20
Disabled People and the Long-term Sick

The financial and social consequences and the sheer scale of the problem of disability have been underestimated in the United Kingdom as much as in other industrial countries. Partly this is because of the dominance of clinical and administrative criteria of disability, which have caused the disabled to be seen as a heterogeneous collection of people with different medical needs instead of a group having predominantly similar, if complex, educational, occupational, financial, housing and social needs.[1] Partly it is because the professional organization of welfare activities on behalf of the disabled has been ill-developed inside and outside government. This chapter will show that limited access to resources on the part of people who are, or have become, disabled accounts for a substantial proportion of poverty. The concept of disability will be discussed and its extent measured, so that its different effects can be examined in turn.

When the survey was being planned, no comprehensive information existed and pilot work had persuaded us that disability was closely related to poverty and that substantial efforts had to be committed to its elucidation.[2] Fortunately that and other work and pressures had also persuaded the government to undertake a national survey and the results of the two surveys can in some respects be compared.[3]

[1] See, for example, *Handicapped Children and Their Families,* Carnegie United Kingdom Trust, Dunfermline, 1964, esp. pp. 10-11 for the categorization of groups ; or Sections VI, VII and VIII of Famdale, J. (ed.), *Trends in Social Welfare,* Pergamon Press, Oxford, 1965.

[2] At the University of Essex in the mid 1960s, two pilot studies of the disabled were undertaken by Sally Sainsbury and Michael Humphrey, and another pilot study of the mentally handicapped by Lucianne Sawyer. A pilot study of the chronic sick by John Veit Wilson also preceded this national survey. See Townsend, P., *The Disabled in Society,* Greater London Association for the Disabled, London, 1967; Sainsbury, S., *Registered as Disabled,* Bell, London, 1970.

[3] Harris, A. I., with Cox, E. and Smith, C. R. W., *Handicapped and Impaired in Great Britain,* Part I, and Buckle, J. R., *Work and Housing of Impaired Persons in Great Britain,* Part II, and Harris, A. I., Smith, C. R. W., and Head, E., *Income and Entitlement to Supplementary Benefit of Impaired People in Great Britain,* Part III, an inquiry carried out by the social survey division of the Office of Censuses and Surveys on behalf of the Department of Health and Social Security and other government departments, HMSO, London, 1971, and December 1972. The inquiry was announced on 23 October 1967 by the Minister of Health and followed a great deal of

The Concept of Disability

From the start, the different meanings of disability should be recognized.[1] There are at least five concepts. First, there is anatomical, physiological or psychological abnormality or loss. In this sense, the disabled are people who have lost a limb, or part of a limb, or part of the nervous system through injury or surgery. Some are blind, or deaf or paralysed, or are physically damaged or abnormal in specific, usually observable, respects by comparison with their compatriots of like age and sex. Such loss or abnormality may have a considerable or an inconsequential effect on activity. Thus someone with discoloured skin tissue, a humped back, a phobia, or even a missing finger may perform as well as an 'ordinary' person of similar age over a vast range of activities.

Secondly, there is chronic clinical condition altering or interrupting physiological or psychological process - such as bronchitis, arthritis, tuberculosis, epilepsy, schizophrenia and manic depression. The two concepts of loss or abnormality and of chronic disease tend to merge, for just as a loss may have irreparable or unchanging effects, so long-continued disease usually has some lasting physiological or anatomical effect.[2]

Thirdly, there is functional limitation of ordinary activity, whether that activity is carried on alone or with others. It is therefore not quite coincident with a limitation of role, in the sociological sense, though, of course, it is very close to it. The simplest example is incapacity for self-care and management - such as being unable or finding it difficult to walk about, negotiate stairs and wash and dress. But by considering different reference groups, an estimate can also be made of the individual's relative incapacity for household management and performance of different general roles as husband, father or mother, neighbour or friend, as well as of any limitation of capacity to follow specific occupational roles.

A fourth meaning is pattern of behaviour which has elements of a socially deviant kind.[3] This pattern of behaviour can be determined by an impairment or pathological condition - such as a regular physical tremor or limp, or an irregularly recurring fit. Thus, activity might not necessarily be limited, or only limited, but different. But the behaviour may not be determined only or even at all by physiological impairment,

---

pressure by the Disablement Income Group and others about the desirability of a new pension scheme.

[1] The following passage draws on a similar passage in the author's paper, *The Disabled in Society*, pp. 3-6.

[2] See also the analysis by Nagi, S. Z., 'Some Conceptual Issues in Disability and Rehabilitation', in Sussman, M. B. (ed.), *Sociology and Rehabilitation*, American Sociological Association, Washington, DC, 1966, esp. pp. 100-3.

[3] Goffman, E., *Stigma: Notes on the Management of Spoiled Identity*, Penguin Books, Harmondsworth, 1968; Freidson, E., 'Disability as Social Deviance', in Sussman (ed.), *Sociology and Rehabilitation.*

but by a mixture of what society expects of someone in certain situations and what the individual falls into doing. Sociologists have called attention to the concepts of the sick role and of illness behaviour.[1] Society expects the blind or the deaf or the physically handicapped to behave in certain approved or stereotyped ways. Individuals come to learn what is expected of them by nurses and doctors, and by their families and neighbours. Individuals can be motivated towards such behaviour when their physical or neurological condition does not compel it. A family or sub-culture can condition it. There are cultural differences in disability behaviour. People of different nationality or ethnic group vary in their stoicism in face of pain or impairment.[2] People may also be motivated to simulate deafness, blindness and other types of impairment. People with little or no impairment may play the disabled 'role'. Those with the same kind and even degree of impairment may see it differently. One might act up to the limit of his capacities, even at the risk of exposing his abnormality. Another might refrain from actions of which he is capable. In each case, the sociologist would explore variations in social conditions and processes for an explanation for the difference.

Finally, disability takes on the rather general meaning of a socially defined class and status. In some respects this can be 'subjective', and in others 'objective'. An individual who is 'disabled' is not just impaired, or limited, or different in his activities; he occupies a position in the social hierarchy determined by the kind of resources allowed to people like himself and a (usually) corresponding status which the disabled, when recognized as such, occupy in that particular society. By virtue of the social perception of disability, he attracts a mixture of deference, condescension, consideration and indifference. Resource or class level may not be defined very clearly or consistently, and the proportion of the population who are accorded the status of 'disabled people' may vary in different societies. There are populations which do not recognize or identify mild forms of mental handicap, schizophrenia or infirmity, for example. In working-class British society, euphemisms for certain handicaps are used. People have 'nerves' or are 'hard of hearing' or are 'a bit simple'. The technical, conclusive and often stigmatizing labels are avoided. A place is not taken in a rank of a hierarchy. This may mean that special needs may be overlooked and social resources withheld; but it may also mean that people are not set apart like lepers or treated with aloof condescension. Disability usually means inferior and not just different status.[3] Social perception is at least in part related to material conditions and opportunities. Society designs buildings and methods of

[1] See, for example, Mechanic, D., 'The Concept of Illness Behaviour', *Journal of Chronic Diseases,* vol. 15, 1962; Mechanic, D., Response Factors in Illness: The Study of Illness Behaviour', *Social Psychiatry, vol.* 1, August 1966.

[2] See, for example, Zborowski, M., 'Cultural Components in Responses to Pain', *Journal of Social Issues,* vol. 8, 1952; Jaco, E. G. (ed.), *Patients, Physicians and Illness,* The Free Press, New York, 1958.

[3] See ten Broek, J., and Matson, F. W., 'The Disabled and the Law of Welfare', *California Law Review,* vol. 54, No. 2, May 1966, p. 814.

transport, organizes occupations and develops codes and rules which circumscribe social behaviour - and hence 'creates' disability. The status of 'disabled person' is governed loosely by general public opinion and more exactly by the rules of entitlement to social security, the definition of interest on the part of voluntary associations, employers and public services, membership of clubs and centres and the special sets of relationships with doctors, nurses and social workers.

Each of these conceptions of disability can be pursued fruitfully to achieve a fuller understanding of the phenomenon and therefore of policies of aid and service which would be effective. Each has its drawbacks. For example, the isolation and study of particular clinical conditions is necessary if advances in medical treatment and prevention are to be made, but may in the process emphasize the separateness rather than the similarity of many disabled conditions, with consequential confusion, fragmentation of effort and injustice.

Each of the conceptions can be considered subjectively as well as objectively. We might list them for convenience as conceptions of (a) 'impairment' (combining the first two, which might be regarded as merging); (b) 'functional incapacity' ; (c) 'disability deviance' ; and (d) 'disability status' and 'class'. The individual and the group may take a different conception, in any of these respects, from that of society as a whole, and attempts to provide independent or objective criteria may produce a different conception still. This amounts to saying that individual, collective and objective assessment of disability, or of impairment, functional incapacity, deviance and social rank may not be concordant. For example, although society may have been sufficiently influenced in the past to seek to adopt scientific measures of disability, so as to admit people to institutions, or regard them as eligible for social security or occupational and social services, these measures may now be applied in a distorted way, or may not be applied at all, or may even be replaced by more subjective criteria by hard-pressed administrators, doctors and others. At the least, there may be important variations between social' and objective assessments of severity of handicap.

Two Operational Definitions

Two measures which corresponded with the conceptions listed above of 'impairment' and 'functional incapacity' were developed in some detail in the survey.[1]

[1] During 1966-7 there were consultations among a number of research workers engaged on studies of disability. Present at one meeting at the end of 1966, arranged by the directors of the poverty survey, were Walter Holland, who was in charge of a study of the disabled from St Thomas's Hospital, Margot Jefferys, supervising with Michael Warren a series of studies of impairment of function, particularly of the upper and lower extremities, from Bedford College, London, and Sally Sainsbury, undertaking a pilot study of the disabled in Essex, Middlesex and London. There was common agreement that the local-authority registers of the handicapped were grossly deficient and that methods had to be devised to establish the true numbers. All were

First, we asked whether each person in the household suffered from any condition which prevented him from doing things which an ordinary person of the same age might expect to do - prompting whether he or she had any trouble with chest or lungs, back or spine, joints, sight, hearing, speech, nerves, fits or blackouts, diabetes, a mental handicap or anything else, and also presenting the individual with a similar list on a card. Depending on the answer, further specific questions sought to confirm whether or not, in the informant's opinion, the condition really did have a restricting effect on activity (see page 1141). This approach allowed vague or general claims to disablement to be tested. It was comprehensive, if summary, and searching, and meant that clinical conditions were often called to our attention which might otherwise have been missed or their effects underestimated. Our objective was to find whether the individual really did claim to have one or more disabling conditions. People saying they had trouble with the chest or lungs were asked whether they became breathless or had any pain or fits of coughing when they hurried. People saying they had trouble with the back or spine or joints were asked whether they had any difficulty in moving freely and fully and using their hands. Those saying they had trouble with nerves were asked four specific questions about depression, anger, concentration and sleep. They were also asked whether they were consulting a doctor. Such supplementary questions had been found in research previously by doctors and epidemiologists to be reliable indicators of serious disabling conditions.

Table 20.1 presents the full list and shows the proportions of males and females in the sample having trouble with different bodily and mental faculties; and also, among them, those saying further that in one or more specific respects their activity was restricted. Thus 62 per cent said they had trouble with chest or lungs, and most of these, representing 4.7 per cent of the entire sample, also said they became breathless or had pain or fits of coughing. The incidence of trouble with chest or lungs was higher among males than females, but with back or spine, speech, fits and mental handicap was about the same among males as among females. Trouble with joints, nerves, sight, hearing and diabetes was, however, more common among females than males. The proportion of women having trouble with nerves was much higher than of men, and this applied to all age groups over the age of 20. The relative excess was maintained after supplementary questions had been put, and was also confirmed in the proportions saying they were seeing their doctors about this condition. About four fifths of the men and three quarters of the women saying they had trouble with nerves also said they were seeing a doctor about their trouble. Altogether more than a fifth of the population had trouble of one sort or another, and 12 per cent a definitely disabling condition. It should be noted that this latter figure is a slight underestimate, because people saying they had some other trouble than the

---

experimenting with functional tests or criteria, though there was disagreement about the extent to which the same set of criteria could be applied to groups of people suffering from widely different types of disability.

items listed in Table 20.1 were not asked any specific supplementary questions and were therefore excluded from the total with a marked or specific disablement condition.

Table 20.1. *Percentages of males and females with disablement condition.*

Trouble with	*% with condition said to give trouble*			*% with marked or specific restriction of activity*		
	Males	*Females*	*Males and females*	*Males*	*Female*	*Males and females*
Chest or lungs	7.0	5.5	6.2	5.1	4.3	4.7
Back or spine	3.5	3.9	3.7	1.8	1.8	1.8
Joints	3.9	6.2	5.1	2.6[a]	3.3[a]	3.0[a]
Nerves	2.0	6.7	4.4	1.5	6.0	3.8
Sight	2.1	3.5	2.8	1.8	2.6	2.2
Hearing	2.1	3.0	2.6	1.6	2.6	2.1
Speech	0.4	0.4	0.4	0.3	0.4	0.3
Fits or blackouts	0.6	0.6	0.6	0.7	0.7	0.7
Diabetes	0.5	0.6	0.6	0.5	0.7	0.6
A mental handicap (apart from nerves)	0.5	0.4	0.5	0.5	0.4	0.5
Any other trouble	3.9	5.3	4.6	-	-	-
At least one of above	20.6	25.3	23.0	9.9	14.3	12.2
Total number	2,895	3,069	5,964	2,888	3,059	5,947

NOTE: [a]Estimated on basis of incomplete information.

Secondly, questions about a selected list of activities were designed to establish the degree to which the individual was limited in caring for himself and managing a household. This approach was based on early work with the aged,[1] and had been developed in pilot research with the disabled of all ages.[2] Irrespective of the type of

[1] Townsend, P., *The Last Refuge*, Routledge & Kegan Paul, London, 1962, pp. 257-61 and 464-76; Shanas, E., *et al., Old People in Three Industrial Societies*, Routledge & Kegan Paul, London, 1968.

