	Very **relaxed**	**(N)**	**('/o)**
Very nervous			15	1	104	(50)
A bit nervous	7		13	1	63	(30)
Quite relaxed	2	4	30	1	37	(18)
Very rela ed	0		1	4	6	(3)
Total - o.	74	70	59	7	210	
	(35)	(33)	(28)	(3)		

Source: Survey of tribunal appellants.

From this table it is possible to comment on the relative effectiveness of the tribunal in responding to and alleviating the nervousness which many appellants will naturally feel. The overall level of nervousness can be seen to have been reduced from 80 per cent before the hearing to 68 per cent during the hearing. However, this conceals the relative moves to and from varying states of nervousness. The shaded cells of the table represents those appellants unmoved by the tribunal's efforts to relax them (104, or 50 per cent of the sample). The cells above the diagonal (54 appellants, 26 per cent of the sample) represent the successes of the tribunal, those who became more relaxed during the hearing (even if still a bit nervous). Relatively few (15 appellants, seven per cent of the sample) said they felt worse during the hearing. On balance, therefore, the tribunal relaxed more appellants than it made nervous. With over two-thirds of the sample reporting themselves nervous during the hearing, there is possibly a need to consider further ways in which appellants could be encouraged to relax during their hearing.

20.13 Satisfaction with the appeal process

20.13.1 Satisfaction and outcomes

The experience of the appeals process is likely to be different for appellants who attend their hearing and those who do not. For the latter group the process will be like the internal review - they will have submitted an appeal and subsequently have received a decision. The main difference this time would be that there is no possibility of further involvement with the Benefits Agency. An appeal lodged with a DAT becomes the responsibility of the ITS. There will be no further questions, telephone calls or medical examinations from the Benefits Agency (although it is possible that the DAT itself will require additional information which may necessitate contacting the appellant).

In the survey appellants were asked a general question about their satisfaction with the way in which their claim had been handled, and, where appropriate, a number of specific questions about the tribunal hearing. Tables 20.22 and 20.23 show (a) appellants' satisfaction levels with the conduct of the tribunal hearing and (b) their assessment of whether they had a `fair hearing'. The responses are broken down by the outcome of the appeal.

Table 20.22 Appellants' satisfaction with the conduct of the appeal hearing by outcome of appeal (combined DLA and AA samples)

	Outcome of appeal for appellant	
Satisfaction	**Win** **(N)**	**Lose** (%)
Very satisfied	*72*	16
Fairly satisfied	20	32
Fairly dissatisfied	7	23
Very dissatisfied	2	29
Total	148	62

Source: Survey of tribunal appellants.

Table 20.23 Appellants' assessment of whether they had a fair hearing by outcome of appeal (combined DLA and AA samples)

	Outcome of appeal for appellant	
Fair hearing?	**Win** (%)	**Lose** (%)
Yes	93	48
No	7	52
Total	148	56

Source: Survey of tribunal appellants.

We have discussed at some length in this report the importance of the *outcome effect* on people's responses to questions about their subjective experiences of claiming DLA and AA. In the tables above an *outcome effect is* once again evident in the correlation between the outcome of the appeal and both satisfaction with the hearing and views about whether a fair hearing took place.

20.13.2 Reasons for appellants' views about whether they received a fair hearing

The reasons given by DLA and AA appellants about whether they received a fair hearing showed very similar patterns. In Tables 20.24 and 20.25 therefore we have combined the responses of the two samples. Table 20.24 shows the most common reasons cited by appellants for thinking their hearing was fair. Table 20.25 shows why people thought their hearing was unfair.

Table 20.24 Reasons why appellants thought they had a fair hearing (combined DLA and AA samples)

Reason	**Proportion** of **respondents mentioning reason** (%)
Tribunal listened to what I had to say	37
Tribunal came to the right decision	28
I had a chance to explain things	22
Tribunal were helpful/friendly	16
No. of respondents	166

Source: Survey of tribunal appellants.

Although over a quarter of the respondents to this question appear to have equated the phrase `fair hearing' with the successful outcome of their appeal, it is clear that many people valued the opportunity that the tribunal gave them to put forward their evidence. As Table 20.25 shows, the main reason why people thought the tribunal unfair was that they were unsuccessful, cited by 11 of the 40 respondents. Other reasons were each mentioned by a small number of respondents only, but the table does indicate that people were unhappy when, for some reason, they felt they could not get their message across to the tribunal.

Table 20.25 Reasons why appellants thought they did not have a fair hearing (combined DLA and AA samples)

Reason	**Respondents mentioning reason (N)**
Tribunal came to the wrong decision	11
I had no chance to explain things	7
Tribunal ignored important details	4
Tribunal did not listen to what I had to say	4
Tribunal were unhelpful/unfriendly	4
No. of respondents	40

Source: Survey of tribunal appellants.

By regrouping the wide range of reasons given by appellants into four composite categories, and combining the decisions of all respondents, we can get a better picture of the main concerns of appellants at the tribunal hearing. In Table 20.26 reasons associated with the appellant having their say (such as `they listened to me' or `I was given time') have been grouped together, as have those about the personal treatment of the appellant by the tribunal members. There were also a small number of comments about the competence of the tribunal (for example, `they knew or understood about my condition'), and as mentioned earlier, reasons which reflected people's feelings about the tribunal's decision.

