LCP on point

Could early intervention prevent a retirement disability benefit timebomb?

September 2023

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Foreword

This report has been produced by LCP to highlight a key issue for the UK as part of our mission to improve population health outcomes and shape a more positive future.Given our combination of experience across both the pension industry and health we want to ensure this issue is highlighted, and this report is designed to support policy makers and wider stakeholders in addressing this challenge.No external funding has been provided in producing this report.

Executive Summary

The growing number of people of working age unable to work because of sickness or disability is an issue of increasing concern, both for the individuals concerned and for the taxpayer.

DWP has estimated that the current annual bill of just under £19 billion for working age disability benefits is expected to rise by one third in real terms in just four years' time. Meanwhile, the Office for Budget Responsibility (OBR) devoted a chapter of its 2023 'Fiscal Risks' report to the topic of '[economic] inactivity and health'. The OBR highlighted that 2.6 million people of working age are outside the labour force for health reasons and noted that the UK was an outlier in the extent to which high levels of economic inactivity had persisted beyond the end of the Covid-19 pandemic.

However, one aspect of this issue which has so far been neglected is the extent to which the rising costs of disability benefits may become entrenched, in particular as people make the transition from working age into retirement. Whereas 'incapacity' benefits such as Employment Support Allowance and Universal Credit end at pension age (with the recipients switching onto state pensions), 'disability' benefits continue for as long as the individual has care or mobility needs.

In this paper we look at the potential cost of leaving this growth in working age disability unchecked. We then make the case that a range of preventative health interventions are available which would benefit both the individual concerned and the taxpayer.

We begin by describing the current situation, focusing on Personal Independence Payment (PIP), the main disability benefit for adults[1].

The total number of people of all ages on disability benefits has risen by just over a million in the last decade (from 2013-14 to 2023-24) but is set to rise by another million in just the next three years (from 2023-24 to 2026-27).

Worryingly, we find that the fastest growing duration of claims is those claiming for five or more years, suggesting a rising core of people whose chance of 'flowing off' the benefit is relatively small. We also find a strong link between high levels of disability benefit receipt and areas of economic disadvantage.

[1] Data on PIP can be hard to interpret because hundreds of thousands of working age disabled people are gradually being 'migrated' from the legacy 'Disability Living Allowance' benefit onto the new PIP regime. We have adjusted for this transition wherever possible.

We then look at the position of people who reach pension age in receipt of Personal Independence Payment (PIP) and we undertake some modelling of potential post-retirement outflow rates.

Our key findings are:

- Reducing the care and mobility needs of an individual approaching state pension age could save over £70,000 per person in taxpayer costs if they no longer need to claim for PIP.
- Over half of people on PIP at/after state pension age will continue claiming PIP until they die.
- If a person reaches state pension age (66) whilst still claiming PIP, the median age at which they will flow off due to death or other reasons is estimated to be 77, totalling 11 years of claims.
- Even ignoring the effects of inflation, expenditure on PIP/DLA for retired people could increase to £10.5 billion by 2033 compared with £6 billion currently if no further preventative action is taken.

Given that eligibility for PIP requires an individual to have either care or mobility needs, we then consider the underlying health reasons why claimant numbers may be rising so sharply.

We identify four main headings:

- An expansion in the number of people living with multiple long-term health conditions.
- The rise in mental health conditions both as the main health condition and increasingly as a secondary condition in those with existing physical conditions.
- An increasingly diverse set of health needs in people with chronic conditions.
- The reduced resilience of the NHS to adequately manage the increasing complexity of population health demand.

These diverse explanations suggest that there may be a range of interventions which could help to prevent people from needing to commence a claim to disability benefit and/or could help to shorten durations amongst those who do make a claim. We note that in many cases these interventions could cost far less than the £70,000 per head which we have identified as the average post-retirement benefit bill for someone who would otherwise be on PIP.

Finally, we look at the interventions which are currently being undertaken by the government in this space. We find that these are very often poorly targeted and fail to focus on those most at risk of a long spell on disability benefit. For example, the DWP's recently expanded the Individual Placement and Support in Primary Care (IPSPC) programme is designed to support individuals in receipt of disability benefits, but the list of pilot local authorities chosen to date excludes those where disability benefit receipt is at its highest. Similarly, NHS England's Elective Recovery Programme that aims to increase capacity to tackle the waiting list backlog that worsened materially during the Covid-19 pandemic. Unfortunately, resources have not been allocated most to where unmet health need is the greatest. As our report in March of this year found, despite progress addressing the very long (more than 18 months) waiters, geographical inequalities have become more pronounced.

Despite the scale of the challenge set out in this paper, our conclusion is a positive one. We find that interventions which either prevent someone needing to claim a disability benefit or shorten the duration over which they need benefit, has had a huge economic payback over and above the benefit to the individual. If the rate of return of such interventions is properly measured, there is much that we can do both to improve the lives of individuals and pre-empt a potential retirement disability benefit 'timebomb' from emerging.

01 Introduction

There has been growing concern about the growth in economic inactivity among people of working age since the beginning of the Covid-19 pandemic. For example, the Office for National Statistics estimates[2] that economic inactivity in the 16-64 age group in the quarter from March-May 2023 was around 300,000 higher than in early 2020.

Despite much talk of a 'great retirement' during the pandemic, LCP's research published earlier this year[3] shows that by far the biggest contributor to the net increase in inactivity has come from long-term sickness. This perspective is endorsed by the Office for Budget Responsibility (OBR) in their July 2023 'Fiscal Risks' report[4], which says:

> *"The largest and most durable source of this rise in inactivity has been among those citing ill-health as their principal reason for being out of the labour market."*[5]

Many of those who are out of work due to ill-health become entitled to one of the main benefits for incapacity such as Employment Support Allowance (ESA) or, more recently, Universal Credit. Out of five million households on Universal Credit as of February 2023, more than one million were categorised as having 'limited capacity for work and work-related activity'.

However, whilst there has been a lot of focus on working age 'incapacity', there has been rather less focus on working age 'disability'.

[2] See: INAC01 SA: Economic inactivity by reason (seasonally adjusted) - Office for National Statistics (ons.gov.uk)
[3] See: On point paper – The Great Retirement or the Great Sickness? Understanding the rise in economic inactivity | Lane Clark & Peacock LLP (lcp.com)
[4] See: Fiscal risks and sustainability – July 2023 - Office for Budget Responsibility (obr.uk)
[5] OBR (2023), para 1.5

Whether or not someone is capable of work, they may be entitled to a disability benefit if they face additional costs because of 'care' needs or 'mobility' needs. The main benefit for which they may qualify is now Personal Independence Payment (PIP), which is gradually replacing Disability Living Allowance (DLA) for adult claimants. PIP can be claimed by any adult under state pension age who has additional costs of care or mobility, and it has four important features:

- PIP is not means-tested, and entitlement depends purely on having a care or mobility need.
- PIP does not depend on any prior record of National Insurance Contributions.
- PIP is payable tax free.
- Although PIP can only be claimed by those under pension age (with limited exceptions), payment can continue past pension age provided that the care or mobility need continues.

Whereas benefits such as ESA and Universal Credit stop when an individual reaches pension age, PIP/DLA continue potentially for as long as someone lives or until they cease to be entitled because their care or mobility need has ended. The average PIP/DLA payment to those over state pension age currently stands at around £6,415[6] per year. The potential long-term fiscal impact of a growing number of PIP recipients could be even greater than that of a growing number of economically inactive people of working age receiving ESA or UC.

In this paper we look at the rapidly growing number of people in receipt of PIP, describing who they are, where they live and for what reason they are claiming. We then undertake new modelling to assess the impact of a growing number of PIP recipients who start a claim before pension age but potentially continue in receipt for years or decades after pension age. Finally, we consider what interventions might be needed for the benefit of the individual and the taxpayer to avoid building up a substantial cohort of people who became disabled whilst of working age and will continue to receive PIP throughout their retirement.

[6] Benefit expenditure and caseload tables 2023

02 What do we know about the PIP/DLA population?

Key findings from this section

1. The overall number of people on disability benefits has risen by just over a million in the last decade but is set to rise by another million in just the next three years.
2. The fastest growing duration of claim is those claiming for five or more years.
3. Inflow into PIP from new claims has risen over the last four years. Driving this is:
    a. younger people with issues regarding mental health; and
    b. older age groups with musculoskeletal issues.
4. Constituencies with the greatest number of people in receipt of disability benefits are concentrated in more deprived areas, however the highest growth rates over the last decade are often associated with less deprived areas.

We begin with a description of the main benefits for people with disability before focusing on those for people of working age, looking at recent trends and projections in the numbers receiving and the characteristics of those on benefit.

Description of the key disability benefits

There are currently three main benefits for people with disabilities – Personal Independence Payment (PIP), Disability Living Allowance (DLA) and Attendance Allowance (AA).

The main features of these benefits are as follows:

- **Personal Independence Payment (PIP)** – this is now the main extra cost benefit for disabled adults of working age; the first claims to PIP were made in 2013; there are separate rates of payment for those who have care needs and those who have mobility needs, with those who have greater needs in each case receiving a higher amount; new claims are in most cases not possible beyond state pension age but those already in receipt when reaching state pension age may continue to receive the benefit into and through retirement provided that they continue to have care or mobility needs.

- **Disability Living Allowance (DLA)** – this was the predecessor benefit to PIP, and the only new claims to DLA now are those made by children; however, a large number of people who claimed DLA before PIP was introduced have continued to receive the benefit; the government is gradually reassessing DLA recipients against the PIP criteria with the result that some are being moved over onto PIP (with the amount payable sometimes higher and sometimes lower) or sometimes being moved off benefit altogether; however, this 'migration' process was recently slowed down by the government meaning many existing DLA recipients may continue on the benefit for some time.

