[2018] AACR 15

(MH v Secretary of State for Work and Pensions (PIP)
[2017] UKUT 424 (AAC))

Judge Lane **CPIP/2017/2016**
24 October 2017

Human Rights – Article 14 ECHR – whether suspension of the mobility component for long-term in-patients of hospitals or similar institutions constitutes unlawful discrimination

The claimant was a resident in-patient at a Neurodisability Centre, a publicly funded institution similar to a hospital, where he required round-the-clock care. Thorough an appointee he successfully claimed Personal Independent Payment (PIP). However, payment of benefit was subsequently suspended on the basis that he was an in-patient under regulation 29 of the Social Security (Personal Independent Payment) Regulation 2013. The First-tier Tribunal upheld that decision and the claimant appealed to the Upper Tribunal. The appeal concerned a single issue, namely whether section 86 of the Welfare Reform Act 2012 and regulation 29 discriminated unjustifiably against a person who was an in-patient in an institution similar to a hospital and whose care was maintained out of public funds by providing that the mobility component of PIP was not payable to such a person. The claimant's representatives argued that the claimant was being treated differently than disabled people living at home or in care homes, who would retain payment of the mobility component (if awarded) and that the regulations were in breach of Article 14 of the European Convention on Human Rights (ECHR), as incorporated into UK law by the Human Rights Act 1998, and the UK's obligations under the UN Convention on the Rights of Persons with Disabilities (UNCRPD). The Secretary of State argued that payment of the mobility component to in-patients would amount to double provision as assistance was already provided by the NHS in such cases and that the suspension of benefit was justified to target scarce resources.

Held, dismissing the appeal, that:

1. there were insufficient similarities between in-patients and disabled claimants living at home to require justification under ECHR in respect of the different treatment. Claimants who can live at home remain in their community and are likely to have a range of mobility needs in that community similar to those they had before becoming disabled, and similar to those of non-disabled people living at home. These require the claimant to venture outdoors, or have someone run their errands for them (paragraphs 27 to 28);

2. in-patients and care home residents are also not true comparators. In-patients as a class are substantially less likely to need to mobilise beyond the perimeter of the establishment in comparison to those living in care homes. It was incorrect to say that the mobility needs of in-patients was as great, if not greater, than those at home or in a care home (paragraphs 29 to 31 and 42);

3. if in-patients and care home residents were comparable groups, there was a plain overlap between the scope of the mobility component and the assistance provided to in-patients by the NHS and NHS continuing care packages. On that basis, there was double provision. The elimination of double provision had long been the policy of successive Governments in relation to disability benefits and it was a legitimate aim (paragraphs 53 to 54);

4. the Government's economic policy to control escalating welfare spending and hence maintain the economic wellbeing of the country was a legitimate aim under the ECHR and it was not irrational, unreasonable or disproportionate to choose to target funds in this way (paragraph 61);

5. the UNCRPD, unlike ECHR, was not incorporated into domestic law and the tribunal did not have jurisdiction over the Convention (paragraph 70).

DECISION OF THE UPPER TRIBUNAL
(ADMINISTRATIVE APPEALS CHAMBER)

The appeal is dismissed. The decision of the First-tier Tribunal did not involve the making of an error of law that was material to the outcome of the decision.

REASONS FOR DECISION

1. This decision is given following an oral hearing on 26 April 2017. I apologise for the delay in promulgating it.

2. The appellant, MH, is severely disabled. He did not attend the hearing and brings this appeal through his appointee, IH, who is his brother. IH was represented at the hearing by Mr Makesh Joshi, of French and Co Solicitors. The respondent was represented by Mr T Buley and Mr Toby Fisher, of counsel. I am grateful for their assistance.

3. The appeal concerns a single issue: whether section 86 of the Welfare Reform Act 2012 and regulation 29 of the Social Security (Personal Independence Payment) Regulations 2013 (SI 2013/377) discriminate unjustifiably against a person who is an in-patient in an institution similar to a hospital and whose care is maintained out of public funds by providing that the mobility component of Personal Independence Payment (PIP) is not payable to such a person. It is argued that these provisions breach Article 14 of the European Convention on Human Rights as incorporated into UK law by the Human Rights Act 1998.

Background to PIP

4. PIP is a points-based benefit for claimants who are mentally and/or physically disabled. It arises under the Welfare Reform Act 2012 and its details are set out in the Social Security (Personal Independence Payment) Regulations 2013 (the Regulations) made under that Act. PIP will eventually replace its predecessor benefit, Disability Living Allowance ("DLA").

5. PIP comprises a daily living component and a mobility component. Each component is made up of a number of general activities which are sub-divided into aspects of that activity. These are called "descriptors", to which points are ascribed. The activities and descriptors are found in Schedule 1 of the 2013 Regulations.