Table 20.26 Summary of *reasons* why appellants thought their tribunal was fair or unfair (combined DLA and AA samples)

	Reasons given for fair or unfair hearing					
	Fair		**Unfair**		**Total**	
Reason	(N)	(%)	(N)	(%)	*(N)*	*(N)*
Opportunity to have one's say	118	(52)	19	(40)*	137	(50)
Reaction to the decision	46	(20)	11	(23)*	57	(21)
Personal treatment	43	(19)	14	(30)*	57	(21)
Competence of tribunal	15		2	(4)*	17	(6)
Other	4	(2)	1	(2)*	5	(2)
Number of reasons	226		47		273	

Source: Survey of tribunal appellants.
* Percentages based on fewer than 50 cases.

This table reaffirms the importance of the tribunal giving appellants the chance to have their say. That 30 per cent of the comments from people who thought the tribunal was unfair were concerned with the way in which they were treated also emphasises the importance of the personal nature of the hearing and shows that people are particularly sensitive to being treated, in their view, badly.

20.13.3 Satisfaction with the whole claiming process

Although most DLA and AA appellants said their experiences of claiming were satisfactory, their overall satisfaction with the whole claiming process presents a clear contrast with their experience of the appeal only, as Table 20.27 shows. The responses are broken down by the outcome of the appeal.

Table *20.27* Overall satisfaction with claiming DLA and AA by outcome of appeal (combined DLA and AA samples)

	Outcome of appeal for appellant	
Satisfaction	**Win** (%)	**Lose** (%)
Very satisfied	20	8
Fairly satisfied	36	29
Fairly dissatisfied	22	16
Very dissatisfied	22	47
Total	224	93

Source: Survey of tribunal appellants.

From this table it appears that although there may be a large number of claimants satisfied with their appeal, this does not mean that they will necessarily have ended with a overall feeling of satisfaction with the way their claim had been handled across all its stages. For some of those appellants who win their appeal, their ultimate success is clearly overshadowed by their earlier experiences of receiving unfavourable decisions on their original claim and at the review stage.

20.14 Discussion and conclusion

In this chapter we have examined people's experiences of, and satisfaction with, appealing to a DAT. Our analysis of the DLA data has been hampered, as it was for the review sample also, by the unusually high success rate of the DLA sample explained in Chapter 18. Our interpretations of some analyses based on the outcome of the review have therefore been tentative.

DATs were only introduced when DLA and AA came into being. However, they were not entirely new bodies in the sense that, in their structures and procedures, they have a clear antecedents in both MATs (which among other things, used to hear mobility allowance appeals) and in SSATs. DATs have therefore had the advantage of drawing on the strengths of MATs and SSATs while also avoiding some of their less favoured practices, such as MATs routinely carrying out medical examinations as part of the tribunal hearing.

Apart from people's assessments of the DAT itself the survey of appellants produced useful information on the attendance rates of appellants and about the extent to which, compared with their original claims, they use further evidence to support their appeals.

Attendance at the tribunal hearing is highly desirable from everyone's point of view. Appellants have an increased chance of succeeding with their appeal, and DAT members are able to base their decisions on the fullest possible information by being able to question the appellant directly. Although the attendance rates for appellants themselves (rather than someone attending on their behalf) were reasonably high (72 per cent for DLA appellants and 63 per cent for AA appellants) they do not reach the levels reported in the study of MATs (Sainsbury, 1992) in which around 93 per cent of hearings were attended by the appellant. While it is unrealistic to expect a 100 per cent attendance rate, the results from the

MAT research suggest that the DAT figures could be higher. In Section 2 we saw that most people obtain their information about appealing from official documents. There is a case, therefore, for looking at the information given to people about appealing and possibly strengthening the encouragement to attend. For example, the leaflets DLA 381 and DS668C, called *Notes about an appeal,* include the following two sentences:

> You will be asked if you want to go to the tribunal. The tribunal members would like you to go and tell them about your appeal.

While it is important to maintain a balance between encouragement and direction there is possibly scope for emphasising further the importance of appearing in person at the hearing.

We have also seen that some people, particularly AA appellants, could not attend their hearing because they were too ill or could not get out of their house for some other reason. Although some of these people may fulfil the criteria for a domiciliary tribunal, this facility is not currently mentioned in information leaflets about tribunals. Considering that, by definition. claimants of DLA and AA will have some degree of illness or disability, this is an unhelpful omission. Although it would not be desirable to create a huge unjustified demand for domiciliary tribunals, some thought should perhaps be given to informing people that, in some limited circumstances, the tribunal could take place at their home.

In Section 3 we noted that one-third of AA appellants who submitted a GP's report to the tribunal had not previously obtained a supporting statement with their original claim. This reinforces the suggestion made in Chapter 17 that more encouragement should be made to new claimants to get supporting statements, particularly from their own doctors. More claims with supporting statements might reduce the number of reviews and appeals if adjudication officers were able to allow claims earlier in the process, although of course the supply of additional evidence is no guarantee of success.

The views of appellants about the tribunal documentation suggests that there is considerable scope for making official documents more accessible to people who are likely to have little or no medical or legal knowledge.

Some people with physical disabilities are vulnerable to discomfort or pain when required to travel long distances or for long periods. Their interests are clearly better served by the larger number of tribunal locations suitable for holding DATs than are available for MATs but further consideration could be given to ways of minimising the necessity for people to undertake long and potentially painful journeys. Similarly, access into and around tribunal premises could usefully be reviewed to reduce problems specific to disabled people.

The overall picture to emerge about the conduct of tribunal hearings was positive. Although interpretation of the findings has had to take account of the *outcome effect,* it seems that Chairs generally perform their introductory functions well and that many people are helped by the questioning of the tribunal members. Most appellants found the atmosphere friendly even though over two-thirds were nervous to some degree during the hearing.