- **Attendance Allowance (AA)** – this benefit is payable only to those who are over pension age and provides assistance only with additional costs arising from care, at one of two rates; no help is available to those who have mobility needs which develop after reaching pension age, though those already on PIP/DLA with mobility needs continue to receive help after pension age.

To give a sense of the scale of support currently provided Table 1 shows the number of recipients in 2023-24 and the total cost for each benefit.

Table 1. Main disability benefits – total cost and number of recipients in 2023/24

	Expenditure	Caseload
PIP	£21.8bn	3.2m
DLA	£6.7bn	1.2m
AA	£6.7bn	1.5m

Source: DWP - Benefit expenditure and caseload tables 2023 (Table 1a)

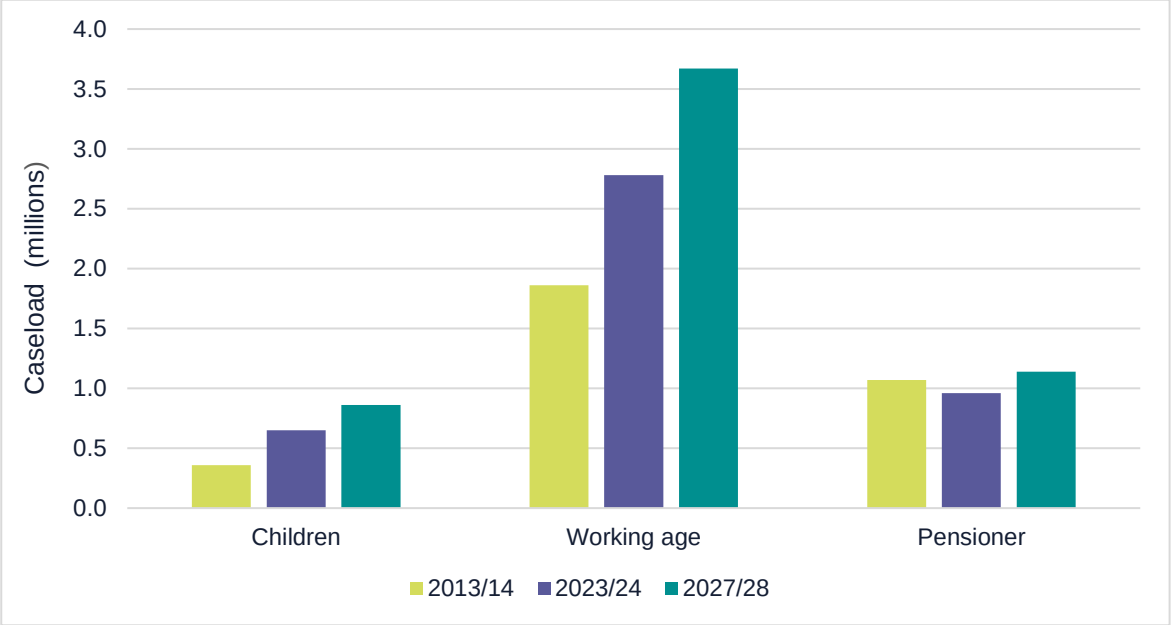
What is happening to the numbers on disability benefits?

As indicated in the previous section, there is currently a protracted transition from the old DLA benefit to the new PIP benefit, at least as far as adult claims are concerned. The PIP caseload of 3.2m currently consists of around 1.9m people whose claim was made since the introduction of PIP and who went straight on to the new benefit and around 1.3m people who first claimed DLA and have now been 'migrated' onto PIP.

In order to assess the overall growth in receipt of working age disability benefits we therefore add together the DLA caseload to the PIP caseload in order to avoid any distortion from people being reclassified from one benefit to the other.

Figure 1 shows the combined PIP/DLA caseload a decade ago, currently, and an estimate for 2027-28, showing how many are children, working age adults and pensioners.

Figure 1. Number of recipients of PIP/DLA in a) 2013-14, b) 2023/24 and c) 2027-28 (forecast)



Source: DWP – Benefit expenditure and caseload tables 2023

A number of key trends are clear from Figure 1.

- The overall number of people on PIP/DLA has risen by just over a million in the last decade (from 2013-14 to 2023-24) but is set to rise by over a million more in the next four years (from 2023-24 to 2027-28).

- The number of children in receipt of DLA continues to rise steadily; out of around 620,000 under 16s currently[7] on DLA, the largest 'main disabling conditions' are learning difficulties (288,000) and behavioural disorders (132,000).

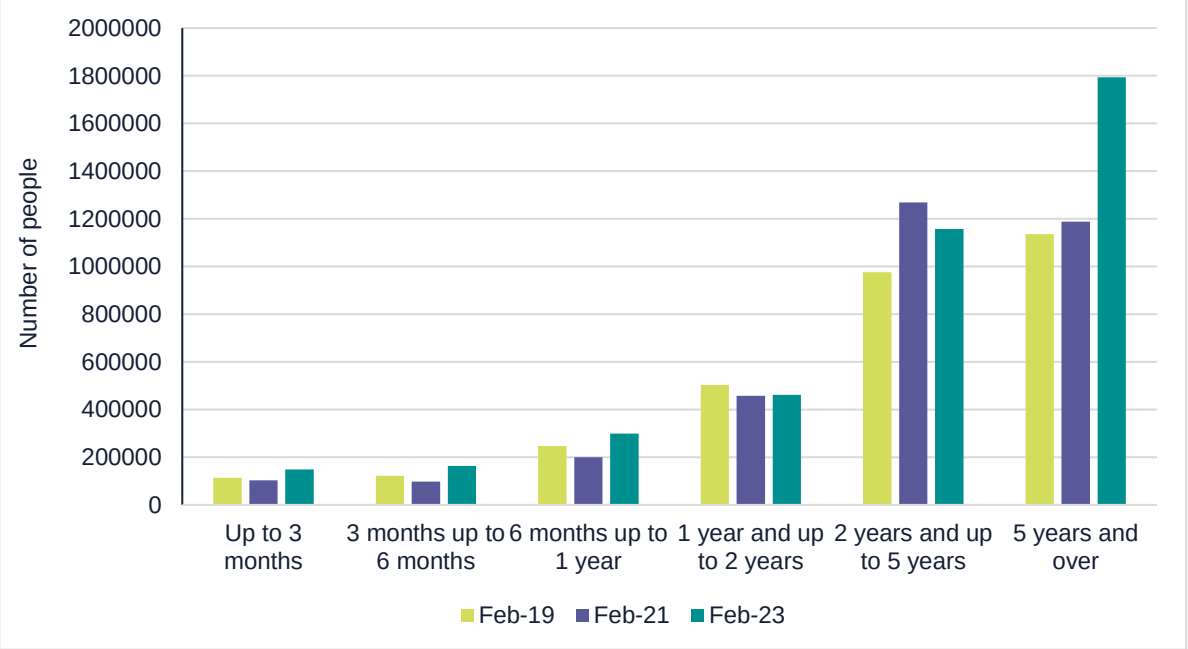
- In the working age population, the growth in numbers of people on disability benefits is also set to accelerate, having risen by just under a million in the last decade, but rising by a similar number in just four years from now.

- Pensioner claims are currently slightly lower than a decade ago but are set to rise again steadily in the coming few years.

A worrying trend is that once people start to receive one of these benefits they can often be in receipt for a long period of time, and it is in the longer durations where the fastest growth in claimant numbers has recently been seen – as shown in Figure 2 below.

[7] As at February 2023, the most recent data available at time of writing.

Figure 2. Claim durations on PIP/DLA in a) Feb 2019, b) Feb 2021 and c) Feb 2023



Source: Stat-Xplore

The chart shows numbers on PIP/DLA in February 2019, 2021, and 2023, broken down by length of claim. The large majority of those in receipt of benefit have been doing so for at least two years, and the fastest growing group is those who have been in receipt for five years or more.

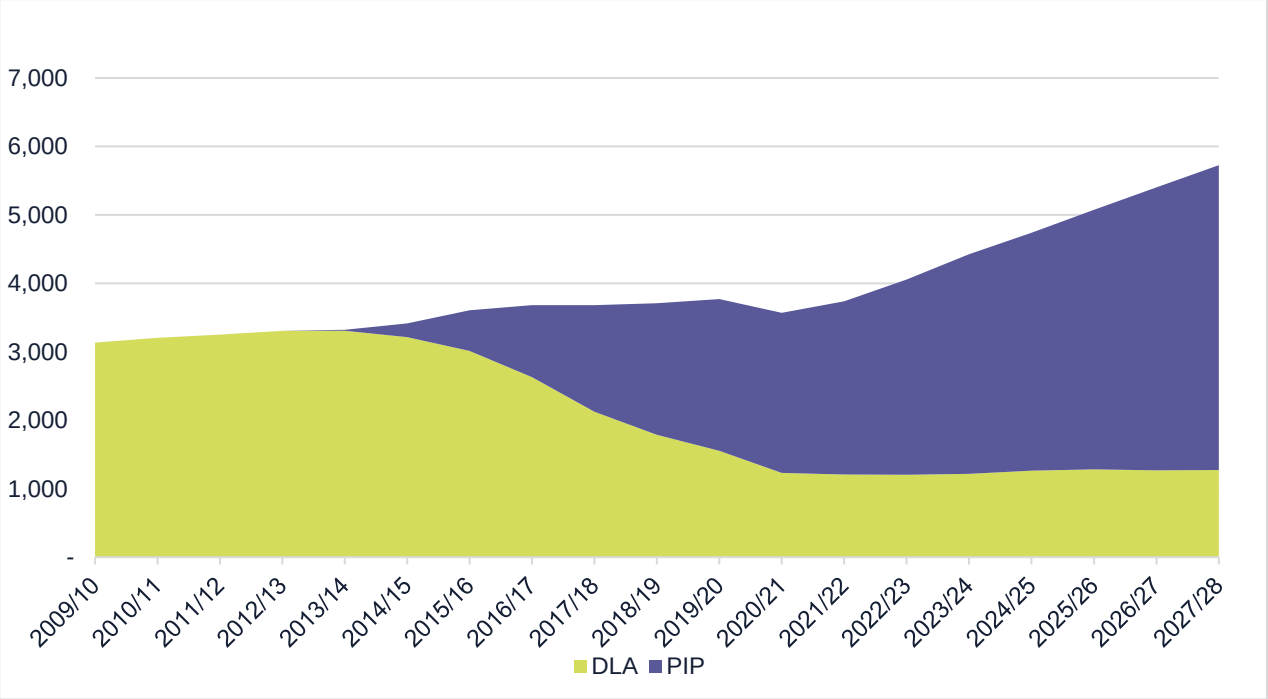
In terms of future spending pressures, this growth in average durations is likely to be a considerable concern. It is common in the benefits system for the chance of someone ending a claim for benefit to decline as the length of time they have been on benefit increases.[8] If we are building up a growing number of people on PIP/DLA with long and increasing durations on benefit, the risk is that these claims will become very long-term and perhaps extend well past state pension age, adding substantially to the overall cost to the taxpayer. Improving the health of this population may help to not only improve the quality of life for individuals but can also help to reduce burden on the taxpayer.

