

Health and Welfare Spending in the UK: Implications for Scottish Constitutional Change

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ABSTRACT: Scotland is holding a referendum on independence next year, which implies that the Scottish Government would become responsible for welfare spending. At present, per capita spending on welfare benefits is very similar in Scotland and the Rest of Great Britain (rGB), but this hides significant differences between Scotland and rGB on specific benefits. Scotland spends substantially more per capita on illness and disability related benefits. Spending on 'earnings replacement' benefits such as Incapacity Benefit (IB) and Employment and Support Allowance (ESA) are 34% higher per capita, and 28% higher on Disability Living Allowance and Carer's Allowance. There is a stronger case for devolving welfare spending where there are fundamental differences underpinning claimant behaviour, and we focus our attention in this paper on the reasons for Scotland's higher claimant rate of earnings replacement illness benefits, and the implications for independence or for the devolution of welfare spending.

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Introduction

The Scottish Parliament already controls the majority of public spending in Scotland. Health, education, transport and housing all fall within the remit of the devolved parliament. However, should Scotland become independent following the 2014 referendum, the Scottish Parliament would become responsible for all areas of public spending. This would include social security and state pensions, which currently account for 30% of UK government spending. Along with defence, welfare is the only major area of public spending that is not devolved to the Scottish Parliament. In Scotland, welfare spending amounted to £16 billion in 2011/12, while the budget controlled by the Scottish Parliament covered some £33 billion of public spending.

It is often argued that Scotland has a more collectivist approach to social policy and would therefore be more willing to increase spending on welfare compared with the rGB. The basis for this argument may rest on Scotland's prominent historical role in the development of trade unions, the co-operative movement and the Labour party. Or that this approach has greater resonance among Scotland's political elite. However, there is no evidence of current differences in public attitude towards welfare between Scotland and rGB¹.

However, should Scotland opt for independence, it would face considerable challenges in establishing a new welfare system, or in adopting the existing welfare system which is itself undergoing substantial change. While a new start may be attractive in principle, in a period of constrained budgets, the likelihood that it would create losers as well as gainers may make this option less electorally attractive. Hence the prospects are that, at least in the short-run, the welfare system in an independent Scotland would not differ significantly from the existing Great Britain regime.

Clearly, this would involve adopting, in whole, or in part some of the reforms to the current system which will be in place by 2016. These changes are driven by two objectives: first, to reduce overall welfare spending as part of wider deficit reduction plans; and second, to simplify the existing welfare system and improve the incentives for people on benefits to start paid work or increase their hours. There have been several recent key policy announcements in this respect.

The introduction of Universal Credit replaces six means tested benefits and tax credits (income Support, income-based Jobseeker's Allowance (JSA), income-based Employment and Support Allowance (ESA), Housing Benefit, Working Tax Credit and Child Tax Credit), tied to some extensions to the conditionality attached to these benefits (e.g. an increase in the level of earnings per week beyond which JSA claimants are not required to increase hours or earnings). It also involves the gradual replacement, from April 2013, of Disability Living

¹ Using data from the 2011 British Attitudes Survey, the authors carried out an ordered logit analysis of responses to the statement "The government should spend more money on welfare benefits for the poor" which were measured on a five-point scale ranging from "Agree strongly" to "Disagree strongly". While both young men and young women disagreed significantly with this statement, there were no significant differences in the responses from respondents living in England, Scotland and Wales. Results available on request.

Allowance (DLA) by the Personal Independence Payment (PIP). Other policies announced in the Autumn Statement 2012 include a cap on the maximum weekly benefit that a family can receive, a cut in funding for council tax benefit, and reductions in housing benefit for those deemed to be ‘under-occupying’ their properties.

The objective of current reforms is to improve incentives for work. These represent an extension of the previous government’s ambitions to ‘make work pay’. For example, it was the previous government which presided over the replacement of Incapacity Benefit by Employment and Support Allowance, intended in part to reduce the number of IB claimants by 1 million by 2016. ESA claimants are subject to a stricter ‘work capability assessment’ than was the case for IB claimants, and, depending on the results of this assessment, receipt of ESA can be made conditional on attendance at work-focused interviews. The current government has announced that all existing IB and IS claimants will be subject to the ESA work capability assessment, and will be transferred onto ESA if the work capability assessment is passed.