As we mentioned above, the main purpose of the survey of appellants was to obtain their views on the operation of the new tribunals. We approached this in a slightly different way to the measurement of satisfaction with the initial claiming process and with the internal review by asking first about satisfaction with the conduct of the hearing, and secondly about whether people thought that they had been given a *fair hearing.* The responses to these separate questions were broadly similar and equally affected by the *outcome effect.* The picture that emerges is a familiar one: among successful appellants satisfaction is very high, around and above the 90 per cent level, but among unhappy appellants satisfaction falls to around the 50 per cent mark. This leaves the same problem that we have faced in relation to the *claims* and the *review* samples of having no adequate measure of overall satisfaction.

Having said that, when we look at the reasons for people's satisfaction and dissatisfaction, we do get a picture of the relative importance of different aspects of the tribunal hearing. It is clearly important for people to feel both that they have been given the opportunity of having their say and that they have been treated courteously by the tribunal members. When people think that they have not achieved either of these they in turn feel that they have been denied a fair hearing. These findings emphasise that the tribunal not only has the judicial task of making a correct decision on the evidence available, it must also convince the appellant that a fair hearing has taken place; in other words, that justice has been done

Chapter 21 Discussion and Conclusion

In Part Three of this report we have examined people's experiences of the review and appeal arrangements for DLA and AA. These arrangements are novel in two respects. First, for DLA and AA, unlike most other benefits, the internal review of decisions is a *mandatory* first tier of a two-tier appeal structure. Claimants unhappy with the initial decision on their claims can only ask the Benefits Agency to review its decision in the first instance. There is no immediate right to a hearing before an independent tribunal. The second innovation is the introduction of a new tribunal, the DAT, with a membership which includes people with knowledge and experience of disability.

As part of its wider commitment to evaluate DLA and AA, the DSS is concerned to know the extent to which claimants are satisfied with these new arrangements. We have attempted to provide some initial answers by carrying out separate surveys of claimants whose claims had been reviewed, and of people who had appealed to a DAT. However, as we have noted, the unusual composition of the DLA review and appeals samples (both containing a preponderance of successful claimants) has restricted the scope of some of our analyses.

In this concluding chapter we discuss a number of issues raised by the analyses of people's experiences of the review and appeal processes. First, we look at what can be learned about overall satisfaction, particularly given the existence of the *outcome effect.* Next we consider, based on the data about why people appeal and on success rates, the question of whether internal reviews and DATs are serving the functions intended for them. The third section considers the lessons that can be learned from our reviews and appeals data for the processing of initial claims. In Section 4 we make a few observations of the possible effect the different structures of DLA and AA might have on the generation of appeals. Section 5 summarises the ideas that have emerged for improving quality of service and for further research, before concluding with some final comments in Section 6.

21.1 Reviews, appeals and satisfaction

In measuring people's satisfaction with both the individual aspects of the review process and with the process overall, the influence of the outcome of the review on people's responses has been clear. This *outcome effect* is strongest on people's assessments of their overall satisfaction, but is also evident in responses to questions about specific aspects of the review. People's responses to questions about their experiences of the DAT are similarly affected. Our conclusion, which we also reached in respect of the survey of new claimants (see Chapter 17) is that any attempt to assess overall satisfaction lacks validity, but that useful lessons can be learned about the individual aspects of deciding initial claims, carrying out reviews or conducting tribunal hearings.

Although the limitations of an overall satisfaction measure are clear, it is interesting to compare the results of the review sample with those from the study of new claimants (in Chapter 16). For the DLA samples, overall satisfaction with the review process was 84 per cent (based on a sample whose success rate was 85 per cent), compared with a satisfaction rate for new claimants also of 84 per cent (but based on a success rate of 74 per cent). For the AA samples, overall satisfaction with the review was 78 per cent (success rate = 64 per cent), and with the initial claiming process, 73 per cent (success rate ='58 per cent). These figures prompt a number of, admittedly tentative, observations about how the *outcome effect* operates. The overall satisfaction rates for the DLA *claims* and *reviews* samples are the same but the success rate of the review sample is ten percentage points higher. This lends support to the hypothesis raised in Chapter 2 that when people are assessing their overall satisfaction with the review they are also taking into account their views about the outcome of their initial claim. The AA success rates are lower than for DLA and, as we would expect from the *outcome effect,* the overall satisfaction scores are lower. Also the slightly higher success rate of the AA review sample is matched by a slightly higher satisfaction score. The implication of these observations for the measurement of satisfaction is simply that while the *outcome effect* is clearly identifiable, *quantifying* its impact is problematic, especially in relation to review claimants for whom the effect is multi-dimensional (that is, comprising separate feelings about the review and the initial claim).

Despite the flaws in current measures of overall satisfaction they could be used as a crude means of comparing changes in satisfaction from year to year. This in itself has limitations (which are discussed in detail in Chapter 16) such as the problems created by changing standards of service. It might be useful, nevertheless, to pay particular attention, not to the satisfaction of the whole population of claimants, but to those who are not successful in their claims, reviews or appeals. Because this group has relatively low satisfaction levels, it might be a more sensitive indicator of changes than successful claimants whose levels are commonly in excess of 90 per cent. In the study of MAT appellants (Sainsbury, 1992) it was suggested that one yardstick of the success of tribunals might be the extent to which *unsuccessful,* rather than successful, appellants feel they have had a fair hearing. In that study, only 28 per cent of unsuccessful claimants said their hearing was fair. That 48 per cent of the appellants in this study said their hearing was fair is at least some indication that DATs have gone some way to achieving one possible, though elusive, objective of a tribunal, the *satisfied loser.*

21.2 Are internal reviews and DATs serving the function intended for the

In Chapter 14 we commented that, although we had no comparable data for other social security benefits, there appeared to be a large proportion of dissatisfied claimants who had made a review request or intended to make one. We estimated that there was an *appeal rate* of over 60 per cent among both DLA and AA claimants.