What is driving the increased numbers?

As Figure 3 shows, in the decade up to 2019-20, the total number of people on PIP/DLA was gradually increasing. Since 2020-21, however, the rate of growth has increased sharply, and the rapid growth is projected to continue until the end of the forecast period.

[8] For example, OBR Fiscal risks and sustainability – July 2023 report suggests that the chance of 'flowing off' incapacity benefits in any given quarter is around 1 in 6 for those who have claimed for less than one year but around 1 in 20 for those who have claimed for more than a year. We provide our own estimates for PIP later in this paper.

Figure 3. Number of people receiving PIP/DLA (thousands). Historical and projected (from 2023-24) data



Source: DWP's 2023 benefit expenditure and caseload tables

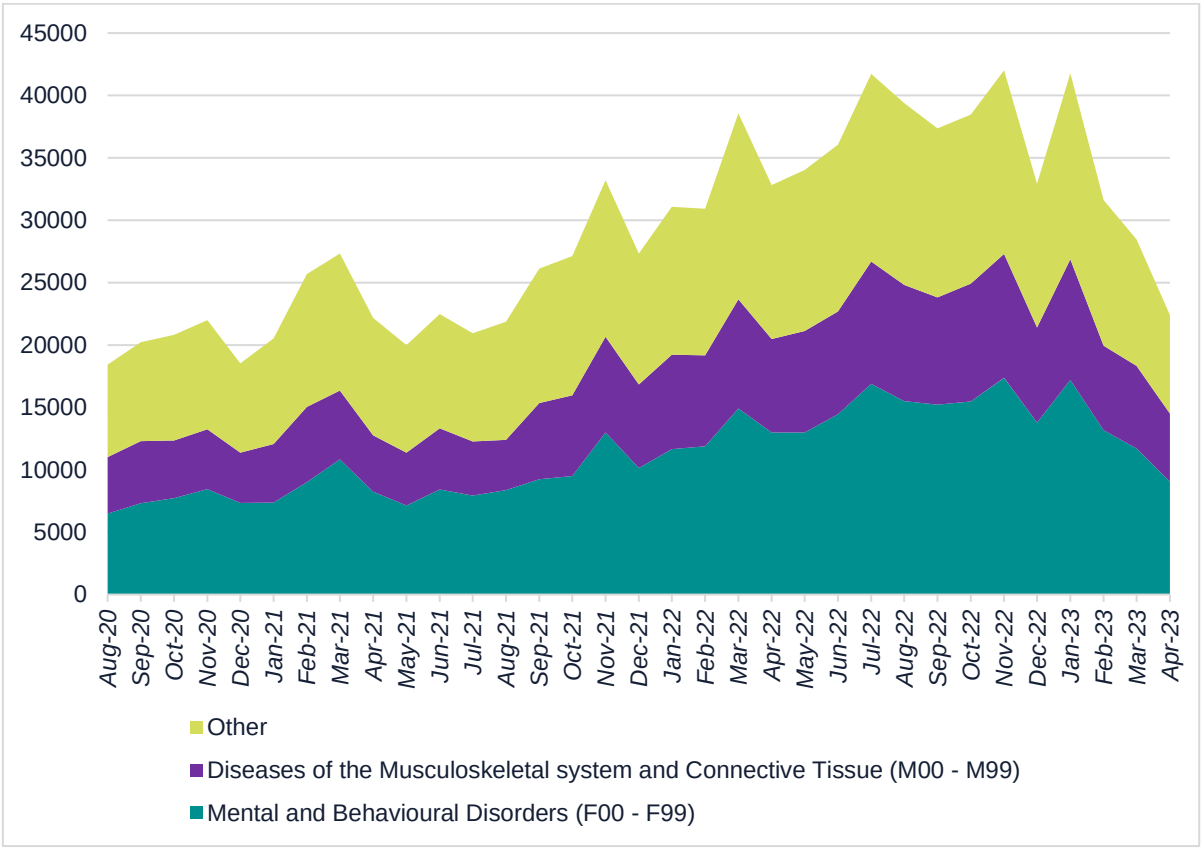
The change in the number of people on any given benefit will depend on the relative size of two numbers – the rate of inflow, as new people claim the benefit, and the rate of outflow, as people either die or no longer need the benefit because their condition has improved. We consider each in turn.

Inflow

One way to look at the growth in numbers is to examine the 'inflow' rate and in particular the inflow into PIP which is the main working age disability benefit for new claims by adults.

There are two routes by which people may enter into the receipt of PIP – either a transfer from DLA following a reassessment or by making a fresh claim. As transfers are simply re-categorisations from one benefit to another, we need to strip these out when looking at new claims. Figure 4 below shows the number of successful new claims to PIP each month for the last three years, excluding transfers from DLA.

Figure 4. Successful new claims to PIP - April 2020 to April 2023



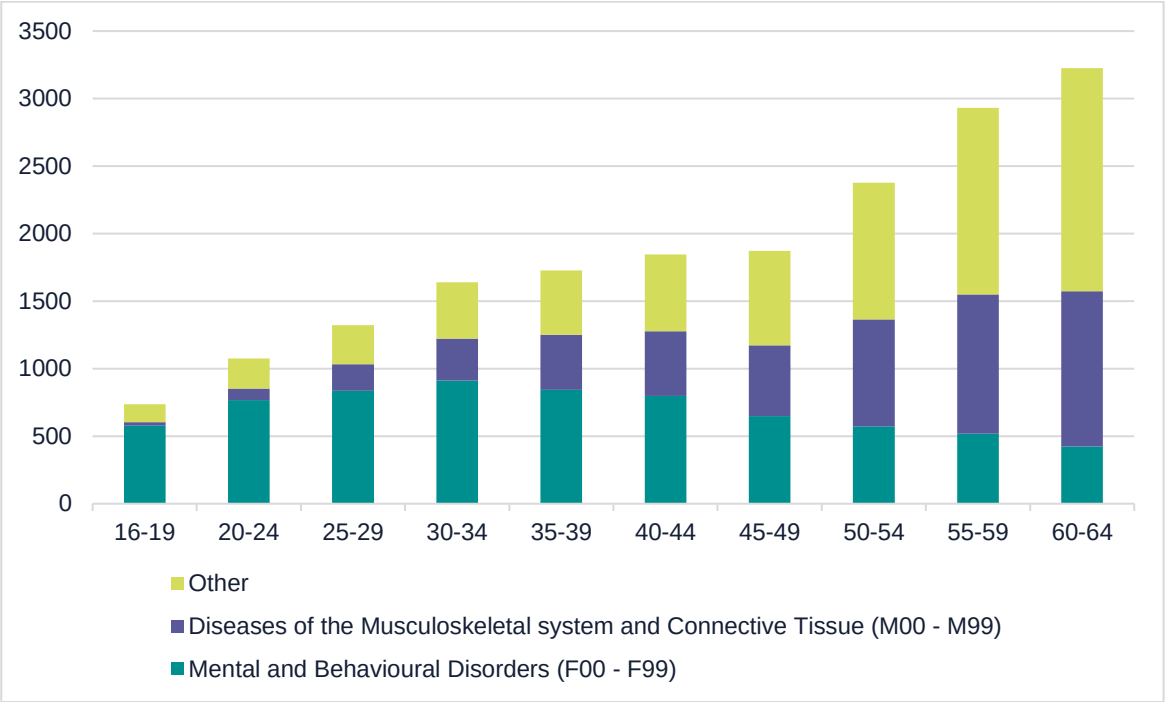
Source: Stat-Xplore

Although there are considerable month-to-month fluctuations in the number of successful new claims, in part reflecting processing disruption during the pandemic, there is a very clear upward trend from a low point of around 15,000 successful new claims per month in mid-2020, to a peak of over 40,000 per month in the last year, although the numbers have fallen back considerably since then.

Looking at the split of underlying conditions, the chart shows clearly that two categories dominate the inflow into PIP – those with 'mental and behavioural disorders' and those with 'diseases of the musculoskeletal system'. These two conditions consistently account for between half and two thirds of all new claims for PIP.

There is however a big difference in the ages of those who claim under these different conditions. Figure 5 provides an age distribution of new claims in April 2023, by condition.