[2] Sainsbury, *Registered as Disabled*, pp. 26-49. This research was carried out in 1965. In 1966, a survey of disabled adults aged 16-64 was undertaken in the United States which developed both the health impairment and functional definitions of disability. Some of the results of this survey were published in 1968, but most papers on the results have been published in the

illness or disability from which people might be suffering, it was hypothesized that they could be ranked according to degree of capacity to perform ordinary activities. Thus disability itself might best be defined as inability to perform the activities, share in the relationships and play the roles which are customary for people of broadly the same age and sex in society. One problem is to distinguish what are the different activities, relationships and roles. We can group activities into those which (a) maintain personal existence, such as drinking, eating, evacuating, exercising, sleeping, hearing, washing and dressing; (b) provide the means to fulfil these personal acts, such as obtaining food, preparing meals, providing and cleaning a home; (c) are necessary to immediate family and household relationships, such as sexual, marital and parental relationships; (d) are necessary to external social relationships, at work, in the neighbourhood, travelling and as one of a crowd; and (e) are necessary to the instrumental roles performed at home and work as a member of society. Many specific activities might be listed. It is evident that some would correlate with others very closely and questions about a selected cross-section might give, for any individual, a broad approximation of his capacities as a whole. We chose to concentrate on the first two of these five groups - that is, on personal and household activities - partly because it is difficult in a national survey to provide an adequate framework of questions about relationships inside and outside the home, and also about possible as well as actual roles performed, but also because these groups of activities tend to underlie and correlate with instrumental and expressive social activities.

Table 20.2 presents the list of activities included in our index, which was produced on the basis of both previous and pilot research.[1] People were asked whether they had difficulty in carrying out any of these activities. If they had difficulty a score of 1 was registered; if they could not carry out the task at all, a score of 2 was registered. The table shows that over a quarter of the sample had difficulty with at least one item, and substantially more women than men had difficulty. In fact, the only item over which fewer women than men had difficulty was that of preparing a hot meal.

While this is not the place for a full discussion of the index adopted, its limitations, and also some of its principal advantages, should be mentioned. Only a sel-

---

period 1970-72. The two most general papers are Haber, L. D., 'Prevalence of Disability among Non-Institutionalised Adults under Age 65: 1966 Survey of Disabled Adults', *Research and Statistics Notes*, US Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, 20 February 1968; and Allan, K. H., and Cinsky, M. E., 'General Characteristics of the Disabled Population', *Social Security Survey of the Disabled: 1966*, Report No. 19, US Department of Health, Education and Welfare, Office of Research and Statistics, July 1972.

[1] The items were chosen from a list of sixty-four examined in a pilot study. Subjective reports on whether difficulty was experienced with particular activities were found to correlate significantly with the time taken by individuals in performing those activities. See Sainsbury, S., *Measuring Disability*, Bell, London, 1974.

Table 20.2. *Percentages of males and females who have difficulty with certain activities.*

Activity	*Percentage who have difficulty or cannot perform activity*			*Total number*		
	Males	*Females*	*Males and females*	*Males*	*Females*	*Males and females*
Washing down (whether in bath or not)[a]	3.2	5.3	4.3	2,315	2,535	4,850
Removing a jug, say, from an overhead shelf[a]	4.5	8.9	6.8	2,313	2,532	4,845
Tying a good knot in string[a]	2.4	4.3	3.4	2,311	2,532	4,843
Cutting toenails[a]	4.8	8.4	6.7	2,313	2,531	4,844
Running to catch a bus[b]	19.5	27.3	23.6	2,313	2,524	4,837
Going up and downstairs[b]	9.0	14.2	11.7	2,312	2,524	4,836
Going shopping and carrying a full basket of shopping in each hand[b]	11.3	22.4	17.1	2,304	2,521	4,825
Doing heavy housework, like washing floors and cleaning windows[c]	12.0	19.2	15.8	2,047	2,276	4,323
Preparing a hot meal[c]	4.0	3.4	3.7	2,048	2,277	4,325
At least one of above	21.6	321	27.1	2,264	2,485	4,749

NOTES: [a]Excludes children in sample under 10 (numbering 1,065).
[b]Excludes children under 10 and bedfast.
[c]Excludes children under 16 and bedfast.

ected cross-section of activities are included; difficulty with each activity is given equal weighting; and changes in individual capacity from day to day or season to season are ignored. These are just three limitations. A more comprehensive approach would have to include a greater number of activities and weight some activities more heavily for some sections of the population than for others, not just by

sex and age, but according to variations in pattern of activity among different classes, communities and ethnic groups. Although people were rated according to present abilities (in the case of the short-term sick, immediately before their sickness), we did ask about variations in disability, and these are discussed below.

The advantages also need to be recognized. The social conception and assessment of disability has had an erratic history. Some kinds of disability have been treated indifferently or stigmatized, while others, like blindness, have attracted wide public sympathy. Both medicine and social service have been susceptible to fashion and fragmentation. Just as there have been consultants for particular diseases and hospitals for particular parts of the body, so there have been a wide variety of statutory and voluntary organizations for different types of handicap, some of them far better staffed and financed than others. As a consequence, local authorities compiled registers of the handicapped which were not only incomplete but were divided quixotically into registers for the blind, deaf, and a general register for the physically handicapped. In social security those disabled in war were, and are, favoured by comparison with those disabled in industry and civil life. Yet, in recent years, society has begun to evolve a more unified conception of disability. Thus, an attendance allowance has been introduced for all severely disabled people and not just for war and industrial injury pensioners, even if it is paid at only two rates, a higher and a lower rate, compared with three rates paid under the industrial injuries disablement scheme and four rates under the war pensions scheme. The Chronically Sick and Disabled Persons Act 1970 has encouraged local authorities to adopt a more comprehensive approach to registration.[1] And the reorganization of local social services departments, following legislation also passed in 1970, together with a more general course of basic training of social workers, has helped to integrate methods of help.

The Need for a New Approach to Assessment

There is, then, an important relationship between society's conception of a problem, and the policies which are followed in relation to that problem. Yet the assessment, or operational definition, of disability is still not subjected to the critical attention is deserves. We are imprisoned within outdated conceptions, and are even unimaginative about alternative forms of assessment. Consider various methods of assessment in Britain. In the mid 1960s the McCorquodale Committee on the Assessment of Disablement reiterated the principle that assessment should be determined by 'means of a comparison between the condition of the disabled person and that of a normal healthy person of the same age', and they recognized that this involved measures of loss of faculty but made no efforts to collect information about either the disabled or 'normal healthy people'. Nor did the committee review the

[1] But that legislation was, in the end, drawn up ambiguously and delayed and even softened in implementation. See Jaehnig, W., 'Seeking Out the Disabled', in Jones, K. (ed.), *The Yearbook of Social Policy in Britain, 1972*, Routledge & Kegan Paul, London, 1973.

rationale of current medical assessment. They gave attention to problems which only affected a small minority of the disabled - such as amputations and loss of limb or eye - and even for these problems did not provide any empirical or even reasoned substantiation for percentage assessments. The committee accepted, for example, the loss of both four fingers and of a leg below the knee as equivalent to 50 per cent disability. The following were each treated as equivalent of 30 per cent disability: the loss of three fingers; the amputation of 'one foot resulting in end-bearing stump'; the amputation 'through one foot proximal to the metatarso-phalangeal joint'; and the loss of vision in one eye.[1] Most informed observers agree that this approach is inappropriate for many kinds of disability and has no bearing on questions of severity of disablement or restriction of function.

A second example of administrative assessment is the Department of Employment's Register of Disabled Persons. To qualify, a person must

(i) be substantially handicapped on account of injury, disease (including a physical or mental condition arising from imperfect development of any organ), or congenital deformity, in obtaining or keeping employment or work on his own account otherwise suited to his age, qualification and experience; the disablement being likely to last for 12 months or more; (ii) desire to engage in some form of remunerative employment or work ... and have a reasonable prospect of obtaining and keeping such employment or work.[2]

No detailed criteria for 'substantially handicapped', 'handicapped in obtaining or keeping employment', 'desire' for work, 'reasonable prospect' of obtaining work and even what is 'suited' to age, qualification and experience have been spelt out and related to empirical evidence by the Department of Employment or independent workers.[3] Society therefore has no clear idea of the numbers of people who deserve, and are getting, help.

A third example is the attendance allowance, introduced in 1971. At the higher rate, the allowance is paid to someone who

is so severely disabled physically or mentally that he requires from another person, in connection with his bodily functions, frequent attention throughout the day and prolonged or repeated attention during the night; or ... is so severely disabled physically or mentally that he requires continual supervision from another person in order to avoid substantial danger to himself or others.[4]

[1] Report of the Committee on the Assessment of Disablement (The McCorquodale Report), Cmnd 2847, HMSO, London, December 1965.

[2] Disabled Persons (Employment) Act 1944.

[3] The Department of Employment did not seek to fill these gaps during its 'comprehensive review' of its policies and services for helping disabled people to obtain and keep suitable employment. See *The Quota Scheme for Disabled People*, Consultative Document, 1973.

[4] Section 4, National Insurance (Old Persons' and Widows' Pensions and Attendance Allowance) Act, 1970.

An Attendance Allowance Board was set up to advise the government on procedures and administration. A medical report has to be completed for every applicant, detailing whether he or she can without help or only with help

(i) change position whilst in bed; (ii) get out of bed; (iii) walk; (iv) use stairs; (v) dress and undress; (vi) wash; (vii) bathe; (viii) shave (men); (ix) eat; (x) drink; (xi) go to the toilet.

Other questions ask about the frequency of help at night and in the day. A modified list is applied to children. This approach represented an important innovation in that it paved the way for the identification of disability according to a set of functional criteria and allowed the classification of the disabled into groups with different degrees of incapacity.

The argument for identification according to functional criteria were also accepted in a national survey mounted in 1968-9 by the government. People were classified into eight categories of handicap in terms of their ability to undertake such activities as feed themselves, change position in bed, get to and use a WC, put on shoes and socks or stockings and do up buttons and zips.[1]

These developments have two principal advantages. Attention is called to the wide range of different effects of disability, with the possibility that social resources will be mobilized less erratically to deal with them or offset them. And although the risks of misclassification must be considerable, degrees of disability are more accurately identified, so that fairer methods of compensation are devised, and benefits and services can be allocated according to some scale of priorities.

The Disabled Population

The number of disabled in the United Kingdom **is** larger than believed by the government. The poverty survey produces estimates which, even allowing for differences of definition, are considerably larger than estimates for the same year accepted by the government on the basis of one of its own surveys.[2] In view of its importance, this finding must be explained in detail and with care.

First, Table 20.3 shows that 122 per cent of the non-institutionalized population both said they had a disablement condition and went on to specify that it prevented them doing things which were normal for someone of the same age. They represented over 6½ million in the United Kingdom, of whom nearly 1½ million had two or more disablement conditions. More women than men had such conditions. It is, of course, important to remember throughout the subsequent analysis that

[1] Harris *et al.*, op. cit., esp. Appendix D.

[2] The estimates were made on the basis of a statement of policy in 1974. Social Security Act 1973, *Social Security Provision for Chronically Sick and Disabled People*, House of Commons Paper 276 1974.

Table 20.3. *Estimated number and percentage having disablement conditions restricting activity and specifying limiting effects on activities* (*United Kingdom*).

Number of disablement conditions	*Estimated number in non-institutionalized population (1,000s)*[a]			*Percentage*		
	Males	*Females*	*Males*	*Females*	*Males*	*Males and females*
None	23,800	23,950	47,750	90.0	85.7	87.8
1 or more	(2,650)	(4,000)	(6,650)	(9.9)	(14.3)	(12.2)
1	2,080	3,100	5,180	7.8	11.1	9.5
2 or more	570	900	1,470	2.1	3.2	2.7
Total	26,450	27,950	54,400	100	100	100
Number in sample	-	-	-	2,888	3,079	5,967

NOTE: [a]Excluding persons residing in hospitals, residential hostels and homes, children's homes and prisons.

disabled people living in most types of non-private households, especially those living in hospitals and residential homes or hostels, are not included. Many of these are elderly, and national estimates have been made of the distribution by incapacity of elderly people in institutions.[1]

Secondly, the findings from applying the incapacity index are given in Table 20.4. The estimates for each specific score on the index must, of course, be treated with caution because they are subject to considerable sampling error. But when different categories are grouped together, the estimates may be treated as reliable to a high degree of probability. There are approximately 1,100,000 persons who are severely incapacitated (with a score of 11 and over), and nearly another 2 million who are appreciably incapacitated (with a score from 7 to 10 inclusive). It will be seen that nearly 12 million in the population who are aged 10 and over call attention to some incapacity, however slight. Yet some of them did not specify any disablement condition in answering the alternative series of questions. If the numbers of these people, shown in the table, are deducted, the total who are severely incapacitated (with a score of 11 or more) and appreciably incapacitated (with a score of 7-10) is reduced from approximately 3,095,000 to 1,935,000. Even this latter figure is

[1] For the elderly in psychiatric and non-psychiatric hospitals and residential homes, see Townsend, P., 'The Needs of the Elderly and the Planning of Hospitals', in Canvin, R. W., and Pearson, N. G. (eds.), *The Needs of the Elderly for Health and Welfare Services*, University of Exeter, 1973. For the elderly in residential homes, see Carstairs, V., and Morrison. M., *The Elderly in Residential Care*, Report of a Survey of Homes and their Residents, Scottish Health Service Studies No. 19, Scottish Home and Health Department, Edinburgh, 1972.

Table 20.4. *Percentages and numbers of people* (*aged 10 and over*) *with different degrees of incapacity.*

Incapacity score		*Percentage*			*Estimated number* (*000s*) *UK*			*Estimated number* (*000s*) *specifying effects of disablement condition*		
		Males	*Females*	*Males and females*	*Males*	*Females*	*Males and females*	*Males*	*Females*	*Males and females*
0		79.1	69.0	73.8	17,160	16,180	33,340	725	950	1,675
1	Slight	5.8	7.3	6.6	1,250	1,720	2,970	205	405	610
2		3.4	4.6	4.1	740	1,090	1,830	225	380	605
3		2.0	2.6	2.3	440	600	1,040	120	195	315
4	Some	2.0	2.4	2.2	430	560	990	250	205	455
5		1.7	3.2	2.5	375	740	1,115	240	450	690
6		1.2	2.2	1.7	265	500	770	160	205	365
7		1.2	1.9	1.5	255	440	695	165	220	385
8	Appreciable	0.5	1.4	1.0	120	335	455	105	165	270
9		0.6	1.5	1.1	135	340	475	85	205	290
10		0.6	1.0	0.8	130	235	365	105	110	215
11		0.6	0.9	0.8	135	205	340	130	150	280
12		0.1	0.7	0.4	30	160	190	30	130	160
13		0.1	0.4	0.3	30	100	130	10	55	65
14		0.3	0.2	0.3	65	55	120	20	45	65
15	Severe and very severe	0.3	0.3	0.3	55	65	120	25	65	90
16		0.1	0.3	0.2	20	65	85	10	35	45
17		0.1	0.1	0.1	30	20	50	10	20	30
18		0.2	0.2	0.2	35	35	70	30	10	40
Total		100	100	100	21,700	23,450	45,150	2,650	4,000	6,650
Number		2,373	2,603	4,976	-	-	-	-	-	-

NOTE: Estimates of population are rounded to the nearest 5,000.