6. If, because of their disablement, claimants score sufficient points from the descriptors from each component respectively, they are entitled to an award of that component. This will be at either the standard rate of benefit for that component or the enhanced rate. A claimant needs to score 8 points for the standard rate of benefit or 12 points for the enhanced rate of benefit. Points scored for activities in one component do not count towards the score of the other component.

7. Even if a claimant scores sufficient points to be entitled to benefit, section 86 of the Welfare Reform Act 2012 permits the making of regulations which prevent payment of either or both components in certain circumstances. I shall refer to this as "suspending" payment. After 28 days[1], payment of both components is suspended if the claimant is undergoing medical or other treatment as an in-patient in a hospital or similar institution where the cost of treatment, accommodation and any related services is borne out of public funds. I shall refer to this group as "in-patients".

8. Regulation 29 of the Regulations was made under that power.

[1] Regulation 30(1). There are exceptions to the rule which are not relevant to this appeal.

> **"86 Hospital in-patients**
>
> (1) Regulations may provide as mentioned in either or both of the following paragraphs–
>
> (a) that no amount in respect of personal independence payment which is attributable to entitlement to the daily living component is payable in respect of a person for a period when the person meets the condition in subsection (2);
>
> (b) that no amount in respect of personal independence payment which is attributable to entitlement to the mobility component is payable in respect of a person for a period when the person meets the condition in subsection (2).
>
> (2) The condition is that the person is undergoing medical or other treatment as an in-patient at a hospital or similar institution in circumstances in which any of the costs of the treatment, accommodation and any related services provided for the person are borne out of public funds.
>
> (3) For the purposes of subsection (2) the question of whether any of the costs of medical or other treatment, accommodation and related services provided for a person are borne out of public funds is to be determined in accordance with the regulations."

9. The details are contained in regulation 29 of the Social Security (Personal Independence Payment) Regulations 2013, made under section 86(3). As relevant, regulation 29 provides:

> **"29 Hospital in-patients aged 18 or over**
>
> (1) Subject to paragraph (3) and regulation 30, no amount of personal independence payment which is attributable to either component is payable in respect of C [the claimant] for any period during which C meets the condition in section 86(2) of the Act (in-patient treatment: costs of treatment, accommodation and related services borne out of public funds).
>
> (2) For the purposes of section 86(3) of the Act, the costs of treatment, accommodation or any related services are borne out of public funds if C is undergoing medical or other treatment as an in-patient in —
>
> (a) a hospital or similar institution under –
>
> (i) the National Health Service Act 2006;
> (ii) the National Health Service (Wales) Act 2006; or
> (iii) the National Health Service (Scotland) Act 1978; or …."

10. Residents of care homes for whom qualifying services are provided from public or local funds are treated differently from in-patients. Although payment of the daily living component is suspended if their care is publicly funded, they remain entitled under regulation 28 to payment of the mobility component if it has been awarded. It is not necessary to examine the details of the funding regimes since no issue arises over it in this case.

> **"28 Care home residents**
>
> (1) Subject to paragraph (3) and regulation 30, no amount of personal independence payment which is attributable to the daily living component is payable in respect of C [the claimant] for any period during which C meets the condition in section 85(2) of the Act (care home residents: costs of qualifying services borne out of public or local funds).
>
> (2) …."

The Common Ground

11. There is no dispute on the facts relevant to this issue: the appellant is severely disabled and entirely incapable of caring for himself. He is resident at a Neurodisability Centre. This institution is similar to a hospital, and it is publicly funded. The appellant needs round-the-clock care from staff to meet his needs. He is incapable of purposeful self-movement. Staff must use a hoist to get him out of bed and he needs a special wheelchair, which he cannot self-propel, to get around. He requires an adapted taxi or something similar to go out of the Centre. He is not considered to have mental competence.

12. Following a claim made through his appointee, the appellant was awarded PIP, having scored 69 points from the descriptors for the daily living component and 24 points from the mobility component.[2] However, payment of benefit was suspended after a period because he was an in-patient for the purposes of regulation 29.

13. The appellant's representative accepts that the appellant falls squarely within the legislation and that payment is suspended, unless they successfully challenge the lawfulness of the legislation. The representative seeks to establish that the legislation amounts an unlawful breach of the appellant's rights under the European Convention on Human Rights as incorporated into UK law by the Human Rights Act 1998. In particular he submits that the legislation discriminates against him on the ground of disability (Article 14, European Convention on Human Rights [ECHR]) in respect of his rights under Article 1, Protocol 1 of the Convention. He also argues that the Regulations are in breach of the UK's obligations under the UN Convention on the Rights of Persons with Disabilities, to which the UK is signatory.