Figure 5. Successful new claims for PIP in April 2023 by age group and condition



As Figure 5 shows, for younger age groups, 'mental and behavioural disorders' are a dominant source of new claims, and account for more than half of all successful new claims for those aged under 35. However, the majority of new claims are not made by those under 35, they are made by those aged over 45. And for this older age group, musculoskeletal conditions are far more important. In particular, for those aged 60-64, which is the age group with the highest rate of claims, around one in three new claims is for this group of conditions.

In summary therefore, we have seen a big rise in 'inflow' into PIP from new claims over the last four years, though the inflow has slowed somewhat over the last few months.[9] The two biggest drivers appear to be new claims from younger people with mental and behavioural disorders and from older claimants, especially those with musculoskeletal conditions.

Outflow

The other parameter affecting the total number of people in receipt of PIP/DLA at a given point in time is the rate at which people stop receiving or 'flow off' the benefit. Trying to assess this on the basis of published data is challenging due to the ongoing process of 'migration' from DLA to PIP. In brief, over the last few years, well over a million people on DLA have been reassessed using the PIP rules. Some have lost entitlement as a result (either because they do not meet the PIP criteria or because they gave up on their claim) whilst others have transferred over to PIP.

[9] Interestingly, the OBR Fiscal Risks Report (p47) says that the percentage of claimants passing the disability assessment for PIP has actually fallen from 60% in 2016-17 to 51% in 2022-23, though this has been 'somewhat offset' by a decline in the percentage of people who 'drop out' after making a claim, down from 29% in 2019-20 to 13% in 2022-23.

This means that the DLA outflow will be a mix of people ending a DLA claim in the normal way (perhaps because their condition had improved) as well as those who were simply reclassified onto another benefit but did not 'flow off' in any meaningful sense.

However, we are able to get some sense of underlying trends in outflow rates by looking at 'pure' PIP data – that is, information about PIP recipients who had not previously been recipients of DLA.

One way of estimating annual outflow rates is to compare the number of people who had been on PIP for 1-2 years in a base year, with the number who had been on PIP for 2-3 years a year later. The decline in this number gives us an outflow rate for people at that duration. We can look at different durations[10] and also see how these outflow rates change over time.

Table 2 summarises the results for the last 5 years. Each cell indicates the percentage of people who had been on PIP for the relevant duration at the date shown who were no longer on benefit a year later.

Table 2. 12-month outflow rates for PIP recipients (excluding DLA transfers in) by duration on PIP at start of year

Duration	April-18	April-19	April- 20	April 21	April 22
1-2 years	16%	11%	13%	11%	12%
2-3 years	13%	11%	13%	12%	13%
3-4 years	9%	8%	8%	8%	8%

Source: LCP and StatXplore

The Table shows that, for example, those who had been on PIP for 1-2 years by April 2018 had a 16% chance of flowing off a year later, but those who had been on PIP for 1-2 years by April 2019 had just an 11% chance of flowing off.[11]

Two key messages emerge from Table 2:

- As expected, outflow rates from PIP fall as durations lengthen; in particular, the outflow rates once people have been on benefit for 3-4 years are consistently markedly lower than for shorter durations; this is a concern if, as appears to be the case, we are seeing a rapid growth in the numbers on PIP with the longest durations.

[10] Published data groups all durations of five years or more as a single group. This means we cannot use the technique shown in the table to assess simple outflows from longer durations on PIP.
[11] Durations of less than 1 year are split into 3 month or 6 month buckets, for simplicity these have been excluded.

- In terms of trends over time, after an initial drop in outflow rates between April 2018 and April 2019, outflow rates are relatively stable thereafter.

Given that the period from 2020 onwards is when numbers on PIP started to rise stadily, this strongly suggests that the growth in numbers in recent years has primarily been driven by a rise in inflow rates rather than a major change in the rates at which people flow off benefit. However, this pattern could change as the number of older people in long-term receipt of PIP builds up.

Geography

In terms of where these people live, there is clear evidence of geographical concentration of receipt of PIP/DLA, and generally in areas of relatively high deprivation. Table 3 lists the Parliamentary Constituencies in England and Wales[12] with the largest absolute number of PIP/DLA recipients in February 2023 (the most recent month available with data for both PIP and DLA).

Table 3. Westminster constituencies with highest numbers of recipients of PIP/DLA over 16 years old (England and Wales only)

Constituency	February 2013 Recipients of PIP/DLA	February 2023 Recipients of PIP/DLA	Percentage increase
Knowsley	11692	14086	20%
Liverpool, Walton	10142	13628	34%
Bootle	9384	11863	26%
Liverpool, West Derby	9012	11636	29%
Blackley and Broughton	8583	11199	30%
Birkenhead	8575	11179	30%
Isle of Wight	7736	11067	43%
Nottingham North	7627	10994	44%
Sheffield, Brightside and Hillsborough	7699	10981	43%
Garston and Halewood	8963	10891	22%

Source: StatXplore

[12] We exclude Scotland from this analysis because the Scottish Government is gradually introducing its own working age disability benefit to replace PIP.

It is very striking that six of the top ten constituencies for receipt of PIP/DLA are all in the Merseyside area and almost all of the constituencies on the list are areas of above-average deprivation.[13] All of the constituencies with very high numbers of people on PIP/DLA have seen an increase of 20%-44% in the numbers in receipt in the last decade.

However, these are not the areas where the growth rate has been the greatest.

The ten constituencies with the highest rate of growth in numbers on PIP/DLA are shown in Table 4.

Table 4. Westminster constituencies with highest percentage increase in numbers of recipients over 16 years old of PIP/DLA in last decade (England and Wales only)

Constituency	February 2013 Recipients of PIP/DLA	February 2023 Recipients of PIP/DLA	Percentage increase
Enfield North	3740	6568	76%
Brent Central	4998	8615	72%
Poplar and Limehouse	4703	8101	72%
North East Bedfordshire	2717	4653	71%
Edmonton	4418	7553	71%
Luton South	3726	6168	66%
Welwyn Hatfield	3103	5130	65%
Mid Bedfordshire	2586	4222	63%
Bethnal Green and Bow	5020	8147	62%
Finchley and Golders Green	3160	5063	60%

Source: StatXplore

Perhaps surprisingly, the list of constituencies where numbers have risen the fastest looks very different to the areas where absolute numbers are the highest. The fastest growth areas are overwhelmingly in Southern England and, in some cases, in areas that might be assumed to be relatively prosperous. Potential explanations for this could be that more affluent areas have better access to healthcare for those disabilities which have been increasing in prevalence, such as mental health.

[13] The only exception to this is the Isle of Wight which is an outlier in terms of having a large constituency size - over 110,000 electors - which explains its appearance in this list.

A better chance of being diagnosed, coupled with better awareness of and access to information regarding benefits, could lead to increasing rates of disability claims in these areas. Further analysis is needed to understand the driving factors behind these trends.

03 What could the future hold?

Key findings from this section:

1. Reducing the care and mobility needs of an individual approaching state pension age could save over £70,000 per person in taxpayer costs if they no longer need to claim for PIP.
2. Over half of people on PIP at/after state pension age will continue claiming PIP until they die.
3. If a person reaches state pension age (66) whilst still claiming PIP, the median age at which they will flow off due to death or other reasons is estimated to be 77, totalling 11 years of claims.
4. Even ignoring the effects of inflation, expenditure on PIP/DLA for retired people could increase to £10.5 billion by 2033 compared with £6 billion currently if no further preventative action is taken.

In this section we explore future costs of PIP for those claiming past state pension age and make the case for interventions targeted at improving the health of this population.

Much of the debate around the growing numbers on benefits for incapacity (for work) and disability has focused on people of working age. This is entirely understandable given the fiscal implications of someone of working age being long-term sick and receiving benefit rather than being in work and paying tax. The focus is also understandable given the tightness of the labour market and the desire to increase labour supply in order to reduce upward pressure on wages.

However, there is a risk that in focusing on working age incapacity, we miss a different risk that of post-retirement disability. To be more precise, the risk that the growing numbers of people of working age claiming disability benefits will continue to do so for long periods of time, including well past pension age, with a big resultant increase in the benefit bill.

In this section we explore this risk further by undertaking some modelling to show how a rising number of people at pension age in receipt of PIP could lead to a big long-term benefits bill for the post-retirement population.

The modelling

With limited exceptions, it is not possible to make a new claim for PIP once you have reached state pension age. But, if you are already on PIP before pension age, your benefit will continue for as long as you satisfy the requirements in terms of having a care or mobility need.

One consequence of this is that we can look at PIP recipients who have already reached pension age (excluding those who have been transferred across from DLA), to estimate 'outflow rates' post pension age. We can do this by working out what proportion of people at any given age are likely to die in the next twelve months and deduct this from the actual number who 'flowed off' PIP. The balance gives us a measure of mortality adjusted 'underlying outflow' among the post-retirement population.

To give a specific example:

- In April 2019 we know that there were 19,321 people aged 66 in receipt of PIP.[14]
- In April 2020 we know that there were 18,371 people aged 67 in receipt of PIP.
- The difference is 950 people who 'flowed off' over the 12 months period; this is an outflow rate of around 4.9%.
- However, we know that on average roughly 1.1% of people aged 66 would be expected to die in the next year[15]; deducting those who died suggests the 'underlying' outflow rate for this age group in this year was 3.8%; this figure (3.82% to two decimal places) is highlighted in Table 5 below.

Table 5 shows the same calculation for different ages (66-73) and over different years[16].