Table 20.5. *Thousands in the United Kingdom who are estimated to be handicapped.*

Degree of handicap	*Govern-ment survey*	*Degree of incapacity* (*and whether disable-ment condition*(*s*) *specified separately as limiting activities*)				*Poverty survey*
		Score				
Very severe	161	Very severe	(15+)	(i)	1 or more disablement conditions	205
				(ii)	No condition specified	120
Severe (score 12 or over)	366	Severe	(11-14)	(i)	1 or more disablement conditions	570
				(ii)	No condition specified	210
Appreciable (score 6-11)	633	Appreciable	(7-10)	(i)	1 or more disablement conditions	1,160
				(ii)	No condition specified	830
Minor (score 1-5)	699	Some	(3-6)	(i)	1 or more disablement conditions	1,825
				(ii)	No condition specified	2,090
No handicap (score 0)		Little or none	(0-2)	(i)	1 or more disablement conditions	2,890[a]
non-motor disorders	757					
motor disorders	540					
Total	3,155				Total	9,900

NOTE: [a]This figure includes approximately 180,000 children aged 0-9.

substantially in excess of the figure estimated in the government survey, which, for purposes of broad comparison, is approximately 1,160,000.[1] The discrepancy has serious implications and therefore requires discussion.

Some of the key figures derived from the two surveys are brought together in Table 20.5. Although the difference between the two is largest among the groups

[1] Harris *et al.*, op. cit., p. 17, adding an estimate for Northern Ireland.

who are least disabled, it is still considerable among the very severely, severely and appreciably handicapped or incapacitated, and remains considerable even when those not in fact both specifying a disablement condition and saying it limits their activities are subtracted from the estimates derived from the poverty survey.

Why Official Estimates of Handicapped are Low

Why are the government survey estimates relatively low? First, children under 16 are not included in them. Children under 10 were not included in the attempts in the poverty survey to assess degree of incapacity and are not therefore included in the poverty survey estimates. But those with a disablement condition, estimated at approximately 180,000, are included, as has been noted. Children aged 10-15, assessed for both incapacity and disablement, are included with adults. They account for only about 100,000 of the total of 9,900,000.

Secondly, the authors admit that some people with impairment are not included.

While the total sample will reflect the incidence of locomotive impairment, whether this impairment is a handicap or not, it only covers those who are handicapped due to mental or sensory impairments. A man who is totally deaf, or blind or mentally impaired, would not be included unless he feels his impairment limits in some way his getting about, working, or taking care of himself, or he also has some physical impairment. The same conditions apply to disorders such as diabetes or epilepsy.

It is later suggested that groups including the blind 'may well be understated', either because people may not consider the impairment to be a handicap or unwilling to admit to their condition.[1] This seems *prima facie* unlikely in the case of the blind, and although the government's survey widens the category to include diseases of the eye and partial blindness, the estimates fall short even of the numbers of blind and partially sighted on the registers of local authorities at the end of 1968. In other instances, the numbers estimated in the government survey seem astonishingly small. For example, 27,000 were estimated to be mentally handicapped, yet in 1968 there were 111,000 mentally handicapped people under the care of the local authorities in Britain alone,[2] and it is known that there are many handicapped people not in contact with the local authorities. An estimate of 252,000 was derived from the poverty survey. Again, 72,000 were found to be suffering from mental illness and nervousness, and although there are no comprehensive statistics of people with mental illness in the community, there were, in 1968, 91,000 in the care of the local authorities and 247,000 *new* outpatients as well as 19,000 new day patients who attended hospital.[3] Yet again, the government survey found 30,000 with diabetes, 41,700 with epilepsy, migraine and dizziness, and 1,187,000 with

[1] Harris, *et al.*, op. cit., pp. 3-4, and 9.

[2] *Social Trends, 1971,* HMSO, London, p. 105.

[3] ibid., p. 105.

diseases of the bones and organs of movement (including arthritis, osteoarthritis and rheumatoid arthritis), while the roughly comparable estimates in the poverty survey - all of them specifically referred to in the questionnaire as conditions affecting activity - were 315,000, 350,000 and 4,670,000 respectively. Even allowing for substantial numbers included in the latter whose degree of handicap may have been mild, the figures from the government survey seem worryingly small.

Thirdly, the definition of degrees of handicap may be a little severe in the government survey but cannot account for much of the discrepancy. The list of activities about which questions are asked is admittedly different from that used in the poverty survey. The chief difference is that the latter includes items which refer to the running of the home as well as to self-care,[1] but the approach is similar in principle and a number of the questions are the same or very similar (involving mobility, control of the body and manual dexterity). In broadly relating the two sets of estimates in Table 20.5, I have tried to allow for the heavier scoring of items in the government's survey,[2] but also for the inclusion of more 'difficult' housekeeping items in the poverty survey. Thus scores of up to 2 in the incapacity index used in the latter have been discounted. It is likely, however, that a substantial proportion of the final two categories ('some' and 'little or no' incapacity) should be discounted in roughly comparing the two sets of estimates.

Finally, and perhaps most importantly, the methods adopted in the government survey seems to have led to underestimation of the handicapped. A large sample of 100,000 households were screened by post. It is possible that a substantial proportion of the handicapped, including some who were severely handicapped, were missed in the survey. Some may have been missed through failure to respond to letters, though personally I do not believe this to be an important factor; some may have been missed because of the design of the postal questionnaire; but probably most were missed because of the lack of skilled probing that can be carried out in interviewing, particularly when two or more methods rather than a single method of approach are employed. Response to the postal questionnaire was 85.6 per cent, and although there was no reason, from a scrutiny of the types of response day by day, to

[1] The authors of the government survey justify the restriction to self-care because, although 'there may be other ways of classifying degrees of handicap taking into account other factors such as the effect of impairment on work and housekeeping ... the only function which applies to the whole sample is self-care.' - Harris *et al.*, op. cit., p. 257. It might be objected, however, that among the items listed shaving is certainly not undertaken by all men, and it would not usually be regarded as equivalent in difficulty to 'combing and brushing hair', which was asked of all women. Putting on shoes and stockings clearly depends also on type of shoes and stockings, and buttons and zips are not necessary, even if common, aspects of dress.

[2] Difficulty in doing certain items was scored 2 and other items 4, compared with 1 in the poverty survey; and inability to undertake the activity without help was scored either 3 or 6 compared with 2. The criteria by which 'minor' activities were distinguished from 'major' activities and thus counted 3 rather than 6 were not satisfactorily defined. See Harris *et al.*, op. cit., pp. 258-61.

believe the impaired were more likely than the non-impaired either to reply or not to reply, it is, of course, possible that relatively more impaired people, especially living alone, were among the non-respondents. At the subsequent interviewing stage about 89 per cent of eligible informants were seen, so the final response from the two-stage approach can be said to represent around 76 per cent of the impaired[1].

The postal questionnaire and covering letter had to be designed to maximize response, and therefore both had to be simply expressed. The opening sentence of the letter states, 'The Government Social Survey is anxious to find out whether people aged 16 or over, including the elderly, can get about and look after themselves, whether they have difficulty, but manage on their own, or whether they have or might need help.' This seems very straightforward and comprehensible, but it is arguable that a direct reference to handicap from the start might have conveyed the objects of the survey more clearly to more people; thus: 'The Government Social Survey is anxious to find out exactly how many in the population have minor, appreciable or severe handicap of any kind.' The one-page postal questionnaire is addressed to the whole household, and it might have been better if there had been a questionnaire for each person, or alternatively, a column for *each* person against the questions on that page so that the chances of omission could have been reduced.[2] The questions, moreover, are not in the form elaborated in the questionnaire at interviewing stage (there is, for example, no reference to getting to and using the WC, and the reference in the postal questionnaire to 'kneeling and bending' does not re-emerge in the interviewing). The first question in a series affecting handicap asks, 'Has anyone lost the whole or part of an arm, leg, hand or foot by having an amputation, or accident, or at birth?' This might predispose some respondents into believing that the other questions were aimed entirely or mainly at people with handicap of this observable kind. The question is, too, the only one which is not wholly related to limitation of activity. Thus, someone with an amputated finger might say he had no restriction as compared with someone else of his age. And the

[1] Harris *et al.*, op. cit., pp. 240-42.

[2] In these respects, the survey of disability carried out in 1966 in the United States was more satisfactory. The Bureau of the Census had adopted a two-stage postal and interviewing approach and the Government Social Survey followed suit (though no reference is made anywhere in the report to this corresponding work in the US). The covering letter sent out in the US was more directly addressed to both 'healthy' and 'impaired' households. Thus it began, 'The Bureau of the Census has been asked by the US Department of Health, Education and Welfare to collect information on the extent to which health problems may affect the normal, day-to-day activities of individuals. The results of this survey will be of great importance to both public and private organizations engaged in planning and research in the area of health ...' Entries had to be made in separate columns *for every individual in the household* and simple Yes/No answers had to be ticked: 'Does your health limit the *kind* of work you can do? Does your health limit the *amount* of work you can do? Does your health keep you from working altogether? (For women) Does your health limit the amount or kind of housework you can do?' Then people were asked to describe the condition causing any limitation and a check-list of possible conditions was printed on the back of the questionnaire.

possibilities of turning the question into a short-list of questions of a kind like our disablement conditions index (or giving a check-list as in the US study), are not developed. Our evidence shows that some people who are in fact functionally handicapped may be missed by a selected list of questions about activities, as presented in the government's postal questionnaire. In using a more comprehensive list in the poverty survey (shown in Table 20.2), 4.2 per cent of the sample aged 10 and over, representing 1,863,000 people, said they had no difficulty with any of the ten items, but declared at another stage of the interview that they had a disablement condition which prevented them from doing all the things which it was normal for people of their age to do.

But even those who might respond positively to a list of questions about functional activities in an interview do not all do so if they are approached by post or if the postal questionnaire is not comprehensive. This seems to be the chief explanation for the government shortfall. Of the 100,000 addresses originally approached in order to assemble a sub-sample of the disabled, rather less than 98,000 proved to be eligible. Of these, 82,516 responded and a sub-sample of 13,541 (16.4 per cent) seemed to include at least one impaired person. My belief is that among the 68,975 households *not* approached for an interview, there were bound to be a substantial number of impaired persons. Indeed, even within the 16.4 per cent of households followed up for interview there were '100 persons, found at the interviewing stage, who had been permanently impaired at the time of the postal survey but who had been omitted from the postal form'.[1] Without following up a sample of the respondents who returned questionnaires saying they were not impaired, it was wrong to conclude that the postal survey had successfully screened out nearly all the impaired.[2] During an interview, questions about impairment can be probed and check-lists can be scrutinized and explained. Interviewers can explain wording to informants. The poverty survey demonstrates both the value of the interviewing of a full random sample and a double-banking' method of approach to ensure that the numbers of disabled are not underestimated.

There is independent evidence supporting the conclusion that the figures from the

[1] Harris *et al.*, op. cit., p. 242.

[2] The decision to screen postally was based partly on the pilot experience of the Bedford College research team. But that experience was extraordinarily slender as the basis for a major decision on a national survey. Thus, only 31 households among 335 responding to a postal questionnaire but saying none of their members were impaired were visited in pilot research, as a check. Three of these refused an interview. In each of the remaining 28 only one member of the household was tested, and yet three impaired people were found. Although it may seem absurd to estimate on such a slender basis, even that experience would suggest that at least 10 per cent of households completing a postal form about impairment negatively in fact include at least one impaired person. Applied to the estimates given above, about 7,000 (i.e. 10 per cent of the 68,975 saying no one was impaired) might therefore be added (or over 50 per cent) to the 13,541 impaired in the sub-sample. See Jefferys, M., Millard, J. B., Hyman, M., and Warren, M. D., 'A Set of Tests for Measuring Motor Impairment in Prevalence Studies', *Journal of Chronic Diseases*, vol. 22, 1969, pp. 303-19

government survey are likely to be underestimates. In a national study of people aged 65 and over, the numbers found to be very severely or severely incapacitated and appreciably incapacitated were approximately 580,000 and 950,000 respectively,[1] compared with 337,000 and 378,000 respectively in the government's national survey of the handicapped. The sampling and interviewing in the study of the elderly were carried out by the Government Social Survey. Another study of the elderly in 1965-6 by the Government Social Survey produced estimates of proportions of people in different areas having difficulty with a variety of functions (getting out of doors on own, getting up or down stairs on own, getting about house on own, getting in and out of bed on own, washing, bathing and dressing) which corresponded so closely with the national figures obtained in 1962 survey that it is difficult to believe that the latter were seriously wrong.[2] These two studies correspond with the results of the poverty survey rather than those from the government's survey of handicap.

More recent national data also throw doubt on the government's estimates of the disabled population. The introductory report of the General Household Survey pointed out that 20 per cent of persons aged 15 and over had some limiting long-standing illness, compared with only 8 per cent in the 1968-9 survey of the handicapped and impaired who had any specific impairment, or had problems with specific activities, or had some other permanent disability which stopped or limited their working or getting about or taking care of themselves.[3] While different definitions were used in these two surveys, this large discrepancy could not be satisfactorily explained, For 1972, a total of 12.1 per cent of the population of all ages in households covered by the General Household Survey were said *both* (a) to suffer from a long-standing illness, disability or informity, and (b) to be limited in their activities as a consequence compared with most people of their own age.[4] This formulation is close in principle to the two-stage formulation adopted in the poverty survey described above, and the results similar. A total of 12.2 per cent in the poverty survey (Table 20.1) were found to have a disablement condition. The General Household Survey data for different age groups also correspond closely with the poverty survey, as shown in Figure 20.1.

[1] Townsend, P., and Wedderburn, D., *The Aged in the Welfare State*, Bell, London, 1965, p. 25. An estimate has been added for both Northern Ireland and the increase in the population aged 65 and over between 1962 and 1968.

[2] Compare, for example, Harris, A. I., assisted by Clausen, R., *Social Welfare for the Elderly: A Study of Thirteen Local Authority Areas in England, Wales and Scotland*, vol. I, HMSO, London, 1968, Table 19, p. 84, with Townsend, P., 'The Needs of the Elderly and the Planning of Hospitals', Table 3, which gives a more elaborate account of the proportions of people of different age in both stages of the 1962 survey who had difficulty in performing certain activities.