In this paper we explore differences in the patterns of welfare spending between Scotland and rGB. We identify a spending gap in Scotland, and explore possible explanations for this. In particular, we examine the poorer state of health reported by Scots, and the implications that this has for welfare benefits. We conclude by discussing the implications of these differences for an independent Scotland.

Spending on benefits in Scotland and the Rest of Great Britain

Table 1 compares benefit spending, and benefit spending per capita, in Scotland and rGB. Overall, per capita spending on welfare benefits is very similar in Scotland and rGB, but this hides significant differences between Scotland and rGB on specific benefits. Scotland spends less per capita on tax credits largely as a result of it having a smaller proportion of families with children, and it spends less per capita on housing benefit because rents in Scotland are lower (Phillips, 2013). But Scotland spends more per capita than rGB on older people’s benefits such as Pension Credit, Attendance Allowance, and other older people’s benefits due to it having a slightly older population.

Scotland also spends substantially more per capita on illness and disability related benefits. It spends 34% more per capita on ‘earnings replacement’ benefits such as Incapacity Benefit (IB) and Employment and Support Allowance (ESA), and 28% more on Disability Living Allowance (intended to help cover care costs) and Carer’s Allowance.

There is perhaps more of a case for adopting an alternative approach to welfare spending (or aspects of it) where there are fundamental differences underpinning claimant behaviour, and for this reason we focus on the reasons for Scotland’s higher claimant rate of earnings replacement illness benefits.

Table 1: Spending on welfare benefits in Scotland and rGB, 2011/12

	Total spending (£m)		Spending per person		Index (rGB=1)
	Scotland	rGB	Scotland	rGB	
State Pension	£6,324	£67,818	£1,203	£1,207	1.00
Tax credits	£2,174	£25,926	£414	£462	0.90
Housing benefit / Council Tax Benefit	£2,111	£25,623	£402	£456	0.88
DLA and Carer's Allowance	£1,525	£12,773	£290	£227	1.28
Illness benefits*	£1,042	£8,333	£198	£148	1.34
Pension Credit	£752	£7,309	£143	£130	1.10
Income support	£670	£6,327	£128	£113	1.13
Attendance Allowance	£481	£4,858	£92	£86	1.06
Jobseeker's Allowance	£461	£4,469	£88	£80	1.10
Other benefits**	£372	£3,715	£71	£66	1.07
Other older people's benefits***	£237	£2,487	£45	£44	1.02
Total	£16,151	£169,637	£3,074	£3,020	1.02

* *Incapacity Benefit, Employment and Support Allowance, Severe Disability Allowance*

** *bereavement benefit, industrial injuries benefit, maternity allowance, statutory maternity pay*

*** *TV licences, winter fuel payments*

Source: DWP

While the UK remains a unitary state, it would in principle be possible to devolve all elements of welfare spending to the Scottish Parliament. However, such a policy is at odds with the traditional public finance argument that state governments should take responsibility for redistribution (Musgrave 1971, Oates 1972). The main argument is that differences in benefit levels could induce migration between sub-national levels of government.

But to add to Scotland's spending power without a concomitant increase in tax powers would further increase the level of vertical fiscal imbalance. Another possibility is to devolve a selection of benefits to Scotland. But the transition towards universal credit will presumably make this more difficult. In any case, on what basis would one decide which benefits were most suitable for devolution?

Another proposal is to devolve power to the Scottish Parliament to ‘top-up’ DWP administered benefits, provided that the Scottish Government meet the cost of this through increases in the rate of devolved taxation, or reductions in block grant. However, being able to vary benefit rates would be a relatively limited extension to Scotland’s policy options. Varying benefit eligibility rules or conditions might be a more powerful way to achieve particular policy objectives, but it seems difficult to envisage this being politically or practically feasible (e.g. how would it be possible to calculate the additional costs of JSA in Scotland if conditionality was relaxed in some way?)