We investigated the reasons why these claimants wanted to appeal as well as the reasons cited by our reviews samples. We concluded that most people's intentions were `relevant' in the sense that they were predominately about some aspect of the original decision or how it was made. There were few claimants who said their reason for asking for a review was because their condition had deteriorated (that is, that there had been a change in their circumstances). This contrasts with the finding from the *Targeting* study that, statistically, a change in the claimant's condition was the factor most strongly associated with a review request. Whether these contrasting findings are reconcilable is not our main concern here, though it is possible to offer hypotheses to explain the apparent inconsistency (see Chapter 7). Review requests within three months can be made on any grounds, including a change in circumstances. What is more important are the reasons why decisions are changed at review.

Decisions based on reviews *outside three months* cannot be appealed to a DAT. Our understanding is that most of these decisions are based on changes in circumstances rather than the identification of mistakes in the original decision. We therefore have an anomaly between decisions based on changes in circumstances *inside* and *outside* three months. The former can be appealed to a DAT, but the latter are treated as *de novo* decisions and subject, in the first instance, to internal review only. The effect of this anomaly is that DATs will hear appeals against decisions based on changes in circumstances which, according to the logic behind the *inside* and *outside* three months distinction, should be subject to internal review only.

While we cannot assess the impact of this anomaly from our survey, it appears that the expensive and time-consuming resource of the DAT may be performing functions which could more appropriately and efficiently be dealt with at a lower tier of adjudication. To investigate this further, however, would require research into the decision-making behaviour of adjudication officers carrying out reviews in the DLA and AA Units, and of tribunals.

21.3 What can we learn about the processing of initial claims?

One of the uses of studying review and appeal procedures is that, in theory at least, useful lessons can learned for the processing of initial claims. The problem is how to interpret, for example, success rates at the higher levels of adjudication. This problem is not new. In his seminal article on administrative reviews, Coleman (1969) posed the question of whether a success rate of, say, 35 per cent at internal review, is an indication of a system sensitive to picking up minor errors in initial decisions and to the changing needs and circumstances of claimants, or whether it is a sign that there are major deficiencies with initial decision making.

Coleman could not answer his own question using administrative data. Nor can we using our survey data. However, the success rates of DLA and AA review applicants and tribunal appellants are, intuitively at least, sufficiently high (at around 50 per cent) to suggest that the question deserves serious attention. If reviews and appeals are primarily overturning earlier decisions because of changes in circumstances, this would require a different policy response (if any at all) than if review adjudication officers and tribunals were finding frequent errors in earlier decisions.

Further research into the decision-making behaviour of review adjudication officers and tribunals, already mentioned as potentially useful in the section above, could therefore provide important indicators about the health of adjudication and whether the review and appeal mechanisms for DLA and AA are doing what was intended for them.

21.4 The structure of DLA and the generation of appeals

We have already noted that, using one possible definition, the *appeal rate* against initial decisions on claims was over 60 per cent for both benefits. Appeals against review decisions were at a similar level for DLA claimants unhappy with their decision, but slightly lower for the AA sample (below 50 per cent). Looking at the actual and intended appellants at both stages we find that while most AA appellants had had their claims rejected, far more DLA claimants had initially been given an award with which they were unhappy.

Though of little policy relevance, this suggests a possible unfortunate irony. DLA is a benefit designed to respond appropriately to the range and severity of people's needs. As a result, there are 11 possible combinations of award that can be made. In contrast, AA is a less comprehensive benefit with a single element (for care) paid at two rates only. The irony lies in the greater scope for dissatisfaction that is created by the complicated structure of the more comprehensive benefit compared with the simpler benefit. The result is that, compared with success rates, DLA generates the greater number of review requests and appeals.

21.5 Summary of ideas about improving quality of service and about further research

The main research aim of this part of the project has been to present data on the views, experiences and satisfaction levels of DLA and AA claimants whose claims have either been the subject of review or have been considered by a DAT. In so doing, we have also been able to identify aspects of service where there is possibly scope for development and improvement, and where there is a need for further research. In this section we summarise these ideas and suggest they warrant serious consideration by DSS, the Benefits Agency and the ITS as appropriate.

21.5.1 Ideas about the internal review

- Reassess the information given in official letters and other documentation about what might happen following a claimant's review request.

  Consider ways to encourage more claimants to supply medical information with their review request.

- Consider standardising the way in which medical information is collected.

- Reassess clearance targets using data on claimant experiences and expectations.

21.5.2 Ideas about the appeal to a DAT

- Reassess the information given in official letters and other documentation about how appeals are dealt with.

- Improve the content and presentation of tribunal documents to make them more accessible to appellants.

- Consider ways of reducing the need for some appellants to undertake long journeys to their hearing, including a review of the number and location of tribunal premises.

- Review the access into and around tribunal premises.

- Reassess clearance targets using data on claimant experiences and expectations, and taking into account the effect of sources of delay outside the control of ITS.

- Consider ways to encourage more people to attend their tribunal hearing.

- Provide appropriate information to appellants about the possibility of holding a domiciliary hearing.

* Continue to emphasise to tribunal members the importance to appellants of being treated seriously and courteously by them, of being allowed to say all that they want to during the hearing, and of having confidence in their expertise and competence.

21.5.3 Ideas about further research

- Investigate the decision-making practices of adjudication officers and tribunals in order to understand the reasons why decisions are overturned.