[3] Office of Population Censuses and Surveys, Social Survey Division, *The General Household Survey*, Introductory Report, HMSO, London, 1973, p. 270.

[4] Office of Population Censuses and Surveys, Social Survey Division, *The General Household Survey, 1972*, HMSO, London, 1975, p. 190.

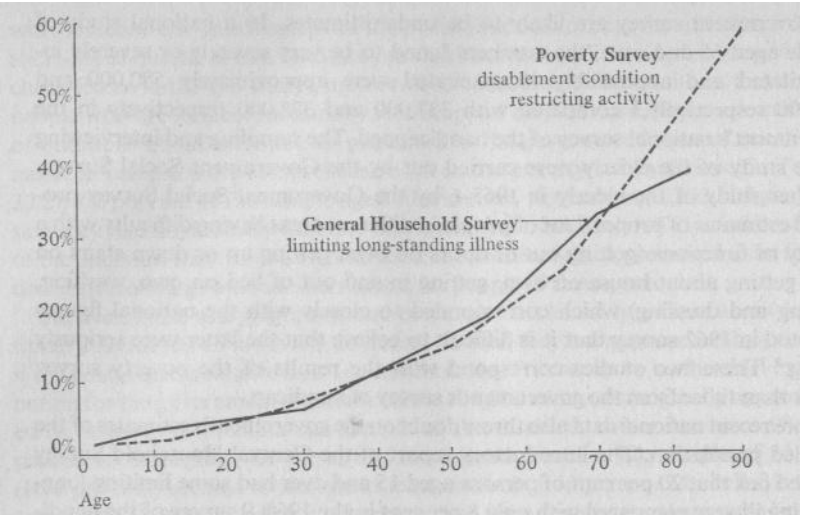

***Figure 20.1**. Two measures of limiting disablement.*

SOURCE: *General Household Survey, 1972,* HMSO, London, p. 190.

Localized surveys of younger adults have also produced much higher rates of prevalence. A research team working in North Lambeth in 1966 and 1967 found that 7.2 per cent of men and 9.7 per cent of women aged 35-74 were disabled in the sense that they were unable to perform unaided defined activities essential to daily life.[1] Comparable estimates from the government's survey in 1968-9 are approximately 2.3 per cent and 3.4 per cent. Even if those with 'minor handicap' are added to the latter figures, they are still considerably below the North Lambeth rates.

Secondly, the results for the adult population under 65 are different from those obtained in other countries. The British government's survey produced estimates of 3.9 per cent of those aged 16-61 who were impaired, including only 1.2 per cent who were 'very severely, severely or appreciably handicapped'. The US survey, however, which was also based on a first-stage postal questionnaire, produced estimates of 17.2 per cent long-term disability among adults aged 18-64, including 5.9 per cent who were severely disabled.[2] Among the severely disabled there were two thirds who were unable to work at all whose functional limitations involved

[1] Bennett, A. E., Garrad, J., Halil, T., Chronic Disease and Disability in the Community: A Prevalence Study', *British Medical Journal*, 26 September 1970.

[2] Haber, L. D., 'Prevalence of Disability Among Non-institutionalized Adults Under Age 65: 1966 Survey of Disabled Adults', *Research and Statistics Note*, U S Department of Health, Education and Welfare, 20 February 1968, p. 12.

'moderate loss, severe loss', or who were 'functionally dependent'.[1] The latter represented 3.6 per cent of the entire population of this age. The discrepancies between the two countries are too great to be plausible. On the other hand, the poverty survey produces estimates which in certain respects are broadly comparable with the US estimates. There were 3.3 per cent aged 15-64 who were appreciably, severely or very severely incapacitated, according to the incapacity index. Altogether there were 12 per cent of this age with a disablement condition.[2]

A national survey carried out in Denmark in 1960-61 found that 6.5 per cent of the population aged 15-61 were *physically* handicapped.[3] Allowing for the exclusion of the mentally ill and handicapped, and of those aged 62-4, the figure is about double the corresponding figure obtained from the British government's survey. Yet certain disabling conditions, such as bronchitis, are known to be more prevalent in Britain. So while differences in the prevalence of handicap between countries should be expected, the British rate again seems suspiciously low.

Careful scrutiny of the estimates derived from the poverty survey, and also of other research in Britain, the United States and Denmark, therefore all point to the same general conclusion. Even when allowances are made for differences of definition and measurement, the government's estimate of the handicapped population of Britain, which was derived from a government survey, are, for the severely and appreciably handicapped and the moderately handicapped, only about half the real figure.

Disability Increases with Age

There is a strong correlation between incapacity and advancing age. As Figure 20.2 shows, the rate of those who are appreciably or severely incapacitated fluctuates around 1 per cent up to the forties and then rises for both sexes in the fifties and more sharply for women than men in the sixties and subsequently. By the early seventies, over a fifth of men and a quarter of women are appreciably or severely incapacitated.

While the proportion of women who are appreciably or severely incapacitated does not begin to outstrip that of men until the fifties, the proportion with minor or

[1] Allan, K. H., and Cinsky, M. E., 'General Characteristics of the Disabled Population', *Social Security Survey of the Disabled: 1966*, Report No. 19, US Department of Health, Education and Welfare, Social Security Administration, Office of Research and Statistics, July 1972, pp. 9 and 27.

[2] After a modification in method, the General Household Survey is now producing estimates of those with limiting long-standing illness which broadly correspond to the United States data about prevalence. See, for example, *General Household Survey*, Introductory Report, pp. 270-71.

[3] Andersen, B. R., *Fysisk Handicappede i Danmark* (The Physically Handicapped in Denmark), vol. 2, Report No. 16 of the Danish National Institute of Social Research, Copenhagen, 1964, p. 109.

some incapacity outstrips that for men from the twenties onwards. The differences between the sexes are shown in Figure 20.2. (See also Table A.71, Appendix Eight, page 1048.)

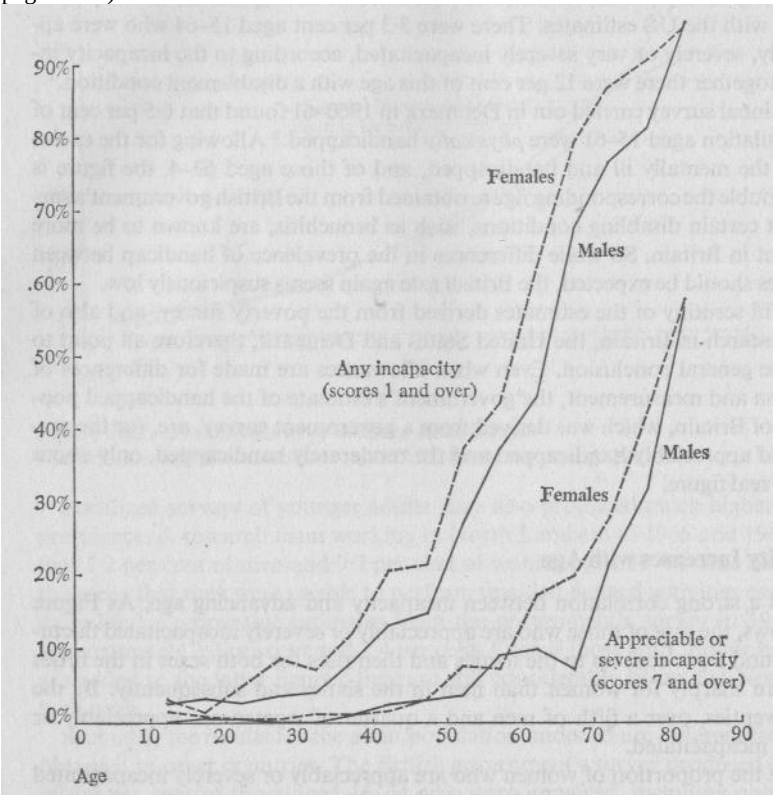

***Figure 20.2**. Percentages of males and females of different ages with any incapacity and with appreciable or severe incapacity.*

There are approximately 325,000 people aged 10-49 who are appreciably or severely incapacitated, but they form only 10.5 per cent of all who are incapacitated to such a degree. But when those of this age with some incapacity (scores of 3-6 on the incapacity index) are added, the total is increased to 1,165,000. This is a substantial number of young people and people in early middle age. As many as 1,945,000 (or 63 per cent) of the total of 3,095,000 who are appreciably or severely incapacitated are aged 65 or over. As many as 3,835,000 (or 55 per cent) of the total with some, appreciable or severe incapacity are of this age (Table A.72, Appendix

Eight, page 1049).

The alternative measure of number of disablement conditions is also strongly correlated with age. The proportion with one or more conditions rises steadily for each successive age group. But whereas among age groups over 50 the proportion of women and of men with one or two or more disablement conditions is broadly the same, substantially more women than men aged 20-29, 30-39 and 40-49 called attention to a disablement condition which restricted their activities. (See Fig. 20.3, and Table A.73 in Appendix Eight, page 1050.) We found that much of this

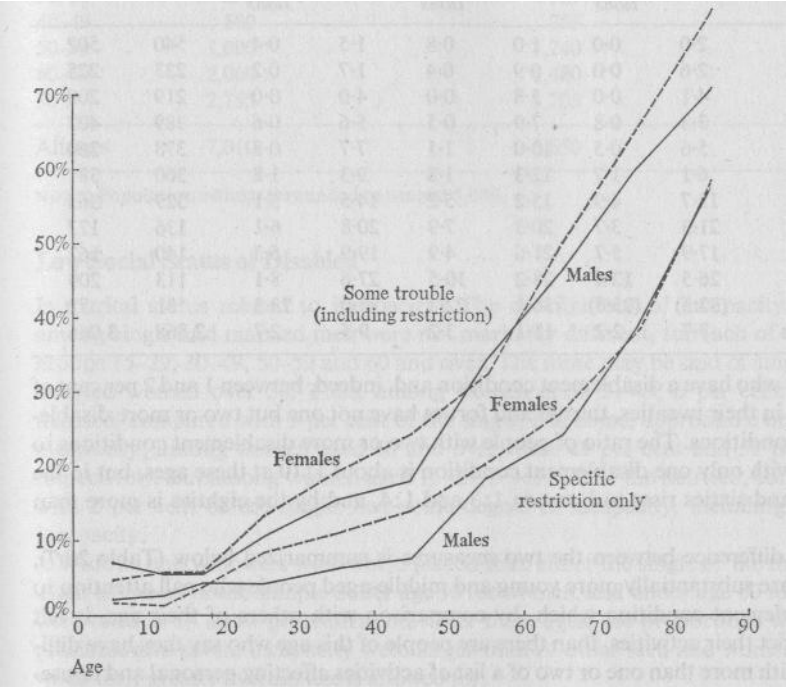

***Figure 20.3**. Percentages of males and females of different ages who have trouble with a disablement condition and have a marked or specific restriction of activity.*

difference was due to the higher incidence of incapacitating mental anxiety among women of this age. The relatively higher incidence among women continues into older age groups, but more of the men than of the women are incapacitated by chest and lung troubles.

Table 20.6 shows that there are significant minorities of even the young age

Table 20.6. *Percentages of males and females of different ages who have one or more disablement conditions which limits their activities.*

Age	*Males*		*Females*		*Males and females*		*Total number in sample*	
	1 disablement condition	*2 or more disablement conditions*	*1 disablement condition*	*2 or more disablement conditions*	*1 disablement condition*	*2 or more disablement conditions*	*Males*	*Females*
0-9	2.0	0.0	1.0	0.8	1.5	0.4	540	502
10-14	2.6	0.0	0.9	0.4	1.7	0.2	233	225
15-19	4.1	0.0	3.8	0.0	4.0	0.0	219	208
20-29	3.3	0.8	7.9	0.5	5.6	0.6	389	407
30-39	5.6	0.5	10.0	1.1	7.7	0.8	378	360
40-49	6.1	1.7	12.3	1.8	9.3	1.8	360	381
50-59	13.7	4.9	15.2	5.2	14.5	5.1	329	363
60-64	21.3	3.7	20.3	7.9	20.8	6.1	136	177
65-69	17.9	5.7	21.6	4.9	19.9	5.3	140	162
70-79	26.5	12.4	28.2	10.5	27.6	8.1	113	209
80+	(32.3)	(25.8)	36.1	22.2	35.0	23.3	31	72
All ages	7.7	2.2	11.1	3.2	9.5	2.7	2,868	3,066

groups who have a disablement condition and, indeed, between 1 and 2 per cent of people in their twenties, thirties and forties have not one but two or more disablement conditions. The ratio of people with two or more disablement conditions to those with only one disablement condition is about 1:10 at these ages, but in the fifties and sixties rises to between 1:3 and 1:4, and by the, eighties is more than 1:2.

The difference between the two measures is summarized below (Table 20.7). There are substantially more young and middle-aged people who call attention to a disablement condition which, by comparison with others of their age, is felt to restrict their activities, than there are people of this age who say they have difficulty with more than one or two of a list of activities affecting personal and household care and mobility. Among the elderly this situation is more or less reversed. More of them admit to difficulty in carrying out several personal and household tasks than actually specify a disablement condition.

The two measures produce roughly the same total numbers, but whereas 68 per cent of those assessed according to the first measure in Table 20.7 are aged 60 or over, the figure is only 48 per cent according to the second measure. The fall is larger for women than for men (Tables A.72 and A.74, Appendix Eight, pages 1049-50).

Table 20.7. *Estimated number of disabled people in the non-institutionalized population of the United Kingdom* (*thousands*).

Age	*Having some, appreciable or severe incapacity* (*with scores of 3 or more on incapacity index*)	*Having disablement condition with specific or marked effect on activities*
0-9	-	185
10-19	160	240
20-29	200	460
30-39	225	585
40-49	580	755
50-59	1,090	1,240
60-69	2,000	1,480
70+	2,755	1,705
All ages	7,010	6,650

NOTE: Population estimates rounded to nearest 5,000.

Low Social Status of Disabled

Is marital status related to incapacity? The distributions of incapacity scores among single and married men were not markedly different, for each of the age groups 15-29, 30-49, 50-59 and 60 and over. The same may be said of single and married women over 30. Thus, among women aged 30-49, 6 per cent of the married, compared with 5 per cent of the single, had some, appreciable or severe incapacity; among women aged 60 and over, were 49 per cent and 51 per cent respectively. But among women aged 15-29, 9 per cent of the married, compared with 2 per cent of the single, had some degree of incapacity, including minor incapacity.