Table 5 'Underlying' outflow rates of post-retirement PIP population (excluding DLA reassessments) by age

Underlying outflow rates (mortality adjusted)	Apr-17	Apr-18	Apr-19	Apr-20	Apr-21	Apr-22	Average
66	6.43%	5.92%	3.82%	3.33%	2.32%	2.59%	4.65%
67	4.73%	4.90%	3.30%	2.94%	3.15%	3.39%	3.22%
68	-0.51%	3.99%	3.85%	4.02%	3.29%	3.37%	3.00%
69		1.37%	3.85%	3.45%	3.85%	3.80%	3.26%

[14] Excluding those who were reassessed from DLA
[15] Combined age adjusted male and female mortality rates from ONS National Life Tables
[16] Because new claims for PIP were only possible from 2013 and can only be made by those under pension age, there are still very few people on PIP today in their seventies. Our analysis therefore focuses on those in their late sixties and early seventies.

70			1.56%	4.37%	3.37%	4.36%	3.42%
71				3.22%	3.55%	4.40%	3.72%
72					5.06%	3.93%	4.49%
73						3.92%	3.92%
					Average of 2021 and 2022:		3.62%

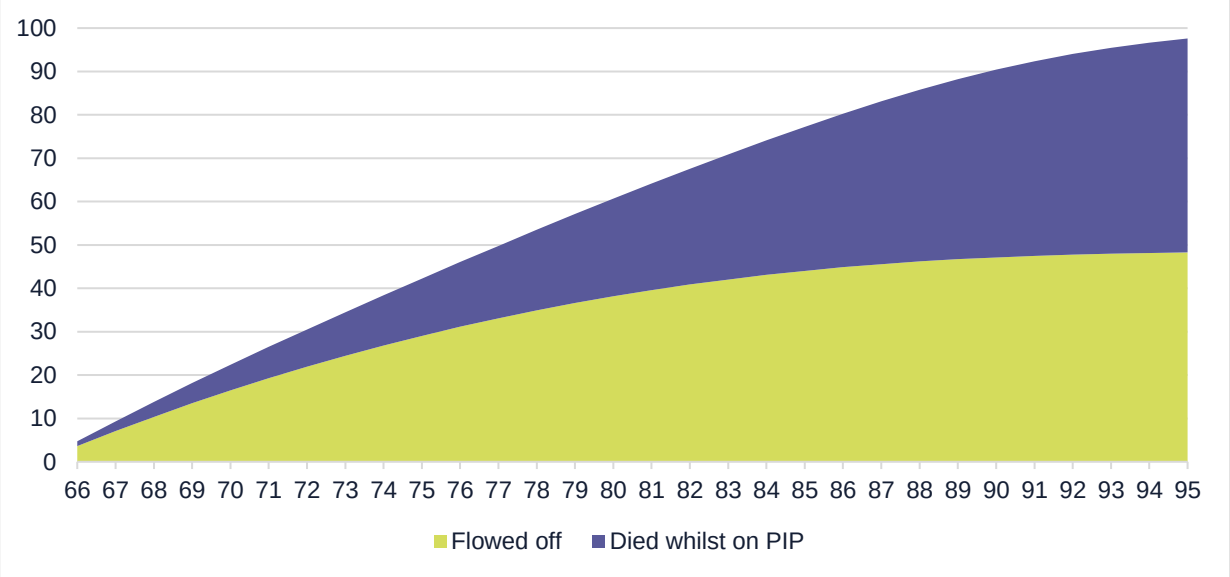
Results are shown back to 2017 for completeness, but in interpreting this table it is worth bearing in mind that PIP was only introduced in 2013 and even then, on a phased basis. Consequently, earlier years should be considered with less weight as a guide to the long-term picture. We have therefore calculated the average underlying outflow rate using the outflow rates in April 2021 and April 2022 only. Outflow rates over this period vary from 2.3% to 5.1% and give an average underlying outflow rate of 3.6%. Given that PIP was recently introduced, and that there is therefore little reliable data for outflow rates for older ages, we have assumed that the 3.6% average outflow rates will also be applicable to ages 74 and older.

Estimating an 'underlying' outflow rate is also made more difficult because we are using mortality rates from a 'normal' (ie pre-pandemic) year, whereas mortality rates were higher for this age group during the pandemic period. This means that the actual number of people who simply 'flowed off' PIP is being overstated in our table because mortality rates are understated for these periods.

Assuming an average underlying outflow rate of 3.6%, Figure 6 shows what would happen to 100 people on PIP at the age of 66 over the following years, in terms of the number who would have died in receipt of PIP and the number who would have flowed off naturally.

As Figure 6 shows, at younger ages, the 'outflow' from PIP is mainly from claims ending naturally – presumably because people no longer have the care or mobility needs which led to the original claim – with only a small number of people dying whilst in receipt. But as people get older it becomes steadily more likely that they will simply die in receipt of PIP rather than flow off. Looking at the picture as a whole, we find that with a 3.6% underlying outflow rate, over half of people on PIP at pension age will continue to receive the benefit until they die.

Figure 6. Cumulative PIP Outflow during retirement per 100 recipients at state pension age



To try to see what this means for spending on PIP, we can use two further pieces of information:

- the average PIP/DLA payment to those in retirement is currently around £6,415 per year[17]; and
- if someone reaches state pension age (66) whilst still claiming PIP, the median age at which they will flow off due to death or other reasons is estimated to be 77.

This means that an intervention which reduces care and mobility needs to the extent that PIP at state pension age is no longer needed could save £70,561 per person[18]. In addition, receipt of PIP can be a 'passport' to higher rates of payment of income-related benefit such as pension credit through the addition of 'disability premiums', which means that the cost saving from someone not needing PIP in retirement could be even greater. This is discussed in more detail at the end of this section.

We also know that there are currently 96,996 people on PIP/DLA who are at state pension age[19]. If we assume, for now, that there will be a 'steady state' of 97,000 reaching pension on PIP/DLA each year, we can then model what this means for total spending on PIP/DLA in retirement.

Our modelling finds:

- In 'steady state', by 2033 there would be about 1.6 million people over pension age in receipt of PIP/DLA; this compares with around 1 million currently.

[17] Calculated as a weighted average from 2023-23 DWP forecasts for caseload and expenditure for DLA and PIP
[18] Calculated as £6,415 * (77-66)
[19] Using most recent cases with entitlement data available for DLA (7,069 in February 2023) and PIP (89,927 in April 2023)

- Ignoring future increases in benefit rates, expenditure on PIP/DLA for retired people would increase by £4.5 billion by 2033, leaping from £6 billion currently to £10.5 billion.

As PIP is a relatively new benefit, and the data that we have for modelling covers such an exceptional period, there is inevitably some uncertainty around projections of this nature.

We can however test the sensitivity of our results to different assumptions about the 'underlying' outflow rate from PIP. The table below repeats the figures for our central assumption of a 3.6% outflow rate but also shows how the figures would be affected if the outflow rate was either 2% or 5%.

Table 6. Sensitivity analysis of projections by 2033 about steady state caseload and expenditure on PIP/DLA to assumptions about 'underlying' outflow rate

Underlying outflow	**2%**	**3.6% (central)**	**5%**
Total expenditure	£12.3bn	£10.5bn	£9.3bn
Caseload	1.9m	1.6m	1.4m

What is perhaps most notable about the results in Table 6 is that, even allowing for a considerably higher outflow rate, we still project that spending on PIP/DLA and caseloads are still likely to increase by more than half of current levels (£6 billion) in steady state.

However, it is likely that we may be erring on the high side for our assumptions about underlying outflow. One particular reason is that we are using a constant outflow rate of 3.6% for people *of* all ages. In reality, given that outflow rates tend to decline with duration, it seems more likely that as people get older and have been on benefit for (say) a decade or more, the odds of them flowing off naturally (eg through reduced care and mobility needs) are likely to drop. This would mean even more people receiving PIP/DLA for longer and only ceasing to claim on death.

Furthermore, our estimates may be conservative given the link between PIP/DLA and other benefits in retirement. As well as the direct cost of paying PIP/DLA for just over a decade on average, there are other costs which might be saved if people no longer needed these benefits.

Where a household is on a low income and claims Pension Credit or Housing Benefit in retirement, the amount that they receive is based on a basic needs figure plus 'premiums' if they are in groups with additional needs. For people on PIP/DLA, these additional premiums are as follows:

- Pension Credit: A 'Severe Disability Premium' is available for anyone on the standard or enhanced 'daily living' component of PIP; this is worth an extra £76.40 per week or just under £4,000 per year.

- Housing Benefit: There are different rates of disability premium. Anyone on any rate of PIP/DLA can get a standard Disability Premium of £39.85 per week or just over £2,000 per year. There is also a Severe Disability Premium, as with Pension Credit, for those on the standard or enhanced 'daily living' component of PIP, worth £76.40 per week or just under £4,000 per year.

The overlap between PIP/DLA and means-tested benefits is surprisingly large. The table below shows information from February 2023 on the just under 460,000 people in England and Wales aged 66+ who are in receipt of PIP/DLA by whether they receive one or both of the main means-tested benefits.

Table 7. PIP/DLA recipients aged 66+ by receipt of means-tested benefits, England and Wales, February 2023

Benefit alongside PIP/DLA	Number of people	Percent
Pension Credit & Housing Benefit	109,646	23.8%
Pension Credit only	42,726	9.3%
Housing Benefit only	59,618	13.0%
No means-tested benefit	248,003	53.9%
All	459,996	100.0%

Source: DWP 'StatXplore' tool, accessed August 2023

Note: percentages do not sum to total because of rounding.

As Table 7 shows, nearly half (46%) of all those aged 66+ who are on PIP/DLA also receive a means-tested benefit. This means that they are potentially getting up to around £4,000 per year extra in means-tested benefits than they would be getting if they were not on PIP/DLA. Using an 11-year duration estimate for PIP/DLA receipt post pension age, this could add up to an additional £44,000 to the potential benefit saving if preventative measures meant that this group no longer needed PIP/DLA at and through retirement.