14. It was clear that the representative intended to argue that the appellant was treated differently than disabled people living at home *or* in care homes, who would retain payment of the mobility component (if awarded) and Mr Buley presented arguments accordingly.

15. Mr Joshi also argued that the mobility component was not meaningless in the appellant's case. Even though very severely disabled, there were occasions the extra money in the mobility component would enable him to get out and about in circumstances where transportation was not supplied by the Centre. (Upper Tribunal bundle page 180).

[2] The claim history is not of any particular importance except to mention that (i) the Secretary of State mistakenly overpaid benefit. There is no issue of recoverability, as I understand it; and (ii) the correct date of the decision under appeal is 12 June 2015.

Article 14 – Was there discrimination on the basis of disability for the purposes of Article 14?

16. The case was argued under Article 14 of the ECHR: -

> "The enjoyment of the rights and freedoms set forth in this convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status"

Article 14 does not provide a stand-alone right to be protected from discrimination. In order to succeed, the appellant must show that one of his rights under another article of the ECHR is engaged.

17. In order to show that the appellant's right under article 14 has been violated, he must show that:

i. he has a status for the purposes of Article 14 (a "protected" status),

ii. he has been discriminated against on the basis of that status (the comparator),

iii. the discrimination interfered with one of the other rights set out in the Articles of the ECHR,

iv. there is no objective and reasonable justification for the distinction. In the context of state benefits, the courts should not intervene unless the impugned rule is "manifestly without reasonable foundation": *Humphreys v Revenue and Customs Commissioners* [2012] UKSC 18 at [19] to [20].

18. Once the appellant shows that he has been discriminated against, it falls on the respondent to show that the discrimination was justified in the sense that it was not "manifestly without reasonable foundation".

19. Mr Joshi submits that entitlement to PIP engages Article 1, Protocol 1 of the ECHR regarding the right to peaceful enjoyment of his possessions. In *R (RJM) v Secretary of State for Work and Pensions* [2008] UKHL 63 the House of Lords held that non-contributory social welfare benefits are a possession for the purposes of Article 1, Protocol 1. PIP is such a benefit, and the Secretary of State accepts that it falls within the scope of A1P1 of the ECHR. There is no need to consider (iii) further.

Status

20. The Secretary of State initially disputed that the appellant enjoyed a status for the purposes of Article 14 but abandoned this position following the decision of the Three Judge Panel of the Upper Tribunal in *TW v Secretary of State for Work and Pensions (PIP)* [2017] UKUT 25 (AAC). Mr Buley accordingly accepts that being a disabled in-patient in hospital or a similar institution is a status protected by Article 14 and I accept this concession. There is no need to consider (i) further.

21. This leaves the questions of (ii) and (iv) :

- whether there is a relevant comparator against which the difference in treatment can be considered discriminatory and

- whether that treatment is justified.

In the instant appeal, both the comparator and justification are disputed by the Secretary of State.

Comparators

22. In *TW* at [44] to [46] the Three Judge Panel considered that a tribunal could tackle the question of justification before dealing with both status and relevant comparators. This is because, if justification is established, the other issues are academic. The Three Judge Panel noted, however, that the analysis of justification might also illuminate the strengths or weaknesses of an asserted status or comparator.

23. I respectfully agree with the decision of the Three Judge Panel and, indeed, am bound by it. But I do not consider that the Three Judge Panel intended to pre-empt consideration of a comparator group first, if that would be a useful.

24. There is no need to find an exact or "sufficiently exact" comparator: *AL (Serbia) v Secretary of State for the Home Department* [2008] UKHL 42 at [21] ff and *TW v Secretary of State for Work and Pensions* [2017] UKUT 25 (AAC). Assessing a comparator appears to be less a science than an art: if there are sufficient similarities to make a reasonably informed person ask "why are they treated differently?" that may be enough to trigger the duty to justify the difference. If a significant dissimilarity emerges, that may be factor to be weighed in justification; or as the Three Judge Panel pointed out, may show the weakness of the comparator itself.

25. The groups put forward for comparison are those living at home, care home residents and in-patients.

26. There are several obvious points of similarity: Because of their disabilities,

i. the claimants in each of the three groups *may* be entitled to PIP for their mobility needs;

ii. claimants with the same levels of disability *may* remain at home, be resident in a care home or be an in-patient, with different outcomes in the payment of benefit.[3]

iii. some of the mobility needs of in each group *may* be met from public funding apart from PIP, for example by a local authority.

iv. for all three groups, each element is meant to help meet the extra costs of transportation and/or daily living associated with their disability, such as the costs of personal visits (for example to see relatives or friends) which are not otherwise borne by other public funds;

[3] Secretary of State's response, [25], albeit made in a different context.

v. claimants are entitled to spend the money as they wish. There is no monitoring.