- Investigate the implementation and effectiveness of the policy of `matching' tribunal members to the appellants who appear before them.

21.6 Final comments

Although we remain sceptical about the use of measures of overall satisfaction, our analysis of the review process and its individual constituents, presents a generally healthy picture. The review, though serving the function of a first-tier appeal, is nevertheless an entirely administrative function. It is not surprising perhaps to find that people's experiences of the review were not dissimilar to those of the new claimants. It seems reasonable to suggest therefore that the lessons from that part of the project could equally be applied to the administration of internal reviews.

A comparable healthy picture emerges from our limited study of people's experiences of DATs. Although criticisms were made by appellants about various aspects of their tribunals, there were no consistent shortcomings that would suggest that anything is radically wrong with either the structure or the procedures of DATs.

In Chapter 20 we made the contrast between the proportions of DAT appellants who said they had had a fair hearing, and their overall satisfaction with the whole experience of claiming and going through the review and appeal stages (the latter being much lower than the former). The lesson to be drawn from this is that although a high quality appeal system is desirable, it cannot be a substitute for the highest standards of decision making and personal treatment at the lower tiers of adjudication.

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Appendix 1 Sample Design of the Targeting Study

The *Targeting* study required a sample stratified between lower rate recipients and unsuccessful applicants. These were to be drawn from the DLA computerised database managed by Benefits Agency staff at the central DLA Unit in the Fylde, near Blackpool. We aimed to achieve interviews with 1000 applicants who had recently been awarded *at least* one lower rate award and a further 500 applicants who were rejected solely on disability grounds, that is, whose care and mobility needs were judged to be insufficient to qualify for an award. The group of lower rate recipients includes people with dual awards with the second component paid at any rate. In addition, it was decided to include 300 recipients of middle and higher rate awards from the Qiia/irl *of Service* study, described in Part Two of this report. This third group also includes dual awards where the second component is paid at the middle or higher rate. The sample design thus includes three strata.

Certain groups of applicants were excluded from the sample by design. These were chiefly:

a. People with terminal illness who applied for DLA under the *Special Rules* and who are not expected, therefore, to live longer than six months. The special rules allow the three-month qualifying period to be waived and recipients automatically qualify for the higher rate care component.

b. Children under five who may qualify for a care award. Children cannot qualify for a mobility award until the age of five but the chief reason for excluding younger children was to simplify survey procedures. Those under five would have required a different disability assessment to that of older children.

c. Former recipients of AA and MobA, who applied for lower rate awards, so-called `top-up' claims. These were a major element of DLA in its initial phase and represent a one-off, historical, situation.

d. Renewal claims, that is, recipients initially awarded DLA for a fixed period who apply for an extension of their award.

The effect of the last two exclusions is to focus the sample on new claims for DLA. The vast majority of these are made by first-time applicants. However, it was expected that the sample would include a few people, previously rejected for DLA, who decide to submit a fresh claim. In such cases, the survey questionnaire addressed issues relating to their latest claim.

The sampling procedure was designed to select *recently decided* claims whether these were successful or not. We wanted to interview applicants as closely as possible to the time of submitting their claim so that their circumstances would not have changed appreciably before the interview. The aim here was to ensure that the survey assessment of their care and mobility needs would produce similar information to the account given on their DLA application form. It was also important for the *Quality of Service* study to interview recent applicants so that their recollections of claiming DLA would be as accurate as possible.

However, not all claims are decided soon after they are received. Further information is required in some cases, including medical examinations, so some claims may be under consideration for several months. Such cases could only have been screened out in the field and this would have greatly complicated the proposed survey. Moreover, these applicants may be of a particular kind, for example they may present complex, changeable or problematic needs, so it was decided to keep them in the sample.

In the event, one week in April 1994 was selected as the sampling point and, working backwards, all applicants who met the criteria for inclusion in the study were selected. The sample thus covered:

- all ages apart from very young children
- people from minority ethnic populations
- all disabling conditions, including people with mental impairment and those who communicate in different ways
- people living in private households and communal establishments
- the whole of Great Britain.

Initially, a clustered sample design was proposed on the grounds that an increase in cost effectiveness allows a larger sample size for a given cost, which offsets the reduction in effective sample size. Further discussion with researchers at SCPR, which was commissioned to carry out the fieldwork, concluded that an unclustered sample was the preferred option. It was easier for staff of the Benefits Agency to draw such a sample and it was not expected to be excessively costly as far as the fieldwork was concerned.

The initial sample size had to allow for subsequent attrition. Be lic lit records are confidential to those administering the benefit so all potential respondents were invited to take part in the survey by a standard letter from the DSS. Around 11 per cent opted out of the target study sample at this stage, much less than expected. Non-contact and refusals in the field accounted for further attrition. Table Al.l summarises the outcome.

Table Al. I Summary of response by sample subgroup: children and adults

Subgroup	**Sample design**	**Number invited**	**Number opting out**	**Number issued**	**In-scope**	**Inter-viewed**	**For analysis**
Lower rate awards	1000	1800	208	2265	2114	1819	1026
Middle/Higher rate awards	300	540	92				303
Unsuccessful applicants	500	900	72				489
Totals	1800	3240	372	2265*	2114	1819	1818

* 603 sample members were held in reserve.

Sample members found to be out of scope during the fieldwork include respondents who had died, moved address and were not traced, in hospital, or who refused an interview. Some addresses were a business, empty or untraceable. Overall, 86 per cent of the sample in scope was interviewed, much higher than the target of 80 per cent. The final sample available for analysis closely mirrors the initial design and includes 1626 adults and 192 children.