Widows and widowers were worse placed than either the single or the married. Their numbers in the sample under age 50 for women, and under age 60 for men, were too few to allow generalization. Over these ages, the proportions with appreciable and severe incapacity were larger than of other men and women, even when their greater average age is allowed for.

The correlation between disability and occupational class is marked. Table 20.8 shows that a significantly higher proportion of the manual than of the non-manual classes had minor, some, appreciable or severe incapacity. The disadvantage of both men and women in the unskilled manual class is particularly striking.

The correlation between disablement conditions and class is even more marked. Among men, those belonging to the non-manual classes who had a disablement condition which limited their activities numbered 7.4 per cent, compared with 11.2 per cent of manual classes. Among women, there were 10.8 per cent and 16.2 per cent respectively. As Table 20.9 shows, there was, for males, a higher proportion of

manual than non-manual people who had a disablement condition among every age group except one, and for females, among every age group except two. When specific occupational classes are examined, the disadvantage at different ages of the

***Table 20.8**. Percentages of males and females aged 10 and over in different occupational classes, according to incapacity.*

Sex incapacity (*score*)	*Professional and higher managerial*	*Managerial*	*Supervisory Higher*	*Supervisory Lower*	*Routine non-manual*	*Skilled manual*	*Semi-skilled manual*	*Unskilled manual*
Men								
None (0)	88	90	87	84	82	85	80	70
Minor (1-2)	8	4	6	7	7	5	10	14
Some (3-6)	3	4	3	5	5	5	7	8
Appreciable or severe (7+)	1	2	4	4	4	4	3	6
Total	100	100	100	100	100	100	100	100
Number	177	146	279	397	166	940	483	298
Women								
None (0)	85	78	83	80	76	72	72	58
Minor (1-2)	7	8	7	8	8	9	11	20
Some (3-6)	6	8	6	7	9	10	9	9
Appreciable or severe (7+)	2	5	4	5	7	9	8	13
Total	100	100	100	100	100	100	100	100
Number	175	148	297	440	317	910	485	273

unskilled and semi-skilled is quite marked (Table A.75, Appendix Eight, page 1051), though the disadvantage of some age groups in the routine non-manual class should be noted. There is, of course, a tendency for young daughters and middle-aged wives of manual workers to take non-manual jobs, which may partly explain why some in this ‘class’ have a disablement condition.

Table 20.9. *Percentages of non-manual and manual males and females of different age, with one or more disablement conditions.*

	Percentage with disablement condition				*Total number in sample*			
Age	*Males*		*Females*		*Males*		*Females*	
	non-manual	*manual*	*non-manual*	*manual*	*non-manual*	*manual*	*non-manual*	*manual*
0-9	1.3	2.6	1.0	2.1	227	310	209	288
10-19	1.7	3.8	3.2	1.9	179	265	218	207
20-29	2.9	4.9	7.0	9.7	139	243	214	186
30-39	4.6	7.5	8.6	13.6	175	200	174	184
40-49	8.3	7.0	11.3	17.6	156	200	186	188
50-59	13.8	21.9	14.0	23.0	138	187	143	204
60-69	25.0	25.5	20.2	30.7	83	184	114	202
70+	36.4	45.6	45.3	42.0	44	92	95	162
All ages	7.4	11.2	10.8	16.2	1,141	1,681	1,353	1,621

Poverty

Not only do disabled people have lower social status. They also have lower incomes and fewer assets. Moreover, they tend to be poorer even when their social status is the same as the non-disabled. This will now be demonstrated. Table 20.10 shows the distribution of cash incomes in relation to the state's standard of poverty. With increasing incapacity, proportionately more people lived in households with incomes below, or only marginally above, that standard. Fewer lived in households with relatively high incomes. More than half those with appreciable or severe incapacity were in households in or on the margins of poverty, compared with only a fifth of those with no incapacity.

More of the incapacitated than of the non-incapacitated are aged 65 and over, and it might be supposed that the correlation shown in the table is explained more by the low incomes associated with advancing age than disability as such. But while changing age distribution underlies the correlation, poverty is still associated with increased incapacity, even when age is held constant. Indeed, when attention is paid to the income of the income unit rather than of the household as a whole, and to household stocks, and assets, the association between poverty and disability is more marked. Nearly three times as many people aged 40 and under pensionable age who were appreciably or severely incapacitated as of those who were not incapacitated were in units with incomes close to or under the poverty line. The increase in risk of poverty with increase in incapacity was marked even among those of pensionable

Table 20.10. *Percentages of people with different degrees of disability living below and above the state's standard of poverty.*

Net disposable household income last year as % of supplementary benefit scales plus housing cost	*Degree of incapacity* (*score*)					
	None (*0*)	*Minor* (*1-2*)	*Some* (*3-4*)	*Some* (*5-6*)	*Appreciable* (*7-10*)	*Severe* (*11+*)
Under 100	5	11	12	11	11	12
100-39	19	25	29	36	39	46
140-99	36	27	26	24	23	24
200+	41	37	33	29	27	18
Total	100	100	100	100	100	100
Number	4,026	453	189	185	197	109

age (Table 20.11). Another method of examining the effects of disability is to examine income according to the level of disability of the most disabled member of the income unit (Table A.86, Appendix Eight, page 1059). There is a marked inverse relationship between increasing income and disability.

More of the incapacitated than of the non-incapacitated, for each major age group, were in debt or had no assets or had less than £100. Fewer had assets over £5,000.

Table 20.11. *Percentages of people of different age with different degrees of incapacity who were living in income units with incomes in previous year below or on the margins of the state's standard of poverty.*

	Degree of incapacity (*score*)			
Age	*None* (*0*)	*Minor* (*1-2*)	*Some* (*3-6*)	*Appreciable or severe* (*7+*)
15-39	25	(30)	(64)	[a]
40-pensionable age	15	22	30	49
Pensionable age and over	48	62	65	73
All ages 15 and over	23	41	52	68
Number all ages	2,802	464	389	311

NOTE: [a]Equals number below 20.

Fewer of the disabled were owner-occupiers, held a personal bank account, owned a car or had personal possessions other than furniture or clothing (such as jewellery, silver and antiques) worth £25 or more.

The next table is perhaps the most compact illustration that the survey can offer of the deleterious effects upon living standards of disability. In this the annuity values of the assets owned by the incapacitated and non-incapacitated are added to their net disposable incomes for the previous twelve months, and the resulting 'income net worth'[1] is expressed as a percentage of the state's standard of poverty, that is, the supplementary benefit rates which were in force at the time of the survey, plus housing cost (Table 20.12). A significantly higher proportion of the incapacitated than of the non-incapacitated, within each major age group, had an income net worth

Table 20.12. *Percentages of people of different age and degrees of incapacity in units whose income net worth*[a] *was below or only marginally above the state's standard of poverty.*[b]

		Degree of incapacity (*score*)		
Age	*None* (*0*)	*Minor* (*1-2*)	*Some* (*3-6*)	*Appreciable or severe (7+)*
15-39	21	(31)	(44)	[c]
40-pensionable age	9	13	27	43
Pensionable age and over	28	36	35	52
All ages	17	25	33	50
Total number, all ages	2,434	416	342	266

NOTES: [a]Annuity value of assets plus net disposable income in previous year (less any income from savings and property) for income units.
[b]Supplementary benefit scales for income units of different size and composition plus actual cost of housing.
[c]Number below 20.

of below, or only marginally above, the state's standard of poverty. The incapacitated were at a disadvantage throughout the income scale. For example, among those in their fifties, only 20 per cent of those with appreciable or severe incapacity, compared with 31 per cent of those with some incapacity and 56 per cent of those with no incapacity had an income net worth of more than 250 per cent of the supplementary benefit standard.

One result of this analysis had not been anticipated. Although the measure of incapacity that was adopted was based on previous research by the author and

[1] For a discussion of the concept and measurement of 'income net worth', see Chapter 5, pages 210-15.

others, it was admittedly crude. We did not expect those with scores of 1 or 2 to be very different in various respects from those with no score at all. After all, they admitted difficulty with only one or two of nine activities listed, and it did I not seem likely that significantly larger proportions of them would have had lower incomes, fewer assets and so on. But a number of tables show that even marginal incapacity, crudely measured, is associated with lower living standards and with different forms of deprivation.

Deprivation

Deprivation as a consequence of, or in conjunction with, low income and low assets takes many forms. Some indices are summarized in Table 20.13. More of the incapacitated than of the non-incapacitated had poor housing facilities. This was not just because a higher proportion of the incapacitated were older people. After all, more late middle-aged and old people become outright owner-occupiers, and some of the most infirm widowed elderly had left their homes to live with their children. We found that more of the incapacitated in each age group had poor housing[1] (Table A.76, Appendix Eight, page 1051).

According to other measures too, more of the incapacitated than the non-incapacitated lived in poor housing. Despite a tendency to be older and to live in smaller accommodation, more lacked heating in winter for at least half their accommodation. Fewer lived in structurally sound dwellings. The only measure of housing according to which the incapacitated did not show to disadvantage was overcrowding. This was because more were older, widowed or lacking dependent children. Even so, nine per cent were overcrowded, ranging from 22 per cent of those in their twenties, 19 per cent in their thirties and forties, 10 per cent in their fifties and 5 per cent of those aged 60 and over. These percentages corresponded closely with the percentages among the non-incapacitated.

The depreciation of the necessities and comforts of life because of disability is complex to trace, if pervasive. During the interviews we had asked whether or not there were any or all of a list of ten consumer durables or fitments in the home. The incapacitated had fewer than the non-incapacitated (Table 20.13). The deficiency was marked among the older age groups, but applied at all ages - although small numbers in the sample at the younger ages have to be remembered. In late middle and old age there was strong evidence of an association between increased incapacity and reduced stock and fitments in the home. Altogether, 35 per cent of those with appreciable or severe incapacity had fewer than five of ten listed items (television, record player, radio, refrigerator, washing machine, vacuum cleaner, telephone, central heating, armchairs or easy chairs for each member of the house

[1] See also Buckle, *Work and Housing of Impaired Persons in Great Britain*, op. cit., pp. 74-81.

Table 20.13. *Percentages of non-incapacitated and incapacitated experiencing certain forms of deprivation.*

Form of deprivation	*Degree of incapacity*			
	None (*0*)	*Minor* (*1-2*)	*Some* (*3-6*)	*Appreciable or severe* (*7+*)
Does not have sole use of four basic housing facilities[a]	18	20	25	26
Not had week's holiday away from home	50	58	60	73
No sole use of garden or yard	12	13	17	19
Less than half rooms heated in winter	59	70	64	65
Deficient in household durables[b]	11	17	24	35
No electricity	2	2	2	4
Fresh meat fewer than 4 times a week	16	27	31	39
Missed cooked meal at least one day in last fortnight	5	10	11	18
Short of fuel	5	5	5	11
No relative to meal or snack during last four weeks	32	39	35	38

NOTES: [a]Indoor WC, sink with tap, bath and cooker.
[b]Having fewer than 5 of 10 listed items, as set out at the foot of page 714.

hold, and living-room carpet) in the home, and only 10 per cent had nine or all ten of the items, compared with 11 per cent and 25 per cent respectively of the non-incapacitated.

More of the incapacitated also had dietary deficiencies and experienced certain kinds of social deprivation. A few measures are given for illustration in Table 20.13. Thus, significantly more of the incapacitated than of the non-incapacitated had missed cooked meals and eaten fresh meat infrequently. Nearly three quarters of those with appreciable or severe incapacity, compared with half of the non-incapacitated, had not had as much as a week's holiday away from home in the previous twelve months.

In all these instances there is no particular reason why incapacitated people should be worse off than the non-incapacitated. In principle, they can go on holiday, visit friends or enjoy a garden like other people. What we have found, however, is not a different pattern of activity and relationships on their part but, rather, a systematic association between incapacity and deprivation. The more severe the incapacity the greater the deprivation. This can be illustrated best by our index of social deprivation. As explained earlier, an index comprising items which included not going on a summer holiday, not receiving relatives or friends for a meal or a snack

in the house during the preceding fortnight, not having adequate housing facilities and not having a refrigerator, as well as not eating customary types and amounts of food, was compiled. The higher the score out of a total of 10, the greater the deprivation. As Table 20.14 shows, there was a markedly significant and progressive

Table 20.14. *Percentages of people with minor, some, appreciable, severe or no incapacity with different levels of deprivation.*

Deprivation index[a]	*Degree of incapacity*				
	None (*0*)	*Minor* (*1-2*)	*Some* (*3-6*)	*Appreciable* (*7-10*)	*Severe* (*11+*)
0-1	19	11	10	6	1
2-3	40	36	31	27	15
4-5	28	32	34	29	35
6-7	11	18	21	32	32
8 or more	2	3	5	7	17
Total	100	100	100	100	100
Number	4,279	521	419	210	117

NOTE: [a]Items as specified on page 250.

association with incapacity. Thirteen per cent of people having no incapacity, compared with nearly half those with severe incapacity, had scores on the index of 6 or more. Nearly 60 per cent of the former had scores of 3 or less, compared with 16 per cent of the latter.

Subjective Deprivation

Evidence has been offered of the lower incomes and greater objective deprivation of the disabled among all age groups. But evidence can also be offered of more of them *feeling* deprived, even at similar levels of income. This may reflect their difficulties in conforming with social norms as consumers. It may reflect greater anxiety, depression or pessimism among them as a consequence of physical and mental limitations. Or it may reflect the greater costs of disability. For any one of these contingencies it would be possible to put forward a case for additional income - whether to meet higher prices or restricted range of consumer choice, to compensate for measurable handicap or to meet the costs of meeting additional needs. Certainly a higher proportion of the incapacitated than of the non-incapacitated said they had difficulty in managing their incomes, even at levels of income above the supplementary benefit standard, as well as below that standard (Table 20.15). A higher proportion also said they felt poor (Table A.77, Appendix Eight, page 1052).

***Table 20.15**. Percentages of non-incapacitated and incapacitated in units with incomes above and below the state's standard of poverty who said they had difficulty in managing on their incomes.*

Net disposable income last year as % of supplementary benefit scales plus housing cost	*Degree of incapacity* (*score*)			
	None (*0*)	*Minor* (*1-2*)	*Some* (*3-6*)	*Appreciable or severe* (*7+*)
Under 140	46	52	54	62
140-99	25	36	29	33
200+	14	22	14	30
All	24	38	39	53
Total number	1,189	247	206	164

NOTE: Heads of households or chief wage-earners only.

Some of the Problems of Disability in the Home

The problems of poverty and of objective and subjective deprivation will be illustrated with individual examples drawn from our interviews, both for those with incomes below the government's poverty standard and for those with higher incomes. (See also the listed illustrations between pages 305 and 335 in Chapter 8, Nos. 1, 3, 6, 8, 11, 15, 17, 18 and 20.)