In-patients v disabled claimants living at home

27. I consider that these similarities are not sufficient to require justification in respect of the different treatment of the disabled people living at home.

28. Claimants who can live at home remain in their community and are likely to have a range of mobility needs in that community similar to those they had before becoming disabled, and similar to those of non-disabled people living at home. They need to get to the shops and appointments, to visit people, go out for a change of scenery, and perhaps visit a pub, restaurant or cinema. All of these will require the claimant to venture outdoors, or have someone run their errands for them. From my experience as an Upper Tribunal and F-tT judge, these claimants usually have a network of carers, friends and relatives who help them on these occasions.

In-patients v residents in care homes

29. Superficially these two groups appear relevantly similar since they are, in addition to the above, not able to live at home. Indeed, they may no longer have any place to live other than the institution or care home. Nevertheless, I am not persuaded that this a true comparator. If it is, it is weak.

30. Judge Markus rightly pointed out in *ML v Secretary of State for Work and Pensions* [2017] AACR 2 at [30], that placement in a care home depends on many factors including the suitability of the individual's own accommodation, the availability of family or other support in the community and the individual's wishes and needs. A care home resident might not require medical treatment or, indeed, a level of care which impinges on their autonomy so significantly that they can no longer access the community. The Low Review, which Mr Joshi brought to my attention and which I refer to later, emphasised the importance to this group of the mobility component to enable them to access the community [section 4.3.6] and the limited funding provided by local authorities for mobility needs not associated with assessed care needs. These differences tend to confirm that there are good reasons for maintaining payment for are home residents, but not necessarily for in-patients.

31. I consider that in-patients as a class are in a very different position from disabled people living in care homes. In-patients as a class are substantially less likely to need to mobilise beyond the perimeter of the establishment in comparison to those living in care homes. The very fact of being an in-patient points to such limitations, whether the individual is physically impaired or in an institution through mental health difficulties that restrict their ability to leave the premises on their own. Their daily activities and mobility needs are likely to be focussed on the institution. The fact that there may be members of this group who are able to go out and about more freely does not detract significantly from the generality.

32. If I am wrong, and there is sufficient to establish that the groups are relevantly similar (albeit, perhaps, weakly so) I go on to consider justification of the difference in treatment.

Care home residents v in-patients: the appellant's arguments on justification

33. Turning first to the appellant's case, Mr Joshi focussed on the purpose of the mobility component of PIP which is to help disabled people to be independently mobile. He further submitted that disabled people living in a hospital or similar institution have the same, if not greater, mobility needs than those living at home or resident in care homes. He referred to a press statement by the then Secretary of State for Social Security, Peter Lilley, (DSS 95/160) when the issue of removing the mobility component from in-patients first arose in 1995. The Secretary of State said:

> "DLA is intended to help with the extra costs arising out of a disability and the mobility component is primarily intended to help disabled people be independently mobile. Hospital patients, especially acute patients, have little scope to be independently mobile whilst in hospital and most of their needs are met by the NHS. Most other social security benefits are either withdrawn or reduced when a person goes into hospital to prevent duplicate provision from public funds. It cannot be right to pay people who are unable to use the benefit for the purpose intended and who are already having most of their needs met by the taxpayer. We believe the move is justified in ensuring that taxpayers' money goes to those best placed to benefit from it"

34. This statement read as a whole does not give a ringing endorsement to Mr Joshi's submission. Mr Joshi did, however, emphasise the first sentence of Mr Lilley's statement, which sets out the underlying rationale for providing help with mobility to the disabled: to help disabled people be independently mobile. Mr Joshi accepts that in-patients have their *basic* mobility needs met by the NHS (or as in this case, by NHS continuing care) but this is limited to help getting around the premises of the hospital/institution, or to go to hospital or other medical or medically-related appointments. An in-patient's personal mobility needs, such as going to the hairdresser, a GP, to the pub or to see family, he argues, are not met. The appellant in this appeal would be unable to enjoy, for example, the occasional visit to his elderly mother, or to go to a concert or to the pub because he cannot afford the cost of an adapted taxi and the physical assistance he needs during the event [Witness statement of IH]. I deal with the specifics regarding the appellant at paragraph 74, on justification.

35. The government's public consultation document CM 7984 *Disability Living Allowance reform*, provides a stronger statement of the government commitment to: -

> "protect the interests of disabled people and prevent discrimination, [which] has helped many disabled people lead more independent lives. It is now universally accepted that disabled people should have the same choices and opportunities as non-disabled people" (Chapter 1 paragraph 12).