Spending on IB, ESA and SDA – the size of the Scottish ‘gap’

The total amount spent on IB, ESA and SDA in Scotland is £1.02 billion, equivalent to £307 per person of working age. In rGB, the amount spent on these benefits is £8.11 billion, equivalent to £232 per working age person. Thus spending on these benefits is 32% higher per adult in Scotland than rGB.

The higher expenditure per adult on these benefits is the outcome of both a higher rate of claims in Scotland, and higher average expenditure per claimant. In Scotland 278,000 working age people claim IB, ESA or SDA, a claimant rate of 8.4%. In rGB, the equivalent rate is 6.6%. Thus the Scottish claimant rate for these benefits is 28% higher than rGB. Expenditure per claimant is £3,649 in Scotland, compared to £3,545 in rGB. Thus expenditure per claimant is 2.9% higher in Scotland¹.

If Scotland exhibited the same claimant rate as rGB, and had the same level of expenditure per claimant as rGB, then its total spending on IB, ESA and SDA would be £773m, some £247m *less* than actual spending.

Explaining Scotland’s spending gap

Clearly, only a small part (12%) of this £247m ‘gap’ is explained by Scotland’s higher *spending* per claimant, with the rest attributable to the much higher *proportion* of claimants in Scotland.

Scotland’s higher claimant rate for ESA, IB and SDA is no doubt due in large part to the fact that its working age population is on average older and less healthy than the rGB population. Data from the Labour Force Survey (LFS) shows that 20.5% of working age Scots claim that they have a health problem which limits their activity compared to 18.5% in rGB. Controlling for Scotland’s slightly older population reduces this difference slightly to 1.5 percentage points. But, even controlling for age, Scots are more likely to say they have a larger selection of the 17 health problems identified in the LFS.

To what extent do these demographic and health factors adequately explain Scotland’s relatively higher claimant rate for disability benefits? One way to examine this is to use the individual-level data in the LFS to model the probability of a working age individual claiming either IB, ESA or SDA given their age and reported health. Table 1 shows the results of three such regressions, where the coefficients can be interpreted as marginal effects

(i.e. the effect on the probability of claiming the benefit resulting from a unit change in the relevant variable). These effects are measured in percentage terms.

Regression 1 models the probability of an individual claiming IB, ESA or SDA as a function of a single variable - whether the individual is Scottish or not. The coefficient suggests that, without controlling for age or health, Scots are 1.09% more likely to claim one of these benefits than someone in rGB. Regression 2 controls for age. The coefficient on the Scottish ‘dummy’ variable falls slightly to 0.9%, reflecting the fact that, adjusting the relationship to include the effects of Scotland’s older population, reduces the likelihood of a Scot claiming IB, ESA or SDA. Regression 3 controls for age *and* two health status variables – whether the individual has an activity-limiting health problem, and the number of health problems that the individual says they haveⁱⁱ. In this regression, the Scottish variable falls substantially, implying that, for a given age and health status, Scots are only 0.186% more likely to claim IB, ESA or SDA than people in rGB.

Table 1: Influences on probability of claiming IB, ESA or SDA

	Regression 1	Regression 2	Regression 3
Scottish	1.090%	0.901%	0.186%
Age		0.299%	0.103%
Age squared		-0.002%	-0.001%
Activity limiting health problem			8.515%
Number of health problems			0.405%
Pseudo-R ²	0.0008	0.0295	0.3833

Notes: Dprobit regressions of benefit status on explanatory variables. In each regression, N=57,672 and all variables are significant at 0.001 level.

As we’ve seen, 12% of Scotland’s £247m spending gap is attributable to higher average payments per claimant. The results in Table 1 suggest that, of the remaining £218m gap, around 83% can be explained by the fact that Scotland’s working age population is on average older and less healthy than that of rGB. A relatively small part (around £37m) of the gap remains unexplained by Scotland’s demographic and health status.

But this raises two subsequent questions. First, why are Scots so much more likely that people in rGB to say that they have a health problem? Second, why are Scots more likely to claim sickness benefits, even after controlling for age and health?

Why are Scots more likely to report having poor health?