04 Why are more people in need of disability benefits?

There are several possible explanations for the increase in the number of people receiving disability benefits and the duration of benefit claims in the UK. Here, we propose three key drivers of this trend in the population's health that are increasingly integral to the link between health and economic prosperity and one key trend in the healthcare system's ability to meet these evolving demands:

- An expansion in the number of people living with multiple long-term health conditions.
- A rise in mental health conditions both as the main health condition and increasingly as a secondary condition in those with existing physical conditions.
- An increasingly diverse set of health needs in people with a chronic condition.
- The decreasing resilience of the NHS to adequately manage the increasing complexity of population health demand.

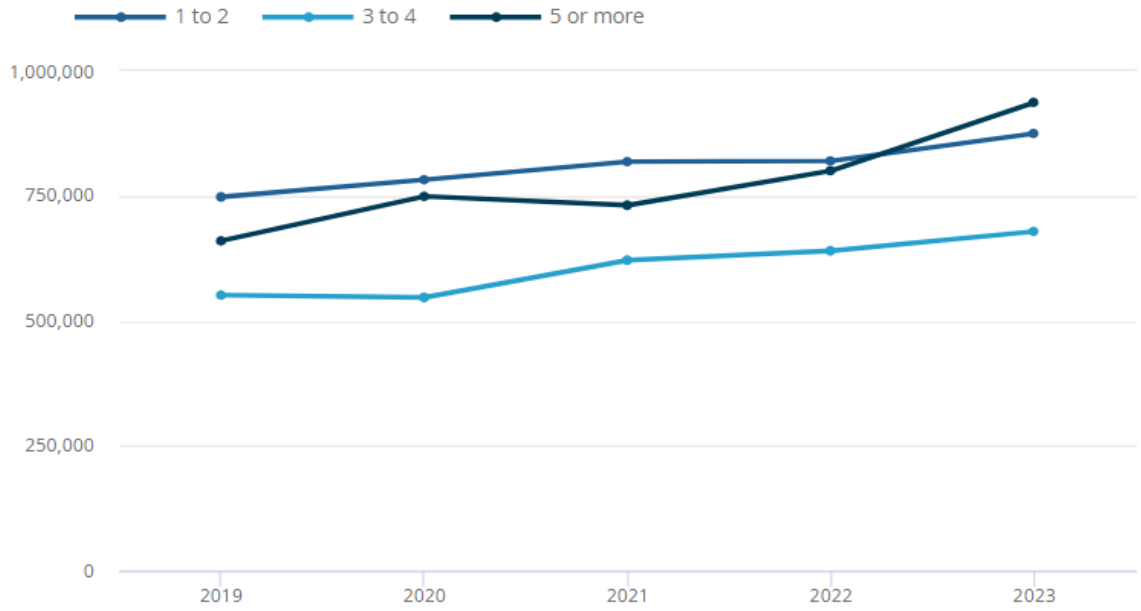
Multiple long-term conditions

An expanded number of people are living with multiple long-term health conditions, which can include physical and/or mental health conditions (eg diabetes, hypertension, depression, symptom complexes (eg chronic pain), or alcohol or substance misuse[20]).

The increase is not exclusively affecting the elderly, with clear evidence of high rates amongst the working-age population. A recent analysis from the Office for National Statistics (ONS) found that among working-age adults (aged 16-64 years), the number of people economically inactive due to multiple long-term health conditions has steadily risen since the pandemic – see Figure 7[21].

[20] https://cks.nice.org.uk/topics/multimorbidity/background-information/definition
[21] https://www.ons.gov.uk/employmentandlabourmarket/peoplenotinwork/economicinactivity/articles/risingillhealthandeconomicinactivitybecauseoflongtermsicknessuk/2019to2023

Figure 7. Number of health conditions of people aged 16-64 years who are economically inactive because of long-term sickness in the UK , January-March 2019 to January-March 2023



Nearly two-fifths (38%) of people in the quarter from January-March 2023 reported having five or more health conditions, a growth from 34% reported in the quarter from January-March 2019[21]. This is consistent with our analysis showing that the greatest increase in the duration of disability benefit claims has been those doing so for 5+ years, which may reflect the increase in the long-term conditions.

This pattern of more people living with multiple health conditions has been observed in the wider literature prior to the pandemic. A study estimating the extent of multiple long-term health conditions among people registered to GPs in England reported that the proportion of people living with basic multimorbidity (defined as two or more chronic conditions) increased from 31% in 2004 to 53% in 2019[22].

Similarly, the proportion of people living with complex multimorbidity (defined as three or more chronic conditions affecting three or more different body systems) increased from 15% to 33% during the same time period[22]. This increase was coupled with a younger age at which people begin living with multiple long-term health conditions, with more working-age adults affected. In people with basic multimorbidity, the average age of onset decreased by 10 years from 56 years in 2004 to 46 years in 2019, while the average age of onset for complex multimorbidity decreased by 11 years (from 66 years in 2004 to 55 years in 2019)[22].

[22] https://www.thelancet.com/journals/lanhl/article/PIIS2666-7568(21)00146-X/fulltext

The same study also described worrying inequalities in multiple long-term health conditions by age, sex, geographic region, and socioeconomic status. Overall, complex multimorbidity was more common in women and in people living in northern regions. Multiple long-term health conditions were more common in the most deprived people compared to the least deprived people (basic multimorbidity 47% in most deprived vs 42% in the least deprived; complex multimorbidity 29% in most deprived vs 24% in the deprived).

Despite all these trends, living with multiple health conditions being more common, beginning earlier in life, and affecting certain population groups (generally those more deprived and in northern areas) more than others – fatality rates for people living with multiple health conditions have generally decreased. While the decrease in fatality rates could be explained by a decrease in conditions associated with high mortality, it does also suggest that people with multiple long-term health conditions are living in poorer health for much longer than before, providing new challenges for these individuals, their relationship with the workforce and for the healthcare system. In addition, the number of people living with major illnesses is projected to increase by more than a third (37%) by 2040[23], with more working-age adults expected to live with multiple conditions, further exacerbating these challenges.

A rise in mental health conditions

The ONS analysis found that over half (53%) of working-age adults who were economically inactive due to long-term sickness in the quarter from January-March 2023 reported experiencing depression, bad nerves, or anxiety – an increase from 48% reported in January-March 2019[21]. Working-age adults experiencing mental health problems is well documented in the literature, with the average age of onset for common mental health conditions in young adulthood from 30 years in people with depressive disorders to 32 years among those with anxiety disorders[24]. This relatively early onset in adult life can have long-term implications for employment and wider economic opportunities. The majority of people included in the ONS analysis reported mental health as secondary to other long-term health conditions such as musculoskeletal disorders, cardiovascular disease and digestive disorders. Our analysis has found that this may also be age dependent, with younger people on disability benefits being more likely to be so primarily for issues surrounding mental health.

The number of people who reported mental health as a secondary condition increased by over 50% between 2019 and 2023, while the number who reported it as a main condition during the same period only increased by 14%.

[23] Health in 2040: projected patterns of illness in England - The Health Foundation
[24] Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies | Molecular Psychiatry (nature.com)

The co-occurrence of mental health conditions alongside other long-term physical health conditions has been widely described. Studies in the UK have reported that around 36% of all people with a long-term physical health condition also have a mental health condition, commonly depression or anxiety[25]. In addition, coexisting mental health conditions are particularly common among people with multiple long-term health conditions, with the risk of depression up to seven times higher among people with more than five chronic health conditions[25,26].

The reasons why people with long-term physical health conditions commonly experience mental health problems are complex. However, living with a chronic condition can cause feelings of stress, worry, frustration, social isolation and low self-esteem, all of which contribute to poor mental health. In turn, mental health conditions can negatively affect physical health by increasing unhealthy lifestyle behaviours such as smoking and reducing the ability of the affected person to manage their own long-term condition by reducing treatment adherence. Overall, this can lead to poorer health outcomes, quality of life and in turn worsen relationship with the employment market.

Coexisting mental health and physical conditions are also associated with increased use of multiple NHS services, and in turn are likely to be associated with increased costs, especially as current services may not support an integrated approach to patient care. The hypothesis of increased NHS costs is supported by an analysis conducted by the King's Fund and Centre for Mental Health in 2012[26] which estimated that mental health conditions increase service costs for long-term physical conditions by 45-75% and may mean that:

> *"Between £8 billion and £13 billion of NHS spending in England is attributable to co-morbid mental health problems among people with long-term conditions."*[27]

Considering that the data used to generate these estimates is over 10 years old and the number of people with both long-term physical conditions and mental health conditions has increased over this period, this figure is likely to be an underestimate. The likely impacts of this upon the ability to work are clear.