1. Disability in late middle age

Mr and Mrs Donaldson are both aged 60 and live in a four-roomed council flat in South London. Although both were in paid employment, Mr Donaldson had been off work sick on two or three occasions in the year, totalling thirteen weeks, and works only with difficulty. His wife works part time. In the previous week he had worked thirty-two hours and she twenty hours. He had been a printing compositor until an illness laid him low. He says it started in the war when he experienced fits of deafness, loss of speech and giddiness when attached to a heavy antiaircraft gun battery. Then he said he was accused of malingering and was put on guard duty, when he was court-martialled for failing to challenge an officer returning to camp. He was in hospital for two years in 1963 and was operated on for the removal of varicose veins and had five other operations. He had electro-convulsion therapy, and after leaving hospital was told he would only be fit to work part-time for the rest of his life. After leaving hospital he took a so-called rehabilitation course. 'It was no

use whatsoever.' It only made it worse because he was taught such menial things and was among many handicapped people. Eventually his former employers gave him a much less well-paid job as a copyholder. He said his earnings dropped from £25 per week to about £14. He cannot stand for more than fifteen minutes without becoming giddy, and has been taken to hospital several times after having a fit or blackout. His fits are characterized by speechlessness, deafness, foaming at the mouth, or giving the appearance of being drunk, and he says that though sometimes fully conscious and aware of what is going on, he is unable to speak or hear. He had spent about fifty days in bed from illness in the last twelve months. He can only get to work by using two buses, and he and his wife have had little help from the council in finding a flat nearer his work. They had been offered three separate flats in tower blocks. His employers do not allow him sick pay for odd days off in the week, and because his job is not skilled he is dissatisfied with it. Last week his net earnings were £13.85 and those of his wife £4.80. This is about average for the weeks when he can work. When off work for an entire week at a time, he can claim £2 from the compositors' sick club. He said he had applied for a rent rebate and would normally have qualified, but because the council take account of eight weeks' earnings, and because he had had unusually little illness in this period, the rebate had not been granted. He and his wife have about £350 in a trustee savings bank. Their flat is comfortably furnished, and they said they could do with one room fewer. A son who married only last year lives near by and they see him and his wife quite frequently and help each other with shopping, occasional meals and gifts. They had not had an evening out in the last fortnight, but had had a fortnight's summer holiday. Mr Donaldson believed their situation was worse than it had ever been, but that they were about as well off as others in the neighbourhood. He did not think they could be considered as poor, and thought that 'some people are getting too much money from the government on false pretences, whilst other more deserving cases don't get anything or don't get enough'.

2. Extreme disability in middle age and old age

Mr and Mrs Millen, both 47, live with a son of 23 and Mr Millen's father, aged 80, in a semi-detached council house in a southern town. Mrs Millen was said to have acute diabetes (believed, however, by the interviewer to be leukaemia) and had been bedfast throughout the previous twelve months (incapacity score 17). The condition had begun five years earlier. The father had Parkinson's disease and was severely incapacitated, spending most of his time in bed or sitting by the bed (incapacity score 18). He had recently returned from a stay of three weeks in hospital. Mr Millen earned £12 net a week as a Gas Board meter reader, and the son £13 as a french polisher. The father had a retirement pension and also a war disability

pension amounting to £8.10, but Mrs Millen had no source of income. Housing facilities were good and the family had a small garden. Mrs Millen's mother calls every day, as does Mr Millen's sister, to prepare meals, shop and look after the invalids.

3. Chronic sickness in middle age

Mr and Mrs Newtonstone, 60 and 58, live in a semi-detached pre-war council house in a Yorkshire town. He is confined to bed much of the time and needs help to sit in a chair (incapacity score 15). He says that nine months earlier, while working as a labourer in a smelting works, an ulcer burst, and after fifteen weeks in hospital he has spent another five months at home in the present condition. During that period his GP has called about once a fortnight. Two of their daughters visit every day to help with shopping and other minor tasks, though Mrs Newton-stone bears the brunt of the work. One of the neighbours has also been very helpful. Their total income is now £9.35 sickness benefit, and the firm continues to pay £1.50, although he received full pay only for the first month of hospitalization. Rent amounts to nearly £3 a week. They had not applied for supplementary benefit, but were very bitter about people 'on the assistance' who were 'car-owners' or who were 'black prostitutes and our own people have to go short'. Until recently Mrs Newtonstone had earned a wage as a canteen worker, so in a short period they have experienced a sharp fall in income. She had not been out for an afternoon or evening for many weeks. They had not been on holiday and were aware they led a very restricted life.

4. Severe disability in middle age

Mr and Mrs Ophelia, 55 and 56, rent a council bungalow in Northern Ireland. They have lived in poverty and on the margins of poverty for years. She is stone deaf in one ear and also suffers from depression, weeping frequently. He has a serious heart condition and is also a diabetic, having been off work, confined to the house for several years (incapacity score 14). He has been ill in bed throughout the last twelve months, and is visited once a week by the G P. He had been a farm labourer. At the time of interview (January 1969) they had £7.30 sickness benefit and received in addition £2.20 supplementary benefit, including an exceptional circumstances addition for a diabetic diet. They have no money assets whatsoever, and only two of a list of ten household durables. They have several married children living locally and are visited every day, getting various kinds of help, and the wife, despite her own condition, returns some of that help. They have not had a holiday this year, and say they cannot afford any extras.

5. Severe disability in old age

Miss Hulpermatch, 89, lives alone in one room in Bristol. She is one of the most incapacitated people in the sample found to be living alone (incapacity score of 14). She gets up for one hour a day and sits in an armchair near the window. She suffers from spinal curvature, arthritis, poor hearing and sight and stomach trouble. Everything she eats makes her feel sick. A district nurse calls weekly and a home help three times a week. The doctor has been five times in the last twelve months. Two other tenants in the house give an average of three hours' help to her every day. One of these is an ex-seaman of 70 who used to store his belongings in her second room for 2s. 11d. a week. When he retired she let him move into the room, still at a sub-letting charge of 2s. 11d. - though he appears to perform many small services in exchange. She pays the other tenant to give her meals. She also has a niece next door who brings food and other gifts. She proclaimed strong opinions. 'I have never voted in my life. I did not believe in woman's suffrage when it was introduced and I have not changed my mind since.' Until she retired at the age of 60 she had sold vacuum cleaners. In 1960 a woman friend who had lived with her for fifty years died, and she had been alone ever since. She does not feel poor. 'I would be poor if I was able to eat three good meals a day because I could not afford to pay for them. But I can't eat so I'm not poor.' She lives in squalid surroundings with no electricity, no functioning bathroom, and has to share toilet facilities. She has a radio but no television and no access to a garden. Pension and supplementary benefit amount to £6.10, of which 60p is said to cover additional medical expenses.

6. Disability in young adulthood and early old age

Mr and Mrs Dobey, 66 and 63, live with a mongol son of 35 in a five-roomed council house in Lincoln. There is no W C indoors, but otherwise facilities are adequate. The house is sparsely furnished and there is no washing machine or refrigerator. They have a small garden at the back. Mr Dobey had been a labourer working with the county council and had been retired for just over a year. He had left school at 12 and held one job most of his working life. 'I had to cycle to work each day, starting at five o'clock in the morning, and I wasn't a minute late in thirty-two years. When I started at 12 I worked for 1s. 6d. per week.' He suffers from bronchitis and can only do physically demanding tasks with difficulty (incapacity score 5). He had spent three weeks in bed this year and obtained a prescription every week from his doctor (by sending a stamped addressed envelope) His son attends an adult training centre and seems very happy. The family gives the impression of being very integrated and contented. Mrs Dobey says she puts food before luxuries and warmth and makes sure they have fresh vegetables every day and salads in summer. She buys three pints of milk every day, always has a Sunday joint, and they also have fresh meat three or four times in the week. She pays a lot of attention to

diet and is anxious to keep her son's weight down. They have a beautiful garden which last year won the local prize for the best garden, and that offers plenty of occupation. They did not have a summer holiday or go away to stay with relatives during the previous twelve months, but had had relatives to stay with them for a fortnight. In the evenings they do not go out, except for Mrs Dobey's weekly trip to play bingo. They go to church (Church of England) every Sunday. A married son lives next door and they see the family every day. They took the view that poverty applied to old people having a job to manage' and felt that it could be reduced by making the devils work harder. The family allowance should be taken away and put on the pension. The young have it too easy and the old have it hard now.' Mr and Mrs Dobey have a combined retirement pension of £7.37½ a week, plus a council pension paid monthly, which is equivalent to £3.45 per week. Their rent is £1.10 a week. They have no savings and their only assets are life insurance policies amounting to a total of about £400. Their son receives supplementary benefit allowance of £4.50. Their total income is rather less than £3 above the state poverty line. They take the view that they could not manage financially without Mr Dobey's occupational pension.

7. Extreme disability in late middle age

Miss Sulman, 25, lives with her mother, 61, in a small semi-detached house owned by themselves in a country town in Suffolk. The mother suffers from chronic arthritis and is bedfast (incapacity score 18). She cannot move of her own accord, or even wash her face and hands. The doctor visits about once a fortnight and a home help five days a week. Mrs Sulman spent about ten weeks in hospital this year. She has not been away on holiday, but a friend has been to stay for a fortnight while her daughter took a holiday. Miss Sulman is a secondary modern schoolteacher with net weekly earnings of about £60 a month (gross £83) or £15 per week. Mrs Sulman has a widow's pension of £4.60 a week and supplementary benefit of another 90p. Miss Sulman sleeps in the same room and makes her mother comfortable during the night, gets breakfast and prepares an evening meal. The home help cleans and prepares a midday meal.

8. Severe disability in middle age

Mr and Mrs Fullmester, aged 56 and 55, live in a tiny terraced house owned by themselves in a rundown area of Liverpool. A lodger lives temporarily in a top room. Mrs Fullmester is usually confined to bed and can only sit in a chair by her bed. She has a heart complaint, enormously swollen legs and weighs 27 stone (incapacity score 16). During the last year she spent twelve weeks in hospital. She is visited weekly by a local-authority bath attendant, but the main task of caring for her has been assumed by her daughter, who lives locally and comes each day, shopping,

preparing meals and cleaning for her. Although known to the council, she is not on the register of the handicapped. Her husband has a job as a driver's mate and his take-home pay for the previous week was £13.50.

Chronic Illness or Invalidity

We have considered four groups of disabled people: children, young adults, the middle aged and the elderly. Merging with them, although more distinct than many would suppose, as we will show, are the chronically ill. Chronic or long-term illness is difficult to define. There are the questions of the *duration* of the illness; expectation of recovery; medical or administrative classification of illness; and whether ill in the sense of being in bed or confined to house or simply having a condition which results in absence from work or school. In the survey we measured:

1. Weeks off work in previous twelve months for reasons of sickness. As a check on this question, the number of weeks making up fifty-two at work, on holiday, unemployed, etc., were listed.
2. Numbers ill on day of interview, and (for economically active people and school children):
   (a) weeks off work;
   (b) weeks off school.
   And for all those currently ill or unwell, the number confined to bed or house, and number of weeks. As a check on these questions, people were asked whether they were seeing a doctor regularly and asked to name the illness.
3. Days illness in bed in previous twelve months. As a check, people were asked about consultations with a doctor.
4. Those with long-term illness or disablement condition (adults aged 15-64 only). Years since long-term sickness or condition started. As a check for this, questions were asked about the year and job held at the time.

For the sample as a whole, Table 20.16 shows how many were chronically ill according to different criteria (see Table A.78, Appendix Eight, page 1053 for more detail). More males than females had been ill for ten weeks or more at the time of the survey, in the sense that they had been off work or school or had been confined to the house or to bed for that period because of illness. They represented three quarters of a million people, nearly half a million of whom were under pensionable age. More than half were in their thirties, forties and fifties. On the strict criterion of spending fifty or more days in bed in the previous twelve months, the numbers of males and females were proportionately about equal.

Nearly a million economically active men and women were found to have had ten weeks or more off work ill during the previous fifty-two weeks, proportionately

***Table 20.16**. Percentages and estimated number in population of men and women chronically ill.*

Definition of chronic illness	*Percentage*		*Estimated total numbers in population (000s)*
	Males	*Females*	
Currently off work or school or confined to bed or house ill for more than 10 weeks	1.6	1.2	760
Employed and self-employed off work ill for 10 weeks or more in last 52	3.9[a]	3.2[a]	945
50 or more days ill in bed in last 12 months	0.6	0.6	340
Has chronic illness or condition	13.1[b]	14.9[b]	4,860

NOTES: [a]Those not employed in course of year excluded from base.
[b]Applies only to those aged 15-64.

more of them being men. More men than women have heavy manual work and work in bad or poor conditions, and there are greater pressures upon them both to sustain paid employment and perhaps occupy the status of someone who is sick rather than someone who is unemployed when both might reasonably be applied.

Finally, people representing nearly 5 million between the ages of 15 and 64 said they had a chronic illness or condition, proportionately more of them being women than men. About half of them had been ill for ten or more years.

There was less overlap between current long-term illness and incapacity or disability than might have been expected. For both our measures of appreciable or severe incapacity (with scores of 7+) and disablement conditions, the vast majority, 81 per cent and 90 per cent respectively, were not currently ill. Only 12 per cent and 7 per cent respectively had been ill for ten weeks or more. Only 5 per cent of those with one disablement condition, and 14 per cent with two or more, had been ill off work or confined to house or bed for ten weeks or more (Table A.79, Appendix Eight, page 1054).

Many people ill for long periods did not have a disablement condition, or rather, because of its uncertain degree or outcome, not one which had yet been recognized medically or socially. Of those who had been ill for ten weeks or more, 60 per cent had a disablement condition. This was about the same percentage as were appreciably or severely incapacitated. The estimated numbers of disabled and chronically ill in the population as a whole are given in Table A.80 (Appendix Eight, page 1054). There were over 400,000 people with appreciable or severe incapacity who had been ill for over ten weeks.