The question of why Scots are more likely to say they have an illness is more difficult to answer because causality probably runs in both directions – i.e. the difference in self-reported health between Scots and people in rGB might be explained by the benefit claimant rate, as much as the difference in benefit claimant rate might be explained differences in self reported health. In other words, the claimant rate and self-reported health might be jointly determined (McVicar, 2011). This raises a series of issues around self-reported health measures, the

extent to which they are correlated with 'objective' measures of clinical health, and the way in which self-reported measures might be subject to bias and justification.

There is certainly some evidence that Scotland has a much greater incidence of various health problems than other parts of the UK. Compared to Scotland=100, England's 0-75 standardised mortality rate is 76, and Wales' is 83. Scotland has a higher death rate than England for every major cause of death (McLaren et al, 2010). Even after controlling for the effects of deprivation, Scotland's mortality rate seems to exhibit a significant unexplained element, which has been referred to as the 'Scottish effect' (Hanlon et al, 2005) and more recently the 'Glasgow effect' following research indicating that deaths in Glasgow were 15% higher than those observed in Liverpool or Manchester, despite the three cities having almost identical deprivation profiles (Walsh et al, 2010).

On the other hand, there is also evidence that, across Western countries, workers tend to report very different rates of work disability, despite apparent similarities in health outcomes. As Kapteyn et al (2007) explain:

'In comparing such self-reports [of health], a basic question concerns the extent to which people living in the same or in different countries use the same response scales when they answer questions about work disability. If they use the same scales, differences in reported work disability reflect true differences across countries in disabilities affecting work. But if response scales differ systematically, adjustments must be made before conclusions about differences in true work disability can be drawn.'

Using vignettes to standardise self-reported health scales, Kapteyn et al (2007) find that a large part of observed differences in reported work disability between residents of the US and the Netherlands results from the fact that residents of the two countries use different response scales in answering standard questions on whether they have a work disability. Perhaps more pertinently in the context of the analysis in this paper, they find that, within the US, response scales differ by gender, age and education. Using the German panel survey, Juerges (2008) finds that the socio-economic characteristics of respondents have an effect on mortality, conditional on individuals' self-assessed health. He argues that these findings 'question the comparability of self-assessed health across different socio-economic groups'.

However, most research on this issue concludes that it is not so much differences in health that influences claimant rates for illness benefits as it is differences in labour market conditions (McVicar, 2011; Beatty and Fothergill, 2005). Claimant rates for illness benefits are correlated with claimant rates for out-of-work benefits, both in space and time. This is likely to occur for a number of reasons, including:

- That illness benefits act as a substitute for unemployment benefits, so that improving labour market conditions result in claimants coming off illness benefits to become economical active. In this respect, the claimant rate for IB and ESA contains an element of 'hidden unemployed'.

- Related to this point, that unemployment can lead to a deterioration in health and thus exit from labour market activity
- That long or repeated periods of unemployment can discourage potential workers, and lead them to ‘give up’ looking for work
- Historically, that higher levels of occupational ill health are associated with particular industries, so that de-industrialisation during the 1980s and 1990s led to large numbers of ‘hidden sick’ losing their jobs in concentrated geographical areas