A full technical report on the survey, including sampling, questionnaires, fieldwork, and data preparation is available from SCPR (McKay and Hales, 1995).

Appendix 2 Representatives of the Targeting Study

As described in Appendix 1, a 100 per cent stratified sample of recently decided claims for DLA was drawn as close as possible to the proposed fieldwork. The best approach to assessing the representativeness of such a sample is to compare its characteristics with those who applied for DLA around the time the sample was drawn. Ideally, we expected to be able to return to the DLA database to extract a comparison group in exactly the same way as the sample was drawn, but this was not possible. Instead, data from the *DLA Quarterly Statistical Enquiry* (QSE) was supplied to the researchers. The QSE is a routine extract from the DLA database which is used for monitoring the administration of the benefit. It has three drawbacks for assessing the representativeness of our sample. The QSE itself is based on a five per cent sample of DLA awards so it too is subject to sampling errors. Second, the QSE relates to awards not applicants, so information on unsuccessful applicants is not available. Third, it covers all awards including those to people with terminal illness who qualified under the *Special Rules*, children under five, and other groups that were excluded from our sample. Differences between the achieved sample and the QSE, therefore, do not necessarily indicate bias in the former.

The QSE data available to us covers the period between the beginning of January and the end of April 1994, and therefore straddles the period when our sample was drawn. It is based on a grossed-up sample of 65,220 successful applicants; information was supplied on their age, sex, main disabling condition, DLA award and region. There are 5100 *Special Rules* cases in the QSE data and 4720 children under five. *Special Rules* cases could be excluded only when looking at the distribution of DLA awards. Children under five could be discounted when considering both DLA awards and the age distribution in the QSE.

The tables that follow compare the sample of DLA recipients, 157 children and 1172 adults, with the QSE data for each of these variables in turn. Recipients with at least one lower rate award, regardless of whether they have a middle or higher rate award for the other component, are shown separately from those with middle or higher rate awards alone, because this is how the original sample was stratified. Cells with fewer than 15 sample members are combined. This chiefly affects a number of disabling conditions.

A2.1 Age

The age distribution of the achieved sample is compared with that of the QSE in Table A2.1, after excluding children under five years from the latter. Differences are small, though children aged 5-15 are somewhat over-represented and those aged 60 and older are slightly under-represented.

Table A2.1 Age distribution of DLA recipients

	All lower rate recipients		**Middle/Higher rate recipients**	
Age group	**Sample** (%)	**QSE** (%)	**Sample** (%)	**QSE** (%)
5 to 15	13	7	7	4
16 to 29	13	12	7	7
30to 39	14	17	12	10
40 to 49	19	19	19	17
50 to 59	28	26	31	34
60 and over	12	18	24	28
Base (= 100%)	*1018*	*23,640*	*303*	*36,860*

Eight sample cases missing.

A2.2 Sex

Table A2.2 shows that the sample of lower rate recipients has a similar sex ratio to that of the QSE though we might have expected to interview slightly more middle and higher rate recipients who were men

A2.3 Region

Table A2.2 Classification of DLA recipients by sex

	All lower rate recipients		**Middle/Higher rate recipients**	
	Sample	**QSE**	**Sample**	**QSE**
Gender	(%)	(%)	(%)	(%)
Males	46	49	49	54
Females	54	51	51	46
Base (= 100%)	*1018*	24,600	*303*	*40,620*

The regional distribution of DLA applicants is represented by the DBC which handled the original claims. There are 11 of these scattered throughout the country, although Glasgow DBC handled too few applicants to be shown separately. The following table shows that differences in regional distribution between the sample and the QSE nowhere exceed four per cent.

Table A2.3 Regional distribution of DLA recipients

	All lower rate recipients		**Middle/Higher rate recipients**	
Disability	**Sample**	**QSE**	**Sample**	**QSE**
Benefits Centre	(%)	(%)	(%)	*(°l%)*
Edinburgh	5	5	5	4
Newcastle	6	5	9	6
Leeds	14	12	11	11
Manchester	6	7	8	7
Bootle	6	8	8	9
Birmingham	18	16	17	15
Bristol	8	6	10	6
Cardiff	6	6	9	10
Wembley	14	16	11	13
Sutton	12	15	7	10
Other*	4	5	7	8
Base (= 100%)	*1026*	*24,600*	*303*	*40,620*

* Includes claims managed at Glasgow DBC and at non-DBC units.

A2.4 DLA award combinations

As described in Chapter 2, 11 combinations of award are possible. The distribution of these in the achieved sample is shown in Table A2.4. Compared with the QSE, which here excludes children under five and people with terminal illness, it can be seen that the sample contains more higher rate mobility awards and fewer dual awards at the higher rate.

To investigate this further, we compared the achieved sample with the one issued to the survey agency which included all those selected for interview, less those who had opted out. The comparison revealed that the apparent discrepancies in the achieved distribution of DLA awards were largely present *before* the field work began. Differences between the issued and the achieved sample are less than one per cent for each combination of award, with two exceptions where the differences are only slightly larger. These are higher rate mobility awards only (57 and 61 per cent for the issued and achieved sample respectively) and dual higher rate awards (ten and seven per cent respectively).