36. The paper goes on:

> "We are committed to further breaking down the barriers in society that prevent disabled people from exercising choice and control, and living active and independent lives…" (paragraph 13).

37. The government may be committed to making further progress which boosts the autonomy and choice which disabled people enjoy, but what disability benefits can actually

achieve must be seen in the light of their limitations, not least of which are the rates of benefits provided. The mobility component of PIP is paid at either £22 per week for the standard rate or £58 for the enhanced rate, and at the same rates for the lower rate and higher rate of the mobility component of DLA respectively.

38. For some claimants, this may be more than enough; for others, it will be far too little to enable them to make the choices they might have made had they not been disabled. Parliamentary Under-Secretary for Work and Pensions Maria Eagle states the purpose of the mobility component more realistically: -

> "as a contribution towards the extra costs faced by severely disabled people who need help with care or have walking difficulties". (Hansard, 25 March 2003)

39. Mr Joshi also submits that the assumptions made by Mr Lilley regarding the mobility needs of the disabled were false. He seeks support for this assertion in Volume 1 of the Low Review: *Independence, Choice and Control – DLA and personal mobility in state funded residential care* in which disabled people interviewed for the Review attest to the importance of the mobility component in supporting their autonomy.

40. Nevertheless, I do not consider that the Low Review furthers the appellant's argument for a number of reasons: The Review deals with the needs of disabled people whose residential *care* was publicly funded. By residential care, the Review means "care homes" rather than in-patient and similar facilities. This is established by the terms used in the Report set out in paragraph 1.1. It is also implicit from paragraph 8.3 of the Review that it was trying to distance itself from the position of in-patients.

> "8.3 Attitudes to disabled people living in residential care
>
> Concerns were raised that the proposal to remove DLA mobility was based on a misconception of people living in residential care, with disabled people viewed as "too ill" or "too disabled" to, or to want to, participate in society in the same way as non-disabled people. At the time of announcing plans to remove DLA mobility, references were made to people in residential care being in a comparable position to hospital in-patients and there was an implication that people would be able to share transport".

41. The Review did not tackle the economic impact of paying the mobility component to either group, which Mr Buley rightly pointed out, was a fundamental concern for the government for DLA and PIP.

42. Finally, I am not satisfied that Mr Joshi is correct when he says that the mobility needs of in-patients is as great, if not greater, than those at home or in care homes.

The Secretary of State's case

43. In case I am wrong and care home residents who are publicly funded constitute a relevant comparator, I proceed to address the question of whether that discrimination is justified. The threshold test is low: is the discrimination manifestly without reasonable foundation?

44. Mr Buley started from the premise that the purpose of PIP is to compensate claimants for the additional costs of different aspects of disability (response at [27]). He then argues that the mobility component, if paid to in-patients (or those in institutions similar to hospital), would amount to double provision for the same contingency out of public funds, and that the suspension is justified in order to target scarce resources.

Double provision

45. Mr Buley put in evidence the statement of Andrew Mitchell, Parliamentary Under-Sectary of State for Social Security, during the Parliamentary debates on 5 December 1996 (Hansard) on what became regulation 12A of the Social Security (Disability Living Allowance) Regulations 1991. I am satisfied that his comments remain as relevant to PIP as they are to DLA:

> "DLA forms an integral part of a disabled person's income. They are free to spend it as they choose. That seems to me to be a perfectly proper and reasonable state of affairs when someone is living in the community. We can all think of the extra costs that might be associated with limited mobility – for example, higher heating bills, higher laundry bills, paying someone else to do the shopping – but the same considerations do not apply while someone is in national health service accommodation. Patients in national health service accommodation have most of their needs met free of charge. Only a small proportion of patients receive DLA mobility component, but hospitals make no distinction between those who do and those who do not when identifying basic mobility needs and seeking to meet them "

He also referred to a further paragraph in Maria Eagle's statement in Hansard of 25 March 2003, Col. 26WH –

> "The rationale basically comes down to the rule against overlapping provision, which is a founding principle of the welfare state…. That principle… basically means that the state will not pay two benefits for the same contingency. It will not pay benefit or income maintenance – such as income support, incapacity benefit or housing benefit – when the needs for which they are paid, namely maintenance, are met free of charge by the national health service for a hospital in-patient. That is why the issue arises and why benefits are downrated at all after a period of hospital admission. That is the basic rule.
>
> All in-patients' disability related needs are met by the National Health Service. … that is why DLA and AA[4] are withdrawn after a shorter period – namely once an adult has been in hospital for 28 days…"

46. Mr Buley also drew attention to the NHS' statutory obligation under section 3 of the NHS Act 2006 to meet all reasonable requirements, to the extent it considers necessary, to arrange for the provision of a broad range of services including accommodation, medical treatment and services for the care of persons suffering from illness. It is responsible for arranging and funding a care package (NHS Continuing Healthcare package) to meet a person's "primary health needs". Where an NHS Continuing Healthcare package is required,

[4] Attendance Allowance

the individual's assessed health and social care needs include his mobility needs (Response, [31] and exhibit RB/16).