Prolonged current illness is associated with low income. Nearly twice as many people who had been ill for over ten weeks as of those who had not been ill live in income units with incomes below or on the margins of the supplementary benefit

standard. The majority of the former had, in fact, been ill for more than thirty weeks. Altogether more than half of those with long-term illness had incomes assessed for the previous twelve months as under or just above the poverty standard, compared with under a third of those not currently ill (Table 20.17). This pronounced association also applies to the larger category of people with chronic illness or

Table 20.17. *Percentages of people experiencing different numbers of weeks of current illness living in units with incomes below and above the state's standard of poverty.*

Net disposable income last year as % of supplementary benefit scales plus housing cost	*Weeks' illness*		
	None	*1-9*	*10 or more*
Under 100	9	7	15
100-39	23	16	43
140-99	29	36	14
200+	39	41	28
Total	100	100	100
Number	5,167	100	72

condition, of whom 64 per cent of the sample said the condition had begun five or more years earlier (24 per cent saying it had begun twenty or more years earlier). As many as 35 per cent were in or on the margins of poverty, compared with 22 per cent of the rest of the population.

There is further national evidence of the impoverishing effects of illness, and particularly of chronic illness. A survey by the Department of Health and Social Security in the early 1970s found that the percentage of those ill for six months who were below or on the margins of a notional supplementary benefit assessment was more than half as much again as the corresponding percentage of those ill for only one month (46 per cent compared with 28 per cent). This government study showed that nearly half the people who had been ill for both six months and twelve months were in or on the margins of poverty. Compared with the period immediately preceding their illness, more than half had sustained a fall in income of more than £5, most of whom of more than £10. The risk of poverty was highly correlated with lack of sick pay.[1]

[1] Martin, J., and Morgan, M., *Prolonged Sickness and the Return to Work*, an inquiry carried out in 1972-3 for the Department of Health and Social Security of the circumstances of people who have received incapacity benefits for between a month and a year, and the factors affecting their return to work, HMSO, London, 1976, pp. 43, 58 and 61.

Mental Illness

Following advice about methodology from epidemiologists, people saying they suffered from mental anxieties and problems, along with those suffering from other disabling conditions, were identified in the survey. Nearly 7 per cent of women, compared with 2 per cent of men, said they had trouble with nerves. These persons (numbering 268 in the sample) were then asked whether they were affected for example,

(i) by depression or weeping so that you can't face your work or mix with other people? [53 per cent affirmative]
(ii) by getting in a rage with other people? [30 per cent]
(iii) by being unable to concentrate? [37 per cent]
(iv) by sleeping badly ? [58 per cent]
or (v) by none of these? [12 per cent]

These criteria had been found to correlate very significantly in other research with those diagnosed as requiring psychiatric treatment or supervision. It can be seen that the great majority specified one or more of these criteria. Moreover, 77 per cent of the total saying they had nervous trouble said they were seeing a doctor

Table 20.18*. Percentages of males and females of different age having trouble with nerves.*

Nervous trouble	*Age* (*males*)						
	0-14	*15-29*	*30-39*	*40-49*	*50-59*	*60+*	*All ages*
None	99.6	99.4	97.4	97.3	95.9	95.9	98.0
Trouble	0.3	0.0	1.0	0.5	0.9	0.9	0.5
Trouble with specified effect	0.1	0.6	1.6	2.2	3.2	3.2	1.5
Total	100	100	100	100	100	100	100
Number	749	621	383	364	339	438	2,894
	(*females*)						
None	99.7	96.2	92.4	89.9	88.8	88.3	93.2
Trouble	0.1	0.3	0.8	1.8	0.5	1.3	0.7
Trouble with specified effect	0.1	3.5	6.8	8.3	10.7	10.4	6.0
Total	100	100	100	100	100	100	100
Number	709	624	367	387	374	634	3,095

about it or were having treatment, and one in four of the others, representing a further 6 per cent, said they *should* consult a doctor about it. These two checks therefore appeared to provide strong support for the use of this measure.

Among all age groups over 15, more women than men complained of nervous trouble, and more said they suffered as a consequence from depression, anger or lack of concentration or sleep. The percentage complaining of nervous trouble also tended to increase with age - though after the fifties there was little further change. On the basis of the findings, we estimated that approximately 2,400,000 in the non-institutionalized population were suffering from nervous trouble, 2,100,000 of whom specified one or more particular effects.

We found that significantly more of those in the sample complaining of trouble with nerves than not so doing were in or on the margins of poverty. This also applied at each age, and especially to people in late middle age (Table 20.19). Conversely, significantly fewer were in units with incomes of twice, or more than twice,

Table 20.19. *Percentages of people with and without depression or other nervous troubles, whose income was below or on the margins of the state's poverty standard.*[a]

Incapacity	*Depression and other nervous troubles*	*No nervous trouble reported*
None (0)	20.5	26.9
Minor or some (1-6)	49.5	34.4
Appreciable or severe (7+)	69.0	66.4
All	46.4	31.6
Age		
15-39	33.9	25.1
40-49	23.8	16.2
50-59	49.0	17.6
60+	62.2	57.5
All ages	46.2[b]	31.5[b]
Incapacity	*Number in sample*	
None (0)	95	4,057
Minor or some (1-6)	95	646
Appreciable or severe (7+)	58	256
All	248	5,079

NOTES: [a]Net disposable income last year under 140 per cent of the supplementary benefit scale rates plus housing cost.
[b]Including children under 15.

the state's poverty standard. The data also suggest that at different levels of incapacity people indicating they were suffering from a psychiatric condition were poorer than people who did not.

Hitherto, evidence of the low incomes of mentally ill people and ex-mental hospital patients has been sparse. Attention has been called to the problems of the single and homeless, particularly men, living in lodging-house areas of the major cities.[1] But psychiatric illness reduces earning power, prevents close relatives from taking paid employment, imposes additional expenses and creates the need for additional, for example, diversionary, spending.[2]

The Disadvantages of Employment

What brings about the low resources of disabled people? Major controlling factors are the economic and social expectations and obligations governing access to employment and, once in employment, access to types of jobs and levels of earnings. We will demonstrate four specific disadvantages: fewer are employed; fewer have high earnings and more have low earnings; more hours tend to be worked to secure the same earnings; and slightly fewer have good conditions of work.

Table 20.20 shows that a larger percentage of non-incapacitated than of incapacitated men and women of different ages were employed or self-employed during the twelve months preceding the survey. A work record was compiled for everyone working at least one week in the year. While there were few non-incapacitated men in their twenties, thirties, forties and fifties who were not employed, the numbers began to fall in the early sixties and fell steeply after 65. We estimated from the sample that there were, in the population, probably between 200,000 and 300,000 men under 65 (half of them over 30) not employed during the previous twelve months (including registered unemployed) who were not incapacitated, even to a minor extent. (Those at school and college are excluded.) There were also some 50,000 men under 65 with minor incapacity who were not employed, as well as 345,000 with some or with appreciable incapacity who were not employed (see Table A.81, Appendix Eight, page 1055). This gives some indication of the scope for an adequate employment policy for disabled people.

Our estimates are subject to large sampling errors but are derived from a sample of the entire population. We estimated that there were 1,220,000 men and 1,245,000 women with some, appreciable or severe incapacity who were under pensionable age. The unemployment 'rate' was, on this basis, 28 per cent for men and 56 per cent for women. The rate would, of course, be higher if disabled people of pensionable age, whether employed or not employed, were to be included in the

[1] McCowen, P., and Wilder, J., *Lifestyle of 100 Psychiatric Patients*, Psychiatric Rehabilitation Association, London, 1975.

[2] See the review by Hughes, D., *How Psychiatric Patients Manage Out of Hospital*, Disability Alliance, London, 1978.

Table 20.20. *Percentages of non-incapacitated and incapacitated men and women of different age employed* (*including self-employed*) *during the previous twelve months.*

	Degree of incapacity							
Age	*Men*				*Women*			
	None (*0*)	*Minor* (*1-2*)	*Some, appreciable and severe* (*3+*)	*All*	*None* (*0*)	*Minor* (*1-2*)	*Some, appreciable and severe* (*3+*)	*All*
15-19	60			59	56			56
20-29	97	91 (94)	65	96	63	57 50	57	62
30-39	100			99	49			50
40-49	99	(100)	(81)	98	68	(64)	(54)	66
50-59	98	97	69	94	57	44	34	50
60-64	92	(89)	(69)	85	36	29	18	27
65-69	(46)	36	(27)	36	(26)	(11)	11	14
70+	(28)	(6)	6	10	(11)	(14)	2	5
All ages	90	68	42	82	57	35	17	46
Total number all ages	1,644	216	267	2,127	1,568	310	490	2,368

NOTE: Percentages not calculated on base of less than 20, and placed in brackets on base numbering 20-49.

calculation. By contrast, the Department of Employment statistics of unemployment among the disabled are based on a limited register of the disabled.[1] None the less, the unemployment rate among those registered has been higher than among the economically active as a whole in all years since the war, and increased in the late 1960s and early 1970s. Thus the rate was 8.9 per cent in 1948, reached a low point of 5 per cent in 1955 and was 7 per cent in 1958, 8 per cent in 1962, 10 per cent in 1968, 11.4 per cent in 1970 and 14.9 per cent in 1972.[2]

A surprisingly large number of men who were appreciably or severely incapacitated (with scores on the incapacity index of 7 or more) were employed. We estimated that there were 300,000. The great majority were satisfied with their jobs, and with conditions of work. While more needs to be known about their employment, the fact that they were employed gives encouragement to energetic efforts to employ others of equivalent incapacity.

In every age group, fewer women than men were at work. There was a substantial number under 60 years of age in the sample who were not incapacitated and who were neither employed nor self-employed. They represented nearly 5½ million in the population (Table A.81, Appendix Eight, page 1055). Those not at work and having minor or more severe degrees of incapacity represented a further 725,000 and 695,000 respectively. But, again, there were appreciably or severely incapacitated women aged under 60 in paid employment, representing 110,000 in the total population.

Altogether, 11 per cent of employees had one or more disablement conditions, rising from 3 per cent of those in their late teens to 16 per cent of those in their fifties and 23 per cent in their sixties (Table A.82, Appendix Eight, page 1056).

About the same numbers of self-employed as employed had a disablement condition, 12 per cent compared with 11 per cent, but not consistently for every age group. (Table A.82, Appendix Eight, page 1056.) According to the alternative measure, 19 per cent of the self-employed (19 per cent of men and 21 per cent of women), compared with 12 per cent of the employed, were incapacitated to a minor or greater degree.

Earnings of the disabled at work were significantly lower than of the non-disabled. Table 20.21 shows that, according both to the measure of incapacity and number of disablement conditions, more of those with incapacity or a disablement condition had relatively low earnings, and fewer had relatively high earnings for the year as a whole. Again, the difference between the non-incapacitated and those with only minor incapacity was significant. For example, there were 35 per cent of employed

[1] The department has admitted that only about half of the disabled people in employment are registered, while about three quarters of unemployed disabled people are registered. Department of Employment Consultative Document, *The Quota Scheme for Disabled People*, HMSO, London, 1973, p. 10.

[2] *Hansard*, 25 November 1974.

***Table 20.21**. Percentages of non-incapacitated and incapacitated men and women, and men and women with and without a disablement condition with gross earnings in previous year as a percentage of the mean.*[a]

Gross earnings last year as % of mean	*Degree of incapacity*			
	Men			*Women*
	None (*0*)	*Minor* (*1-2*)	*Some, appreciable or severe* (*3+*)	*None* (*0*)
Under 60	11	11	17	14
60-79	24	34	26	18
80-99	26	26	31	21
100-39	26	22	15	29
140+	13	7	10	18
Total	100	100	100	100
Number	1,200	121	87	427

NOTE: [a]Men and women aged 20 and over and working 1,000 or more hours in the year.

men with no incapacity, compared with 45 per cent with minor incapacity, who had earnings for the year as a whole below 80 per cent of the mean.

This finding is not much affected either by the tendency of some disabled to be off ill for more weeks of the year than the non-disabled or by the inclusion of small numbers of employees working fewer than thirty hours a week. More men with than without a disablement condition had relatively low earnings in the week preceding the survey (Table A.83, Appendix Eight, page 1056). More full-time male employees had gross earnings under £15 and full-time female employees under £10 (Table A.84, Appendix Eight, page 1057).

Up to the age of 40, the earnings of men with any incapacity score were distributed much the same as for other men, but their numbers in the sample were very small. In the forties and fifties, more had low earnings. For example, 21 per cent of men in their fifties with minor incapacity (scoring 1 or 2) and 23 per cent of those with some, appreciable or severe incapacity (scoring 3 or more) compared with 12 per cent with no incapacity, had earnings in the week previous to the survey of below 60 per cent of the mean. The corresponding percentages with earnings of more than 140 per cent of the mean were 5 per cent, 7 per cent and 12 per cent.

A higher proportion of the lowest than of the highest paid had some degree of incapacity, as Table 20.22 shows. If a comprehensive state scheme of income maintenance for the disabled were introduced, the problems of poverty and relative lack

***Table 20.21**- contd*

Number of disablement conditions				
	Men		*Women*	
Minor, some, appreciable or severe (1+)	*None*	*1 or more*	*None*	*1 or more*
24	10	19	15	20
17	25	25	18	32
18	27	26	21	19
23	25	22	29	22
9	13	8	17	7
100	100	100	100	100
75	1,269	129	440	54

of resources among the disabled both in employment and not in employment would be reduced. But although incapacity is associated more strongly with low than with high pay, clearly it does not explain low pay.

Slightly more of the incapacitated than of the non-incapacitated worked under thirty hours in the week preceding interview. But the great majority worked as many hours, and, indeed, about a quarter of the men worked more than fifty hours, roughly

***Table 20.22**. Percentages of low paid and high paid with some degree of incapacity.*

	Low paid		*High paid*	
	Earnings last week as % of mean		*Earnings last week as % of mean*	
	Under 60	*60-79*	*140-99*	*200+*
Men	25	17	9	(13)
Women	20	16	(5)	(6)
Total men	165	297	67	37
Total women	96	128	40	34

Table 20.23. *Percentages of people with different earnings and hours of work who were incapacitated to any degree.*[a]

Number of hours worked last week	*Percentage with incapacity: average gross earnings last year as per cent of mean*[b]				
	Under 60	*60-79*	*80-99*	*100-139*	*140+*
30-39	24	10	9	8	5
40-49	19	16	15	13	9
50+	27	17	10	15	5
All hours[c]	22	16	13	13	7
Number working all hours	310	521	437	447	233

NOTES: [a]With scores of 1 or more on incapacity index.
[b]In relation to mean for own sex.
[c]Including those working under thirty hours, whose numbers were too few to compute separately.

the same proportion as of the non-incapacitated (Table A.85, Appendix Eight, page 1058). Significantly more of the low than of the high paid working approximately the same number of hours had some degree of incapacity. Put another way, for the same numbers of hours' work, the incapacitated had relatively lower earnings. This is shown in Table 20.23 for people working different numbers of hours. The finding applies both to men and women. Seventy per cent of incapacitated men with gross earnings of below 60 per cent of the mean, and 81 per cent below 80 per cent, were working more than forty hours a week.