Table A2.4 Combinations of DLA awards

Type of recipient	Sample (%)	**QSE** (‰)
All lower rate recipients		
HR care and LR mobility	5	8
MR care and LR mobility	17	19
LR care and HR mobility	30	26
LR care and LR mobility	12	11
LR care only	30	27
LR mobility only	6	9
Base (= 100%)	*1026*	*23,700*
Higher/Middle rate recipients		
HR care and HR mobility	7	16
HR care only	2	3
MR care and HR mobility	20	20
MR care only	10	6
HR mobility only	61	54
Base (= 100%)	*303*	*31,700*

Less obvious, perhaps, is an excess of lower rate care awards over lower rate mobility awards in the achieved sample. Among awards with a lower rate component, it can be seen that 72 per cent include lower rate care and 40 per cent lower rate mobility. Comparable figures for the QSE are 64 and 47 per cent respectively. Again the achieved distribution of lower rate awards is almost identical to that of the sample issued to the field work agency (71 and 41 per cent respectively) so any bias probably reflects the composition of decided claims during the sampling period.

As expected, the achieved sample is not representative of the QSE when the two sample strata are combined and the effects of the sample design are shown in Table A2.5. Each combination which includes a lower rate award is over-represented. By comparison, some of the other combinations are markedly under-represented, including dual higher rate awards, middle rate care and higher rate mobility awards, and higher rate mobility only awards.

Table A2.5 Combinations of DLA awards overall

Combinations of awards	Sample (%)	**QSE** (%)
HR care and HR mobility	2	9
HR care and LR mobility	4	3
HR care only	0	2
MR care and HR mobility	5	12
MR care and LR mobility	13	8
MR care only	2	4
LR care and HR mobility	23	11
LR care and LR mobility	.9	5
LR care only	23	11
HR mobility only	14	31
LR mobility only	5	4
Base (= 100%)	*1329*	*55,400*

A2.5 **Main disabling condition**

Most respondents have more than one disabling condition according to our survey (see Chapter 3) but only the main condition is recorded on the DLA database. In most cases these would be based on reports by the applicants' GP or another health professional involved in their care. Some conditions were reported for comparatively few individuals so these have been combined into one category.

Table A2.6 shows few differences between the sample of lower rate recipients and the QSE across most conditions, including mental health problems. However, we interviewed fewer people with psychoses (Code D44) than might be expected, though people with neuroses (D45) and behaviour disorders (D50), the latter mostly children, are adequately represented in the sample. Among middle and higher rate recipients, people with malignant disease, cancer and neoplasia (D80) are under-represented, probably because they are likely to suffer from a terminal illness and were excluded from the sample. By comparison, half as many people again with musculo-skeletal disorders (D01) were interviewed than might have been expected among those with middle or higher rate awards.

Further examination of *all* DLA recipients who were potential respondents, that is sample members who had not opted out of the survey, revealed that these discrepancies could not be attributed to the field work process. The sample of lower rate recipients that was issued to the field work agency contained seven per cent of people with psychoses, compared with six per cent in the achieved sample. Similarly, the initial sample of middle or higher rate recipients comprised 30 per cent of people with musculo-skeletal disorders compared with 32 per cent in the achieved sample, and four and two per cent of people respectively with cancers.

A2.6 Conclusion

Table A2.6 Main disabling condition

		All **lower rate recipients**		**Middle/Higher rate recipients**	
DLA Code	**Main disabling condition**	Sample (%)	**QSE** (%)	Sample (%)	**QSE** (%)
DO1	Arthritis, rheumatoid and osteoarthritis	18	17	32	19
D02	Spondylosis, disc disease, cervical/lumbar, etc.	5	4	5	5
D03	Back pain not specified	3	2	3	4
D05	Disease of the muscles, bones or joint	7	6	10	7
D06	Trauma to limbs	2	2	5	3
D08	Blindness	6	7		0
D11	Heart disease, coronary, ischaemic, myocardial			8	9
D12	Chest disease, bronchitis, emphysaema, bronchiectasis	2	2	6	7
D13	Asthma	2	3	2	3
D16	Cerebrovascular disease, stroke, hemiplegia	4	3	5	4
D20	Epilepsy	6	6	1	1
D23	Neurological diseases not specified	3	3	2	2
D30	Diabetes mellitus	2	1	3	2
D40	Mental subnormality	12	12	1	3
D44	Psychosis, schizophrenia, manic depression	6	13	1	2
D45	Psychoneurosis, anxiety, depression, phobia, hysteria		3	0	0
D48	Dementia, senile, pre-senile, Alzheimer<,				0
D50	Behavioural disorder, enuresis, hyperactivity	2	2		
D80	Malignant disease, cancer, carcinoma, leukaemia	2	1	2	11
	All others	10	8	11	18
	Base (= 100%)	*1006*	*24,600*	*291*	*40,620*

32 sampling cases missing.

The sample of DLA recipients was designed to reflect the main objectives of the target study and accordingly over-represents lower rate awards. Otherwise, the achieved sample is broadly representative of the population of successful applicants whose claims for DLA were decided during the first four months of 1994. Any discrepancies largely reflect the composition of the cohort of applicants selected for interview, in particular the exclusion of people with terminal illness, and could not be explained by refusals or non-contacts during the field survey. No significant bias was introduced once the sample was drawn.

Appendix 3 Non-response Analysis of the Targeting Study

Not all respondents answer every question that is asked of them. There are various reasons for this: a respondent may refuse to provide information which is considered to be confidential or personal; the information may not be readily available; a question may be irrelevant to a respondent's particular circumstances, or may be perceived as such; an interviewer may inadvertently miss out a question. As a general rule of thumb, if information is missing for more than one in ten of the respondents to whom a particular question should have been addressed, then we might question the reliability of the information obtained.