47. Mr Buley stressed that *some* of the extra costs associated with limited mobility are directly met by the NHS by virtue of the patient living in the institution. The familiar examples are the additional costs of heating, laundry provision and shopping. Further costs associated with limited mobility may be met by the continuing care package as assessed through the NHS Decision Support Tool. One of those needs assessed in a package is mobility, and the package should include appropriate mobility equipment and assistance with mobility by staff at the institution. He argues that meeting these needs from NHS funding and the continuing care package whilst paying the mobility component would be double provision from the state for the same need.

48. But what is meant by double provision? Views were expressed on this by the Court of Appeal in *Secretary of State for Work and Pensions v The Adjudication Officer ex parte Perry and McGillivray* [1998] (unreported, tab 6 of the agreed authorities bundle), which Mr Buley brought to my attention. That case dealt with two claimants' unsuccessful judicial review actions to test the lawfulness of regulation 12A of the Social Security (Disability Living Allowance) Regulations 1991, as amended. It was argued before the Court that regulation 12A was unlawful because the mobility component of DLA was not actually duplicated in the provision made to in-patients.

49. Simon Brown LJ, with whom the rest of the Court agreed, dismissed this argument (transcript page 7):

> "In the widest sense the benefits enjoyed by in-patients in hospital undoubtedly do overlap those non-means tested benefits, like disability living allowance, to which section 73 [of the Social Security Contributions and Benefits Act 1992] is directed. Both involve use of public resources. The concept of overlapping does not, to my mind, necessarily connote double counting.
>
> There is an inevitable element of arbitrariness in the entire scheme for the payment of the mobility component of Disability Living Allowance. The sum, which is in any event determined on a non-means tested basis, manifestly will be insufficient for the purposes of some claimants and more than sufficient for the needs of others. Likewise, as between the higher and lower rates of payment, the arrangement implemented by the regulations for long-stay patients…necessarily has about it something of a political compromise such as characterises the field on non-means tested benefits. This is on analysis an irrationality challenge with to my mind no possible prospect of success".

50. It is necessary to bear in mind that the question before the Court of Appeal in *ex parte Perry* was whether a particular regulation (12A) of the Social Security (Disability Living Allowance) Regulations 1991 was unlawful because it was *ultra vires* (made outside the power granted by legislation). This is not the same as the question that arises in this appeal, which is whether the solution adopted amounts to unlawful discrimination under Article 14.

51. As previously stated, in welfare cases, the test to apply is whether the asserted discrimination "is manifestly without reasonable foundation". In my view, the more tenuous

the connection between the right taken away and the provision removing it, the harder it will be to say it is not manifestly without reasonable foundation. Neither party referred specifically to the content of the activities in the mobility component, but in my view it cannot be right to ignore that issue when considering if there really is "double counting" or "overlapping" payment, as submitted by Mr Buley.

52. Neither the Welfare Reform Act 2012 nor the Social Security (Personal Independence Payment) Regulations 2013 state expressly that mobility is to be judged out of doors, and some of the descriptors in both activities set out in Schedule 1 of the Regulations can be construed as applying indoors or outdoors. Activity 1 – planning and following journeys – contains descriptors such as (1b) – "needs prompting to be able to undertake any journey…." and (1e) "cannot undertake any journey…" which can refer to what happens before the individual leaves the house (if he ever does) (*MH v Secretary of State for Work and Pensions (PIP)* [2016] UKUT 531 (AAC), at [44]). Similarly, planning the route of a journey (1c) requires cognitive skills which are likely to be applied before an individual leaves home. Activity 2 – "moving around" – should be taken as referring to outdoor mobility, at least as regards the surface against which an individual's ability to move around is tested. In *DT v Secretary of State for Work and Pensions* [2016] UKUT 240 (AAC) [9] the Secretary of State submitted as much and the Upper Tribunal accepted that submission. But a person who cannot stand and move more than one metre, 20 metres or perhaps no more than 50 metres, is likely to require help with mobility, indoors or out.

53. Looked at from this perspective, there is a plain overlap between the scope of the mobility component and assistance provided by the NHS and NHS continuing care packages. There is no need for a precise correspondence between the scope of the mobility activities in PIP or DLA, and the provision made by the NHS: it is not inherent in either DLA or in PIP that *all* of a claimant's mobility needs are met by the benefit. This point is made crisply by Shiemann LJ in relation to DLA in his brief judgment in *ex parte Perry* at page 5.