Table 20.24*. Percentages of non-incapacitated and incapacitated with differing conditions of work.*

Conditions of work (index)[a]	*Men: degree of incapacity*		*Women: degree of incapacity*	
	None	*Minor, some or appreciable*	*None*	*Minor, some or appreciable*
Very poor (0)	39	39	12	12
Poor (1-6)	8	8	10	13
Fair (7-8)	17	25	28	35
Good (9-10)	36	28	50	40
Total	100	100	100	100
Number	1,180	211	484	75

NOTE: [a]For a list of the ten items, see page 438.

Finally, slightly fewer of the incapacitated than of the non-incapacitated enjoyed good conditions of work, as measured by an admittedly crude index (Table 20.24). (The ten items are listed on page 438.) There did not appear to be much variation according to degree of incapacity.

Disabled Housewives

In the mid 1960s, public attention was called to the plight of disabled housewives in the United Kingdom. Partly because of the historical exclusion of married women from the obligation to pay national insurance contributions, even when employed, and a consequent lack of entitlement to benefits in their own right, housewives when disabled usually had no claim to benefit. Pressure groups like the Disablement Income Group quoted stark anomalies in the social security system, and the public became aware of the fact that people who were equally disabled were treated very unequally. They might be getting a relatively high weekly benefit if they were disabled in war or industry, a relatively low benefit if they were long-term sick, or nothing at all if they were the wives of men in paid employment, even if considerable sums had to be found, or were needed, for aids and services. Following the announcement of government proposals, including one for a non-contributory invalidity pension in September 1974, MPs staged a protest at the exclusion of married women, and gained the government's agreement in principle that a small category of housewives should become entitled to a reduced rate of invalidity pension. A non-contributory invalidity pension scheme was introduced in November 1977.

The poverty survey adds to previous knowledge about housewives in at least two respects - in giving estimates of numbers, according to severity of incapacity, *and* risk of being in poverty relative to other married women. We estimated that there were approximately 2,100,000 married women with some, appreciable or severe incapacity, including 715,000 who were appreciably or severely disabled. Two thirds of the latter were aged 60 and over, but we estimated that some 195,000 were aged under 60, including approximately 65,000 under the age of 50. For the reasons discussed earlier, for the disabled population in general, these estimates are higher than those produced in the corresponding government survey.[1] The government had accepted an estimate of only 40,000 disabled housewives who would qualify for benefit.[2]

Married women who are disabled are significantly more likely to be in or close to poverty than women who are not disabled. As Table 20.25 shows, there is a systematic relationship between income and severity of disablement, despite the fact that any direct association must be blurred by the inclusion of the husband's

[1] See pages 699-705 above.

[2] Social Security Act 1973, *Provision for Chronically Sick and Disabled People,* op. cit., p. 14.

***Table 20.25**. Estimated numbers of disabled housewives, and percentages whose incomes were above and below the state's poverty standard.*

	Estimated number (000s)[a] *of married women*			
Aged	*No incapacity* (*0*)	*Minor incapacity* (*1-2*)	*Some incapacity* (*3-6*)	*Appreciable or severe incapacity* (*7 or over*)
15-29	2,390	110	75	10
30-39	2,300	135	100	10
40-49	2,070	285	175	45
50-59	1,230	550	285	130
60+	485	585	570	520
All	8,480	1,670	1,200	715
	Percentage in income units with income expressed as a % of supplementary benefit scale rates plus housing cost			
%				
0-99	4.0	11.5	8.4	11.5
100-39	16.8	23.1	32.1	35.9
140-99	30.4	26.9	23.7	21-8
200+	48.9	38.5	35.9	30.8
Total	100	100	100	100
Number	925	182	131	78

NOTE: [a]Estimated to nearest 5,000.

earnings and other income. This relationship exists at younger and not only older ages. Thus 29 per cent of married women aged 15-59 in the survey with some, appreciable or severe incapacity were in or close to poverty, compared with 19 per cent of married women of that age with no incapacity. The corresponding figures for the over-sixties were 54 per cent and 38 per cent.

Explanations of Poverty among the Disabled

In general, the greater poverty of disabled people is explained by their uneven or limited access to the principal resource systems of society - the labour market and wage system, national insurance and its associated schemes, and the wealth-accumulating systems, particularly home ownership, life insurance and occupational pension schemes; by the indirect limitation which disability imposes upon the capacities of relatives, pooling personal resources in full or part in the household or family, to earn incomes and accumulate wealth themselves; and by the failure of

society to recognize, or to recognize only unevenly or fitfully, the additional resources that are required in disablement to obtain standards of living equivalent to those of the non-disabled.

Part of this explanation applies to other minorities and is discussed in a number of the chapters in the latter part of this report, and particularly the conclusion. Here attention will be called to matters which could be demonstrated or illustrated for the disabled and long-term sick from the survey. First, we have seen how disability restricts access to employment. It is not just that employers are less likely to employ people who are disabled or that people are less likely to apply for jobs which they are incapable of carrying out. Disablement restricts the range of possible choice of jobs - because journeys would take too long, and transport is non-existent or costs too much; because redundancy or dismissal from certain types of job makes other employers reluctant to recruit, often unjustly; and because employment is organized inflexibly so that the disabled cannot be accommodated into its operations. There are two aspects of work organization. It could be said to have been planned 'thoughtlessly' because some types of potential employees have been excluded. Or put more strongly, by excluding part of the population potentially employable, it could be said to 'create' disablement. More of the earnings of those disabled people who are employed are low and, indeed, they tend to work more hours to secure the same earnings as the non-disabled. Conditions of work are sometimes bad - presumably because a number of disabled feel that as beggars they cannot be choosers and because some employers operate with 'marginal' workers who have poor pay and/or poor conditions of work, and who may include other minorities as well as the disabled. After disablement, people are often re-employed at much lower rates of pay in jobs which are called, sometimes euphemistically, 'light'; or for a time they are allowed to retain pay and seniority rights while being deprived of responsibility, before being obliged, or persuaded, to accept redundancy or premature retirement. A substantial sum at 55 or 60 can have its immediate attractions, but by comparison with a non-disabled man who serves out his full term of employment to 65, the financial 'reward' (assessed over the rest of life, including pension as well as lump sum on retirement, and related to years of working service) may be puny. These are only some of the ways in which remuneration, responsibility and reward from employment are reduced.

The social security system has a number of disadvantages. Except for those with relatively large families, incomes are normally much below those of people currently in employment, even when they are of comparable age. The war pensions and industrial injury schemes are sub-systems which are relatively more generous than other contributory and non-contributory national insurance schemes, but they are limited access schemes: the majority of disabled people have no entitlement. Within the sickness insurance system, contribution rules sometimes reduce the incomes received initially by the sick or disabled. After six months, entitlement to earnings-

related supplement ceases. Subsequently invalidity benefits do not do much to cushion the fall in income experienced by most men who have been receiving earnings-related sickness benefits. Of course, some disabled men start off at a disadvantage, because their employment has been interrupted before its final termination, and entitlement to earnings-related benefit has been reduced, or because of disability has brought them to a level of pay which has been so low for so long that they may not be entitled to any supplement at all. Long-term receipt of sickness and invalidity benefit or supplementary benefit is also subject to a series of checks and investigations by special officers of the Department of Health and Social Security. While efforts are made to administer these in a humane way, they often reflect popular prejudices about abuse of the social security system and are not informed by professional instruction about the nature and additional needs of different forms of disablement. Additional allowances are received by a minority. Thus, in November 1974, only 27 per cent of sick and disabled people receiving supplementary benefit were also receiving an 'exceptional circumstances addition'.[1]

Other resource systems than the social security system have rules and administrative procedures which obstruct or limit access. People with a disablement condition have difficulty in obtaining life insurance, or have to pay high premiums. Building societies and banks are reluctant to make loans, or only at special rates. Motor insurance cover may be difficult to obtain. In general, credit, and therefore the means to accumulate wealth on a small as well as a large scale, is restricted.

Disability can also have the indirect effect of reducing the resources or access to resources of the immediate family. The best-documented instances are those of wives and daughters who give up work, or lose time from work or can only accept low-paid work near by, because of the disability or illness of a husband, child or parent. By introducing the invalid care allowance for those of working age who can show they have been obliged to give up paid employment, though not for wives, the government has conceded the principle.[2]

Many of the harsh and inconsistent features of the employment and wage system, the social security and other resource systems, merely reflect popular prejudices and low standards of information. Neighbours are sceptical of men who appear to have nothing wrong with them. They suppose they should be back at work and that they are living on the state. Often they do not know that the man may be epileptic, diabetic, manic depressive or have a terminal cancer, and has been medically advised not to work or cannot get work; or they may not understand what these conditions involve, psychologically and socially no less than clinically. It may be possible in some circumstances to change the resource systems of society without

[1] DHSS, *Social Security Statistics, 1974,* HMSO, London, 1975, p. 156.

[2] Social Security Act 1973, *Social Security Provision for Chronically Sick and Disabled People,* op. cit.

directly attacking popular prejudices and malinformation. Changing them may also have some effect on reducing those prejudices and improving that standard of information. But, in the long run, much will depend on the level of public education and on determined efforts to make employment and other occupations and pursuits more rather than less widely available to people of all ages.

Although invalidity benefit became payable from September 1971 as a replacement of sickness benefit after six months' incapacity for work, it added only small amounts to the incomes of most of the minority of disabled people who qualified for such benefit. The benefit includes an invalidity pension which was at first paid at the same rate as sickness benefit, but later at a higher rate. In late 1978, for example, the single rate was £19.50 a week, compared with £15.75 a week. The rate of £19.50 was the same as for the retirement pension. An invalidity allowance could be granted in addition to the invalidity pension - £4.15 per week if incapacity began before the age of 35, £2.60 before 45, £1.30 before 60 for men or 55 for women, and nothing if after that age. The amounts are not related to degree of disablement, and four men, all aged 61 with equally severe disablement, might be receiving different amounts and, presuming they lived into their 80s, would go on receiving these different amounts for the next twenty years irrespective of any change in the severity of their disablement.

The new benefits for disabled people introduced in the early 1970s increased certain incomes relative to the non-disabled, but did not increase them much for more than a minority. They further complicated the anomalous structure of state support. The attendance allowance, first introduced in 1971, was paid in 1976 at a higher rate to 139,000 people and at a lower rate to 121,000.[1] The non-contributory invalidity pension was expected to be paid to 150,000 (in addition to patients in psychiatric hospitals), the vast majority of whom have their supplementary benefit reduced, leaving them with the same amount of income as before. The invalid care allowance was planned for only 11,000 recipients, and the mobility allowance (paid by 1978 at a rate of £10 a week) for only 100,000.[2] Most blind, mentally ill and mentally handicapped people, as well as all those of pensionable age, do not qualify for this allowance. Organizations representing disabled people have argued in detail that government schemes of income support are uneven and inequitable, and that a comprehensive scheme of allowances graded according to severity of disablement is necessary.[3]

[1] *Social Security Statistics, 1976*, HMSO, London, 1978, p. 96.

[2] Social Security Act 1973, *Social Security Provision for Chronically Sick and Disabled People.*

[3] Disability Alliance, *Poverty and Disability: The Case for a Comprehensive Income Scheme for Disabled People*, London, 1975; see also Disablement Income Group, *Realizing a National Disability Income*, London, 1974.

Summary

The scale of disability in the United Kingdom has so far been underestimated. The survey produces estimates which, even allowing for differences of definition, are considerably larger than government estimates for the same year. Twelve per cent, representing over 6½ million, both said they had a disablement condition and that it prevented them doing things which were normal for people their age. According to an alternative measure, 15½ per cent of people aged 10 and over, or 7 million, had some, appreciable or severe incapacity, including 1.1 million with severe incapacity. Although nearly 3 million of the 7 million were aged 70 and over, and nearly 2 million in their sixties, over 2 million were under 60 years of age.

More of the working than the middle class, particularly unskilled manual workers and their families, are disabled. Increasing incapacity is correlated with falling cash incomes and 58 per cent of those with appreciable or severe incapacity, compared with 24 per cent of the non-incapacitated, were in households with incomes below or close to the government's supplementary benefit standard. At successive ages, greater incapacity was associated with greater risk of being poor.

The incapacitated also had fewer assets and personal possessions of different kinds, and when the value of these are taken into account, the gap between the living standards of the incapacitated and non-incapacitated widens. Indeed, the difference is marked for people at every age (see in particular, Table 20.12, page 713).

These differences corresponded with differences in measures of various forms of deprivation. Compared with the non-incapacitated, more of the incapacitated lived in poor housing, had poor facilities, missed cooked meals, ate meat infrequently, were short of fuel and lacked winter heating. Fewer had been on a week's summer holiday. More confessed to difficulties in managing on their incomes.

Prolonged current illness is also associated with low income. Nearly twice as many people who had been ill for over ten weeks as of those who had not been ill lived in income units with incomes below or on the margins of the supplementary benefit standard.

The vast majority of people with a disablement condition were not currently ill, and of those who had been ill for ten weeks or more, only 60 per cent had a disablement condition. On the basis of the survey, it was estimated that there are at any one time three quarters of a million people who have been ill off work or school or ill in bed or confined to the house for ten weeks or more, including over 400,000 with appreciable or severe incapacity.

Significantly more of those in the sample complaining of trouble with nerves than not so doing were in or on the margins of poverty. This applied at each age. A disproportionately large number of them were women. There was evidence, too, of the mentally ill being poorer than other people at similar levels of incapacity.

Four specific disadvantages of the employment system are demonstrated: fewer of the incapacitated than of the non-incapacitated are employed; fewer have high

earnings and more have low earnings; when they secure the same earnings, they tend to have to work longer hours; and slightly fewer have good conditions of work.

We estimated there were 2,100,000 married women with some, appreciable or severe incapacity, including 715,000 who were appreciably or severely disabled. These women were more likely than other married women to be in income units in or close to poverty.

The principal argument of the chapter is that poverty among disabled people is explained by society denying them access to different kinds of resource. This is discussed in relation to the employment and wage system, the social security system and other resource systems. There are multiplier effects of deprivation from disability which are not fully recognized. Disabled people often need a higher income than the non-disabled to secure comparable living standards. People are unable to get work and their relatives sometimes have to give up work too, or are obliged to accept low-paid jobs. They are prevented from sharing, or sharing to the same extent, the activities and pleasures of most people of their age.