An increasingly diverse set of health needs in people with a chronic condition

Chronic physical conditions that were previously considered individual diseases are increasingly occurring together, with patients experiencing multiple health conditions at a time. These conditions may arise by chance alone due to how common they are; however, they usually tend to occur as 'predictable clusters of disease' within the same person due to shared genetic, behavioural, or environmental factors.[28]

[25] Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study - The Lancet
[26] Associations between physical multimorbidity patterns and common mental health disorders in middle-aged adults: A prospective analysis using data from the UK Biobank - The Lancet Regional Health – Europe
[27] Long-term condition and mental health Chris Naylor February 2012 (kingsfund.org.uk)
[28] Rising to the challenge of multimorbidity - PMC (nih.gov)

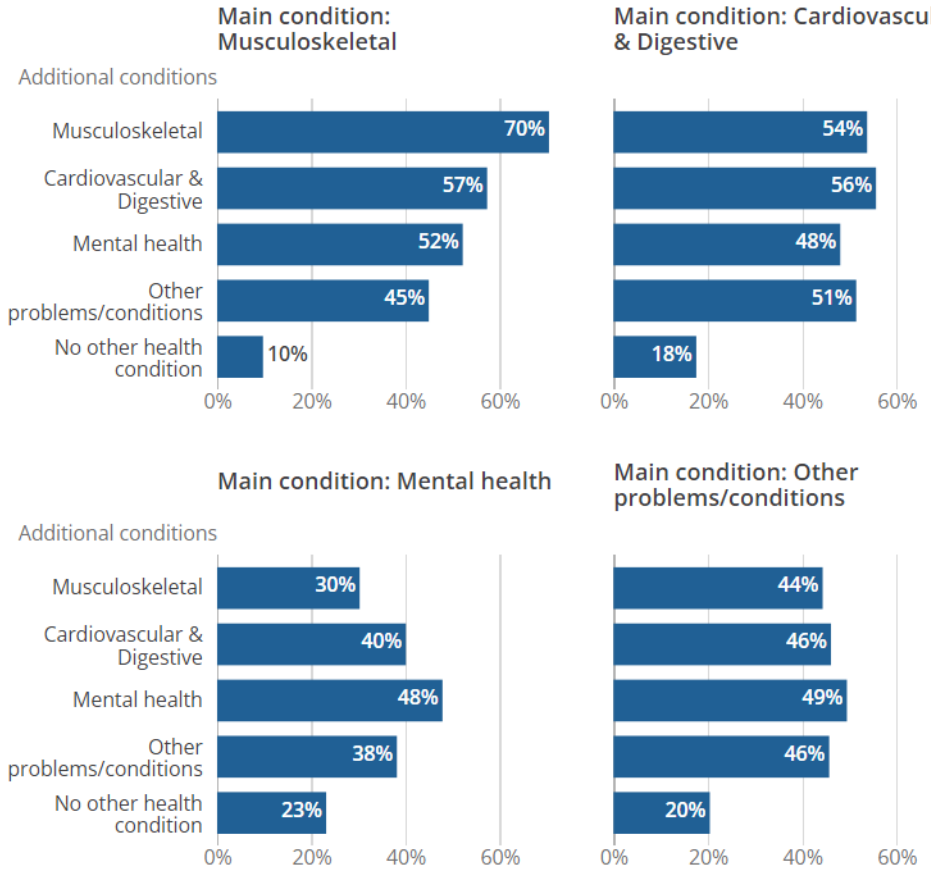
This means that for those with an initial chronic condition, with the likelihood of developing additional conditions being high, this increases the risk of their health affecting their ability to work and the scale of the hurdles to overcome to return to the workforce when they are unwell.

The ONS analysis revealed the most common combinations of health conditions among working-age adults who were economically inactive due to long-term sickness.[21] In people who reported their main health condition as musculoskeletal (eg arthritis or rheumatism in arms, hands, legs, feet, back, or neck) in the quarter from January-March 2023, over 70% reported a further musculoskeletal condition, 57% reported additional cardiovascular and digestive conditions (including chest or breathing problems, asthma, bronchitis, diabetes, cardiovascular disease), 52% reported additional mental health conditions, and 45% reported other conditions (Figure 8). Similarly, in people who reported cardiovascular and digestive conditions as their main health problem, 56% reported additional cardiovascular and digestive conditions, 54% reported musculoskeletal conditions, and 48% reported additional mental health conditions.

Similar patterns have been observed in the wider literature. Studies in people with musculoskeletal disorders such as rheumatoid arthritis and osteoarthritis find coexisting conditions. Prior work has found that people with osteoarthritis were at least two times more likely to have other musculoskeletal conditions (eg tendon disorders, other long-term joint diseases) compared to people without osteoarthritis.[29] Another study found that cardiovascular risk factors and diseases were the most common co-occurring conditions in people with musculoskeletal disorders with hypertension (37%) affecting the largest number of people.[30] Prior work that LCP have published with the National Institute for Health and Care Excellence on how coexisting conditions vary among people with type 2 diabetes over time found that hypertension, a condition with evidence of shared causes with diabetes, was the most common coexisting condition over the 10-year study period, affecting 48% of people.[31] Musculoskeletal conditions such as back pain and osteoarthritis were the second and fifth most common additional conditions among people with type 2 diabetes, affecting 40% and 16% of people respectively. Depression was the fourth most common additional condition during the study period, affecting 26% of people.

[29] Clinical comorbidity in patients with osteoarthritis: a case-control study of general practice consulters in England and Wales - PMC (nih.gov)
[30] Prevalence and pattern of comorbidities in chronic rheumatic and musculoskeletal diseases: the COMORD study | Scientific Reports (nature.com)
[31] Variations in comorbidity burden in people with type 2 diabetes over disease duration: A population-based analysis of real world evidence - PMC (nih.gov)

Figure 8: Combinations of health conditions for people aged 16 to 64 years and economically inactive because of long-term sickness, UK, January to March 2023



Decreasing resilience of the NHS to cope with increasing demand

The NHS is, by the measure of a number of routinely collected metrics, experiencing increasingly intense system pressures that are delaying and/or disrupting usual patient service and experience. Prior to the pandemic, mounting pressures were generally attributed to staff shortages, declining staff wellbeing, burden on general practice due to increasing chronic diseases and insufficient funding.[32] The Covid-19 pandemic has exacerbated these issues and highlighted the additional impact on NHS services of inequalities in illness patterns and healthcare services, with demand on NHS services becoming greater and more complex. These pressures continue to be present, impacting patient care but doing so in variable ways across the country.

During the Covid-19 pandemic, as with the whole healthcare system, primary care was under increased pressure as GPs were at the forefront of the response while also managing large volumes of non-Covid routine care. This increased burden, combined with persistent issues in the GP workforce's capacity to manage with increased workloads, may have led to people not being diagnosed with chronic conditions and sub-optimal management of those with diagnosed long-term health conditions.[33]

[32] An NHS under pressure (bma.org.uk)
[33] Pressures in general practice data analysis (bma.org.uk)

One such illustration is the disruption to the management of cardiovascular disease (CVD) during the Covid-19 pandemic.[34] There was a decline in the dispensing of medications to manage CVD risk factors such as hypertension, with nearly 500,000 fewer people across England, Scotland, and Wales starting antihypertensive treatment between March 2020 and July 2021. This reduction in medications was predicted to result in over 13,000 new CVD cases if people remained untreated over their life course.

NHS elective care services have also been worsening, with more patients waiting longer than ever before. Waiting lists for patients referred by a GP to consultant-led services for specialist review and procedures, such as a hip replacement, were already increasing prior to the pandemic, with over 4.5 million people in England on the waiting list for care in February 2020[35]. However, waiting lists have risen rapidly following the Covid-19 pandemic, leading to a backlog that is likely to take years to reduce to pre-pandemic levels. The latest figures in England for June 2023 suggest over 7.5 million people are waiting for elective treatment, and the average waiting time is 14.3 weeks, almost double the average waiting time of 7.5 weeks in February 2020[35]. Many patients are waiting for treatment longer than the 18-week NHS target – figures from June 2023 suggest approximately 41% (3,091,288) of patients are waiting over 18 weeks, while just over 5% (383,083) are waiting more than a year for treatment[35].

A similar and perhaps more alarming trend has been observed for waiting times for emergency care. Figures from July 2023 show that 109,515 patients were waiting over four hours from, a decision to admit to hospital being taken to the admission occurring, an increase of nearly 30% from pre-Covid waiting times in February 2020 (78,646 patients)[36]. Similarly, the number of patients waiting over 12 hours from decision to admission in July 2023 was 23,994, some 58 times higher than it was in June 2019 (462)[36]. Waiting times for ambulances to arrive to transport patients to emergency have also risen. In England, average response times for time-critical or life-threatening incidents (eg cardiac or respiratory arrest), which have a target response time of seven minutes were 8.4 minutes in 2021-22, an 18% increase from the average response rate of 7.2 minutes in 2018-19[37]. Each of these measures represent patients receiving sub-optimal care, which is likely to impact longevity and quality of life alongside being a bell weather measure for the wider healthcare system resilience and performance.

Demand for mental health services has accelerated following the Covid-19 pandemic, with 4.6 million referrals made to mental health services in England in 2022, a 22% increase from 2019 figures[38]. The number of people in contact with mental health services has also increased. The latest figures for England show that over 1.13 million adults were in contact with secondary mental health services in May 2023[39], an increase from 1.08 million adults observed in February 2020[40].

[34] The impact of the COVID-19 pandemic on cardiovascular disease prevention and management | Nature Medicine
[35] Waiting List Tracker (lcp.com)
[36] NHS backlog data analysis (bma.org.uk)
[37] Why have ambulance waiting times been getting worse? - The Health Foundation
[38] Mental health pressures data analysis (bma.org.uk)
[39] Mental Health Services Monthly Statistics , Performance May, Provisional June 2023 - NHS Digital
[40] Mental Health Services Monthly Statistics - Final February, Provisional March 2020 - NHS Digital

Although more people are now in contact with mental health services, there are still many people waiting for access to community mental health care as services cannot meet increased demands. The National Audit Office estimated that at the end of June 2022, 1.2 million people were on the waiting list for community-based NHS mental health services[41]. Additionally, treatment targets are not being met. In 2021-22, 1.2 million people accessed NHS talking therapy services, which aim to treat common mental health conditions like stress, anxiety, and depression – 22% below the NHS target of 1.6 million[41]. These metrics all reflect a healthcare service currently unable to effectively manage an increase in demand for its services which is likely to be contributing to the increasing number of individuals living in poor health and in turn requiring disability benefits, and for longer.