54. On this basis, I consider that there is double provision. The elimination of double provision has long been the policy of successive governments in relation to disability benefits, and I do not see it as being other than a legitimate aim.

55. Even if I am wrong in my analysis of double provision, I consider that the conclusions of the Court of Appeal in *ex parte Perry* are relevant in the present context, and I adopt them. There is an overlap in payment from public funds in a broad sense having regard to the limitations on an individual's life as an in-patient. An in-patient's day to day needs will generally be within the perimeters of the institution and these are provided for directly or, where relevant, through NHS Continuing Care. This is certainly so for the appellant, as is shown in his Care/Risk plan (page 9) and the evidence of Caroline Skevington, Service Head of Nottingham Citycare Partnership, 28 December 2016. Their position can sensibly be distinguished from those of publicly funded care home residents who are not subject to in-patient regimes.

56. It is almost inevitable that there will be patients who want to do more than is possible within the strictures of the NHS funding schemes, and who will feel aggrieved because they do not have the flexibility that comes with a benefit that can be spent however the recipient thinks best, as are PIP and DLA. But I do not consider that that makes the change from the cash payment of benefit to an individual to provision of equipment and services by the NHS

based on a tighter, more clinical template either disproportionate or manifestly unreasonable if, at the end of the day, the individual's realistic needs are met.

Targeting scarce resources

57. *Humphreys v Revenue and Customs Commissioner* confirms that, in matters of economic or social strategy (of which this appeal is an example), national authorities are in principle better placed than judges to appreciate what is in the public interest on social or economic grounds. The legislature's policy choice should be respected unless it is manifestly without reasonable foundation.

58. Mr Buley submitted that Andrew Mitchell's statement in the House of Commons in 1996 remained relevant (Hansard, 5 December 1996) -

> "Expenditure is rising on such a scale that it should be crystal clear …that without effective targeting we shall not as a country be able to continue affording DLA. My first point, therefore, is that this is about targeting DLA mobility and not about cutting disability benefits. But targeting effective support where it is most needed means taking a long, hard look at our priorities, across all benefits…We need to examine all aspects of current provision to be certain that decisions made about benefit entitlement and payability are still sustainable in the current financial climate."

59. The figures supplied by Mr Mitchell during the Parliamentary debates in 1996 showed sharply rising costs for DLA: £2 billion in 1992, £2.8 in 1993-4, £3.1 billion in 1994-5, and in 1996 it was estimated at £3.7 billion. Planned spending for 1997 was £4.4 billion, and by 1998-9 was projected to be £5.5 billion. I was not given up-to-date figures, but it is clear that the trend is one of substantial year on year increase. The need for affordable expenditure is obvious.

60. It is, of course, possible to think of other ways in which Parliament could have managed expenditure in this field whilst retaining parity of treatment between in-patients and care home residents, but that is not the task of a tribunal. The task is to decide if the discrimination (insofar as care home residents are a valid comparator, which I do not accept) is not manifestly without reasonable foundation.

61. Given the weakness of the similarities between the two groups, the method chosen was justified. It continued a policy that was based on a rational view about the kinds of mobility needs in-patients were likely to have, as a group. Those needs could sensibly be met through the duties placed on the NHS to provide a wide range of care needs and continuing care packages. The evidence produced by Mr Buley shows that the suspension effected reasonable savings for DLA, and there was no reason to think that savings would not continue with PIP. These savings were part of the government's economic policy to control escalating welfare spending and hence to maintain the economic wellbeing of the country. That is a legitimate aim under the ECHR (*R (SG) v Secretary of State for Work and Pensions* [2015] UKSC 16 at [63], per Lord Reed). I cannot see that it was irrational, unreasonable or disproportionate to choose to target funds in this way.

Miscellaneous matters

62. This leaves two further matters that require comment: the UN Convention on the Rights of Persons with Disabilities and the case of *Mathieson v Secretary of State for Work and Pensions* [2015] UKSC 47.

UN Convention on the Rights of Persons with Disabilities

63. Mr Joshi argued that the UK was in breach of its duties under the UN Convention on the Rights of Persons with Disabilities, to which it is signatory.

64. Article 20 of the Convention sets out a party's duty "to take effective measure to ensure personal mobility with the greatest possible independence for persons with disabilities".

65. The measures include:

> (a) facilitating the personal mobility of disabled persons in the manner and at the time of their choice, and at affordable cost;
>
> (b) facilitating access by disabled persons to quality mobility aids, devices, assistive technologies and forms of live assistance and intermediaries, including by making them available at affordable cost;
>
> (c) providing forms of training in mobility skills to disabled persons and specialist staff working with them; and
>
> (d) encouraging producers of mobility aids, devices and assistive technologies to take into account all aspects of mobility for disabled persons.