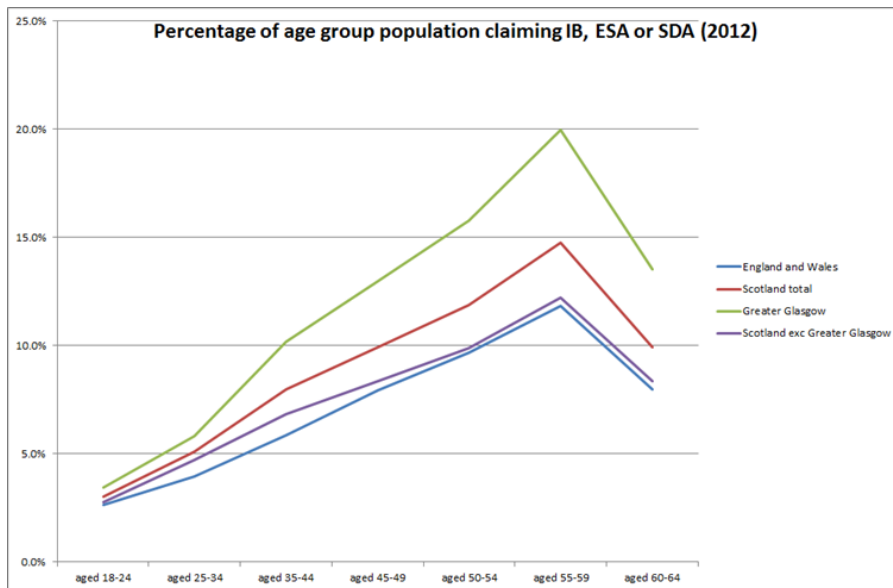
What can we conclude from this discussion? Scots’ poorer self-reported health no doubt reflects to a large extent ‘real’ differences in observed health status compared to people in rGB. But there is a complex set of jointly determined relationships between labour market conditions, health status, and claimant rates for both illness and out-of-work benefits. Higher rates of self-reported health and higher claimant rates for illness benefits in Scotland are no doubt due in part to the legacy of high worklessness in some parts of Scotland. This contention is backed up by two pieces of evidence. First, Scotland’s health gap relative to rGB seems to increase with age (Table 2). Second, Scotland’s ‘claimant gap’ relative to rGB is focussed in Greater Glasgow (Figure 1);

Taken together, these two facts provide suggestive evidence that Scotland’s health gap and claimant gap are in large part due to the legacy of industrial restructuring, particularly in Greater Glasgow. The extent to which worklessness affects health or vice versa is less clear. However, it is worth noting that, among those in work, there is little difference between Scotland and rGB in terms of self-reported ill-health.

Table 2: Probability of Scot having an activity-limiting illness, conditional on age, relative to rGB

Age category	Probability
18-39	0.476%
40-49	1.878%
50-64	2.955%

Figure 1: Percentage of age group population claimaing IB, ESA or SDA (2012)



Why are Scots more likely to claim sickness benefits, even after controlling for age and health?

Although the effect is small, the evidence presented above suggests that Scots are more likely to claim illness benefits than their rGB counterparts, conditional on age and health status.

Why might this be so? The discussion in the preceding section suggests that socio-economic factors and local labour market conditions may well explain this apparent 'discrepancy'.

However, benefit rates are set nationally in the UK, despite wage differentials between regions. It is possible that the relative generosity of benefit rates in lower wage regions might influence claimant rates. Faggio and Nickell (2005) find a strong relationship between regional wages and prime age male inactivity, and this relationship appears stronger between regional wages and regional rates of inactivity restricted to those inactive on health grounds. Another possible explanation is that eligibility rules for these benefits are applied less harshly in Scotland than rGB. It is perhaps difficult to envisage this happening, although Ritchie et al (1993) report evidence that doctors were more likely to certify individuals as entitled to disability benefits where they felt their chances of getting a job were low (responsibility for work capability assessment has since transferred from GPs to DWP commissioned agencies).

Conclusions

The fact that welfare is reserved at UK level aligns with what is often referred to as the 'traditional theory of fiscal federalism' (Musgrave, 1959; Oates, 1972). The traditional theory contends that central government should have the basic responsibility for income redistribution, given the mobility of economic units (the contention being that efforts at redistribution at a sub-national level will be undermined by the mobility of workers, with the result being no redistribution but deadweight losses from inefficient locational decisions (Oates, 1999)).

However, even the traditional theory of fiscal federalism would allow for decentralisation of some aspects of welfare spending if preferences for or costs of redistribution varied across jurisdictions.

References

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Notes

ⁱ This difference is due to expenditure per IB claimant being around 5% higher in Scotland than RGB, which is in turn a result of the fact that 5% more IB claimants receive 'payment' (as opposed to NI credits only). For ESA, 1% more Scottish claimants receive payment than in RGB, but this is compensated for by the fact that the average payment, of those receiving it, is 1% less in Scotland than RGB.

ⁱⁱ Instead of one explanatory variable for the number of health problems an individual has, we can alternatively run Regression 3 with 17 dummy variables to represent which of the 17 categories of health problem each individual has. Doing this reveals qualitatively similar results, although the coefficient on the Scottish dummy variable falls slightly further, to 0.167%.