[41] Progress in improving mental health services in England (nao.org.uk)

05 Targeted interventions to improve health and reduce disability benefits

In light of our findings that individuals relying on Personal Independence Payment (PIP) at pension age can have a dependency duration of 11 years and costs exceeding £70,000, the need for innovative interventions becomes evident.

There are two over-riding principles which should inform action to tackle the increase in disability benefits:

- The £70,000 PIP costs during retirement provide a healthy budget for targeted health interventions to mitigate this cost and drive further prosperity gains for the individual and wider economy. We provide example costs of interventions relevant to some of the health conditions cited as the commonest causes of PIP claims throughout this chapter.

- The demand and need for PIP are unequally distributed across the country, as are the health conditions and healthcare system pressures contributing to this demand. Initiatives aiming to tackle the increases in demand for PIP should have resources targeted proportional to that need.

This section delves into strategic opportunities for targeted interventions and highlights practical programmes aligned with different phases of the disability benefits life course.

There are three key phases in the disability benefits life course of an individual with a health condition that provides opportunities for targeted intervention to improve their health, reduce their requirement for disability benefits and, in turn, add material value to the UK economy through greater productivity and a reduced benefits bill. These are:

- preventing the requirement for disability benefits by reducing the onset of ill-health;
- reducing the risk of those with long-term conditions requiring disability benefits; and
- reduce the duration of disability benefits receipt by addressing amenable deterioration in health.

These three phases have complex causes and several opportunities for intervention, and these include initiatives led by the Department for Work and Pensions, the Department for Health and Social Care and the NHS. We now identify examples of effective interventions and/or initiatives worthy of more targeted efforts and provide recommendations to the key bodies involved.

Preventing the requirement for disability benefits by reducing the onset of ill-health

While there has been increasing awareness of the value of preventing ill-health, including the UK government's strategy to increase healthy life expectancy by five years and reduce corresponding inequalities, there has been little if any progress to date. People are living with multiple chronic conditions from earlier in life and yet much of this can be prevented or postponed through tackling known modifiable risk factors. Approximately 50% of the disease burden in England remains due to four risk factors that can be addressed – poor diet, tobacco, excessive alcohol and physical inactivity. Effectively tackling these risk factors through creating an environment that is health promoting, rather than health harming, and makes the healthy choice, the easy choice, would go some way to improving the health of the workforce today and tomorrow with corresponding reductions in disability benefits.

Two of the commonest conditions present in those claiming disability benefits, and particularly of the increase in recent years, are musculoskeletal and mental ill-health conditions. The recent occupational health initiatives announcement by the government should target preventive action in the workplace for each of these conditions, alongside early identification and management. The ONS data also found these conditions to be, in the majority of cases, secondary to other conditions such as cardiovascular diseases. The workforce across the NHS should therefore be trained to 'Make Every Contact Count' and signpost available services to support those at risk and/or need of such support[42].

For context, Public Health England (now UK Health Security Agency and Office for Health Improvement and Disparities) identified cost-effective interventions in 2017 that represented good value for money, specifically for musculoskeletal conditions.[43] These included:

- Cognitive and Psychological Approaches (CBT), including Exercise (£243.03 per person)
- STarT Back (Stratified Risk Assessment and Care) (£2.20 per person)
- PhysioDirect (Early telephone assessment and advice) (£9.28 per person)
- Self-Referral to Physiotherapy (£2.00 per person)
- Yoga for Healthy Lower Backs (£292.61 per person)
- ESCAPE-pain (£312.22 per person)
- Vocational Advice in Primary Care (£44.17 per person)

[42] Making Every Contact Count (MECC) | Health Education England (hee.nhs.uk)
[43] PHE Final Report 2017: Return on Investment of Interventions for the Prevention and Treatment of Musculoskeletal Conditions

Targeted application of these interventions could prove to majorly offset costs. For example, cost savings from just one person needing PIP over the course of their retirement would provide funds for 7,000 people to receive Early telephone assessment and advice.

Reducing the risk of those with long-term conditions requiring disability benefits

The Department for Health and Social Care's (DHSC) Major Conditions Strategy provides an opportune moment to more effectively maintain the health of those living with chronic conditions and reduce their risk of disability benefit requirements. While mental illness and musculoskeletal conditions are two of the six conditions forming the recent call to evidence, several major conditions, including some that have seen larger increases in waiting list numbers during the pandemic, such as rheumatology and dermatology, have been omitted. Two specific areas that should be actively considered include:

- Repurposing the NHS Health Checks programme: this programme, for those aged 40-74, provides a check-up to assess for early signs of common chronic conditions such as heart disease or diabetes. It is delivered by GPs with a payment for carrying out the programme. Currently, the whole population (without any of the assessed conditions) are invited over a five-year period. However, attendance and therefore the benefits of the programme tend to not be felt in communities with highest risk of ill-health. The purpose and delivery of the Health Check programme should be reviewed, both regarding who the programme targets – with much more proportional focus, and corresponding financial incentives to primary care, towards those at the highest risk of ill-health, and on how this is delivered with more multi-modal delivery via community assets and local anchor institutions (including NHS sites).

- Whilst the programme has previously been under scrutiny for not being cost-effective, a more targeted approach based on health risk and need may prove to be.[44] Payments made by, for example, Liverpool City Council to their GPs for NHS Health Checks were £5.11 per invited individual and £16 per participant. Whilst these costs scale up quickly for a national diabetic population, a targeted approach in reducing risk may prove to be cost saving and would be a worthy recipient of a targeted pilot.

[44] Kypridemos et al 2018

Cost savings from reducing the risk of those with long-term conditions needing disability benefits can be illustrated with the examples below:

- The breadth of conditions contributing to disability benefit claims, and recent increases, suggests that the increased waiting times for elective care are likely to be contributing to this. Our recent analysis estimated that delivering against the target set by the Elective Recovery Plan could deliver an estimated increase in production of £73 billion over five years. Furthermore, those aged 55-74 were shown to have the largest potential gain net production, over £32 billion, should the NHS achieve its elective recovery targets. Almost a further £25 billion would be gained from those in the 25–54 year-old bracket.

- Collaborative care, an intervention of low intensity psychological treatments, has been demonstrated to be a cost-effective method of treatment for comorbid physical and mental illness.[45] While more explicit evidence on the ability of such interventions to maintain their effectiveness for the duration of a person's lifetime is needed, the cost of collaborative care can be delivered for £2,140 per person, far within the potential cost saving of £70,000 through avoided benefit payments.

- In April 2023, the NHS published commissioning recommendations following a clinically led national assessment to better understand the products available and how they meet the needs of all people living with diabetes.[46] Recommended diabetes meters for those with type 2 diabetes were shown to cost roughly £5.50 per unit. Avoiding just one person needing the £70,000 in post-pension age disability benefits would be enough to cover almost 13,000 people with a diabetes meter, which itself would drive further health and economic benefits through enabling people with type 2 diabetes to live well for longer.

The observed disruption to the detection and management of chronic conditions is likely to be felt over many years to come as the later diagnosis filters through to earlier and poorer outcomes. While this has been identified and described most starkly in cardiovascular disease to date through a reduction in diagnosis and preventive medications, it is likely to have affected the majority of chronic conditions including respiratory, diabetes, cancers and immunological conditions. It is likely that several similar groups who have 'missed' their diagnosis and/or are having their condition less well managed are also at risk of requiring disability benefits and therefore targeting catch-up efforts at such populations are likely to have short and medium term benefits on the healthcare and benefits system. The scale of this disruption, nor the individuals and groups most affected, is largely unknown yet these insights are vital. A review should seek to address these questions to inform both DHSC, NHSE and DWP's ongoing approaches to tackling the increased economic inactivity and underlying causes.

[45] Camacho et al 2016
[46] Commissioning recommendations following the national assessment of blood glucose and ketone meters, testing strips and lancets (england.nhs.uk)

Reducing the duration of disability benefits requirement by addressing amenable deterioration in health

- The recent initiative launched by the Department for Work and Pensions - the Individual Placement and Support in Primary Care (IPSPC) programme, launched in April 2023 – is providing on-the-job employment support and advice initially to more than 25,000 people across several localities across England. Our analysis has identified large variations across geographies of the burden of disability benefits and recent increases with Merseyside accounting for many of the 10 areas with most PIP claimants yet not receiving IPSPC programme funding. The IPSPC should be proportionally targeted to areas according to relative need and pace of increasing need.

- Businesses have an increasing role in preventing the onset of ill health and providing an environment to enable a faster return to full health through embedding occupational health initiatives through to building on flexible working patterns[47]. The advent and implementation of local Integrated Care Systems that aim to integrate services for healthcare and the drivers of health should be leveraged to ensure local services are tailored and targeted to the needs of local people. Such examples include access to support services such as Employment Advice in NHS Talking Therapies, which combines psychological treatment and employment support for people with mental health conditions.

Reducing the duration of claims for those with amenable health issues may strengthen the case for interventions that have already been demonstrated to be highly cost-effective. This may be particularly true for interventions that treat musculoskeletal issues, such as hip and knee replacements. Treating a patient for a primary hip replacement will cost the NHS £6,571[48], although future cost savings of such interventions are typically only considered from the perspective of the NHS. Broader cost savings to the taxpayer, such as those through avoided disability payments, could also be factored in where appropriate. These considerations strengthen the case for a health, rather than illness-based funding model and improved collaboration between governmental departments such as the DHSC and DWP.

[47] New plans to boost health in the workplace to keep people in work - GOV.UK (www.gov.uk)
[48] NICE NG157 Evidence review for hip replacement weighted average of HRG codes HN12A to HN12F

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