66. It is argued that suspending the mobility component for the appellant and fellow in-patients is inconsistent with personal choice and with effective measures to ensure their personal mobility with the greatest possible independence.

67. That may be so, but it is notable that, despite the very expansive opening sentence of Article 20, the measures envisaged under Article 20 are cast in vague terms of "facilitating", "providing training/skills", and "encouraging others". Whilst these measures are stated to be inclusive, they fall far short of requiring (or even expecting) expenditure regardless of economic feasibility.

68. It would be possible to argue that *any* state, no matter how generous its public funding, fell short of the vaguely expressed objectives in Article 20. The correct approach must be to consider these vague obligations in light of the provision made overall by the complex systems of funding for the disabled made in our domestic law. This includes a multitude of benefits and provision for the disabled from other forms of public funding, including the NHS, a point made on behalf of the Secretary of State in the witness statement of James Bolton, Head of Strategy for the Disability Benefits, Decisions and Appeals Division of the Department of Work and Pensions.

69. It would not be rational if this considerable funding from the public purse was so inadequate that the UK was in breach of these Convention obligations. But if it is, the tribunal must apply the law as set down by Parliament.

70. In any event, at the end of the day, the UN Convention does not take the appellant's argument any further. Unlike the European Convention on Human Rights, the UN Convention on the Rights of Persons with Disabilities is not incorporated into our domestic law. The tribunal does not have jurisdiction over the Convention.

Bright Line Rules - Mathieson v Secretary of State for Work and Pensions

71. This case was central to the appellant's arguments when the respondent was contesting whether the appellant's status as an in-patient brought Article 14 of the ECHR into play. Once the Secretary of State accepted that status was established, its importance shifted to the Supreme Courts discussion of when "bright line" rules were appropriate when considering the justification of a general rule.

72. The bright line rule in this case suspends payment of the mobility component for long term in-patients but not for publicly funded disabled care home residents or for disabled people living at home. Parliament inevitably makes choices about when individuals will be entitled to a benefit and when they will not, and there may be hard cases that fall on the wrong side of the line. This, however, does not invalidate the general rule provided the rule is beneficial overall: *Mathieson* at [27] per Lord Wilson (approving *R (Animal Defenders International) v Secretary of State for Culture, Media and Sport* [2008] UKHL 15, per Lord Bingham at [33].) His lordship also accepts Lord Hoffmann's observation in *R (Carson) v Secretary of State for Work and Pensions* [2005] UKHL 37 that a line has to be drawn somewhere and "All that is necessary is that it should reflect a difference between the substantial majority of the people on either side of the line" [41].

73. The appellant's argument is that this rule does the opposite because in-patients, and in particular the appellant, have *greater* mobility needs than the disabled living either at home or in a care home.

74. That does not stand up to scrutiny, either as regards the appellant or the class of in-patients as a whole.

75. As regards the appellant, I accept as reliable the evidence of Caroline Skevington, Service Head of Continuing Care, regarding his day to day life. She states that in addition to health care assistants, the appellant has the services of a psychologist, physiotherapist, speech and language therapist, activity staff (who arrange activities for the residents) and an occupational therapist on site. His DOLS advocate visits regularly and the GP with whom he is registered visits him at the institution. A dentist is to visit the appellant at the institution after experience showed the appellant to be unable to cope with treatment off site. His Care/ Risk Plan indicates that he sees a dietician on site and he is taken to a chiropodist regularly. Staff are available to lift him by hoist to his wheelchair and push him when he wants to go out. Indeed, the notes in the Care/Risk plan show that staff accompanied him on a visit to see his mother. He does not have to do food shopping or go to the laundry. He rarely wishes to engage in activities planned for in-patients or to join others in the communal area, so the submission that he would enjoy a trip to the pub or a concert may be over-optimistic.

76. The appellant's activities are consistent with his severe disability and challenging behaviour. His modest transportation needs may be logistically complicated, but I do not see how they can be accepted as greater than those of disabled people living at home or in care home. I can only conclude that the appellant in this appeal has substantially *less* need to travel off site than disabled people living at home or in care homes.

77. It is finally necessary to consider whether drawing the line where regulation 29 did is beneficial overall, or reflects a difference between the substantial majority of the people on either side of the line. It should be apparent from this decision that I consider it more likely than not that in-patients have fewer mobility needs than the asserted comparators and that they are met by other forms of funding.

78. There will always be hard cases where individuals have needs or desires beyond those which can be reasonably met by the provision made by public funding. This would be the case even if the mobility component remained payable to in-patients. I cannot see that the bright line rule is invalidated.