An examination of the adult questionnaire, which contains 315 questions, revealed that information was missing in fewer than one per cent of cases (median 0.6 per cent, interquartile range 0.2 to 2.4 per cent). However, information on 13 questions was missing for between ten and 12 per cent of the sample. These include the 12 questions from the *General Health Questionnaire* which interviewers failed to administer to 171 respondents. They represent just over ten per cent of the adult sample and, if they are excluded, the actual refusal rate for individual items of the GHQ does not exceed 1.5 per cent. The remaining question, for which information was missing in 12 per cent of cases, asked respondents with a spouse or partner to estimate their combined total income from all sources, after all compulsory deductions for tax, National Insurance and so on. Although a few respondents apparently refused to answer this question, the main reason for the missing information was, not surprisingly, that respondents could not provide an estimate.

This analysis suggests that non-response was not a widespread problem and that, with the possible exception of information on `family' income, no significant bias was introduced by respondents failing to answer the questions asked of them.

Appendix 4 Statistical Methods

The survey data were analysed using the SPSS statistical procedures described in Norusis (1993a, b). Although the sample was not drawn at random from a specific population, we adopted a conventional value, $p < 0.05$, to define `surprising' results of statistical analyses. This means that differences or associations which are unlikely to arise more than five times in a hundred are considered to be statistically significant. The term `significant', therefore, is used only when referring to the result of a statistical test.

When analysing cross-tabulated data, we used adjusted standardised residuals to pinpoint significant categories and aid interpretation. Significant residuals identify the cells in a table with more or fewer respondents than might be expected by chance alone. To compare several means or averages, multiple comparison procedures were used to avoid the danger of calling too many differences significant. Essentially, these procedures adjust the observed significance level so that the difference between pairs of means must be larger for it to be considered significant.

In this report the OR is frequently used as a measure of association for tabulated data, to describe the direction and strength of statistical relationships between variables.[32] The range of an OR is 0 to infinity, with 1.0 representing lack of association. Confidence intervals are estimated to decide whether an observed odds ratio is significantly different from no-association. For a 2 x 2 table, the OR is calculated as follows where *a* to *d* represent cell frequencies:

	Predictor or explanatory variable		
	present	absent	
Response or outcome variable	a	b	OR +
	c	d	*(a/))/(cfd)*

In general, the odds of an event occurring are defined as the ratio of the probability that it will occur to the probability that it will not occur. Thus the odds of a positive outcome having the attribute represented by the explanatory variable are defined *as a/b.* This is divided by the odds that a negative outcome has the attribute, *cfd,* to give the OR.

When the OR is significantly greater than 1.0, this means that the odds of a positive outcome having the attribute are greater than the odds of a negative outcome being so described. That is, the attribute is more likely to be associated with a positive outcome than a negative one. In this case, the OR shows by how much the odds *increase* with a positive outcome, as opposed to a negative outcome, and represents the degree of association between the two variables. If the ratio is

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[32] The odds ratio is variously known as the *cross-product ratio or relative risk*.

significantly less than one, the odds of a positive outcome having the attribute are less than the odds of a negative outcome being so described. In this case, the OR shows by how muc.h the odds of a positive outcome having the attribute *decrease* compared with those of a negative outcome. The size of the OR indicates the strength of the association and shows how likely it is that cases with the attribute have a positive outcome.

Making statements of this kind about a statistical association between variables, does not necessarily mean that the relationship is of any practical importance, let alone a causal one. There may be other factors common to both the response and the explanatory variable which explain the observed relationship.

An example from Chapter 6 will illustrate the interpretation of ORs. The following table shows the number of lower rate recipients and unsuccessful applicants for a DLA care award who said they needed help preparing a hot meal (compare the first entry of Table 6.1).

Table A4.1 **Preparing a hot meal**

Type of applicant	**Needs help** (%)	**Does not need help** (%)	**Base** (= 100%)
Lower rate care recipients	498 (72)	190 (28)	688
Unsuccessful applicants	150 (40)	221 (60)	*371*

14 cases missing.

The odds of lower rate recipients needing help preparing a hot meal are 498/190 = 2.62, while the odds of unsuccessful applicants needing such help are 150/221 = 0.68. The OR is 2.62/0.68 = 3.85 (using all decimal digits the actual value is 3.86). This is statistically significant because we are 95 per cent confident that the OR lies between 3.0 and 5.0, so it is unlikely to encompass the value 1.0 or no-association. We can infer that needing help preparing a hot meal increases the odds or chances of a lower rate award nearly four times. Another way of expressing this is to say that there is a 3.9 greater `risk' of a lower rate award among applicants needing help preparing a hot meal than among applicants who do not need such help. Or, lower rate recipients are nearly four times as likely to need help preparing a hot meal as unsuccessful applicants.

Apart from simplicity, the advantage of the OR is that the degree of association is unaffected by sample size, or by the order in which the categories of a variable are written down. ORs also play a central role in loglinear models, including logistic regression which we have used to analyse the outcomes of applications for a DLA award. For reasons discussed in Part One of this report, it was important to evaluate each adjudication boundary separately, comparing lower rate recipients first with unsuccessful applicants and then with middle or higher rate recipients. Logistic regression is appropriate when the outcome or dependent variable has just two values.[33] These models also allow two or more attributes, or independent variables, to be considered at the same time. When a multiple logistic regression is estimated, each OR is adjusted for the effects of the other variables in the equation to show the *net* increase or decrease in odds. Although the outcome or dependent variable can have only two values, independent variables may have any number of categories or be continuous measures. In Chapter 5, the severity scores for each type of disability, set out in Annex 2.2, are treated as continuous variables. In this case, the OR shows the amount by which the odds change when the disability score increases by one unit.

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[33] Linear discriminant analysis could have been used but this requires more assumptions than logisitic regression.

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