Prescribing welfare benefits advice in primary care: is it a health intervention, and if so, what sort?

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Summary

There is increasing provision of welfare benefits advice in primary care (WBAPC). This reflects the present government’s recognition of the association between socio-economic and health inequalities. However, the assumption that increasing an individual’s income will improve their health is not based on clear evidence. This paper reviews the relevant evidence, using four categories of pathways from poverty to ill-health: individual material; environmental material; individual psychological; environmental psychological. A description is offered of the scope and limits of WBAPC as a health intervention: one that primarily offers relief from psychological stress for service users, who tend to be middle-aged or older and suffering from chronic disease or disability. WBAPC may also make a small contribution to the physical health of individuals and to the social capital of communities. Thus to define the scope of WBAPC does not diminish its value to its beneficiaries, who carry a significant burden of both poverty and illness, nor does it in any way weaken the ethical argument for public policy to seek to reduce inequalities, and for primary care to play its part in that.

Keywords: welfare benefits, primary care, poverty, health promotion

Introduction

Services that offer welfare benefits advice in primary care (WBAPC) have been established for over a decade,1 and there is a good deal of current interest in providing such services. Many schemes already exist,2,3 and 39 per cent of a random sample of 71 Primary Care Groups and Trusts reported some joint working with local authorities in the area of welfare benefits.4

There are two sorts of rationale for situating such advice services in primary care. First, health professionals concerned about the socio-economic problems of their patients will welcome arrangements that make it easier for them to refer patients to relevant and accessible help. Second, the alleviation of individual poverty by WBAPC can be seen in itself as a health intervention (‘prescribing citizens advice’),5 whether as treatment or health promotion. This rationale, where it exists, is usually implicit, although it has been made explicit in a number of attempts to detect the health impact of such services,5–7 and in the readiness of health-related organizations to fund such schemes (Health Action Zones, Primary Care Groups and Trusts).5–8

The present government has acknowledged the damaging effects of poverty on health at a population level,9,10 and this perception is shared across much of the National Health Service: for example, many Health Improvement Programmes include sections on the socio-economic determinants of health.11 The government has implemented policies to address the challenge of poverty in general (changes in the welfare benefits system, the setting up of the Social Exclusion Unit, Education Action Zones, neighbourhood renewal initiatives, etc.), and its association with poor health in particular (Sure Start, to support deprived families with young children, and Health Action Zones in deprived communities).

If poverty affects the health of populations, then it seems to follow that increasing the income of badly-off individuals should improve their health. However, the causal pathways that link socio-economic status (SES) and health at both population and individual levels are very complex. The literature shows that different aspects of poverty affect different people in different ways at different times. For this reason, it is in fact far from clear just how we should expect increased individual income to improve individual health.

This paper sets out to define WBAPC’s potential as a health intervention. It describes four types of pathway from poverty to health, and uses those as a framework for exploring the contribution to each that WBAPC can reasonably be expected to make.

In selecting from the vast literature on poverty and health, I have focused on evidence that relates to the potential of WBAPC to make a difference to health. There are thus significant exclusions. For example, many studies have found an association between better health and higher levels of education.12,13 However, as WBAPC is unlikely to affect educational levels for...
most of its users, this aspect of the poverty–health relationship is excluded from this discussion. Similarly, the absence of a full discussion of macro-economic policy and its influence on health should be understood in this pragmatic light: although WBAPC may be the agent of macro-economic changes such as welfare benefits policies, it is not itself such a change. Furthermore, WBAPC will generally make only a limited impact on the cumulative effects on health of an individual’s whole life-course, which are therefore not discussed here.

The pathway from ill-health to poverty

Before setting out and using the framework of pathways from poverty to ill-health, it is necessary to consider briefly the reverse hypothesis, i.e. that it is ill-health that causes poverty.

Self-evidently, this hypothesis has some truth in it: disability or major illness is likely to reduce the ability of individuals thus afflicted to earn money. There are many individual cases where financial hardship is the result of an illness-related inability to work, and this is certainly the case among clients who use WBAPC services, among whom claims for illness- or disability-related benefits are common. Blane points out that failing health in later life in the working class is likely to be a significant form of health-related downward mobility. However, research suggests that, in aggregate, such cases make only a limited contribution to the total burden of ill-health. Poverty created by ill-health is likely in its turn to have a further impact on health, in the same way as poverty arising from other causes: the potential for such impact is the subject of the rest of this paper. Where ill-health causes poverty, and not the other way round, WBAPC cannot logically be classified as a health intervention, because it tackles only that part of the burden of poverty that results from ill-health, not the ill-health itself. This is not to underestimate the significant role of WBAPC in relieving financial distress caused by illness.

Pathways from poverty to ill-health

Four types of pathway from poverty to ill-health are identified here, arranged in two pairs (see Figure). The first pair includes the impact of material factors on health, working first at individual level, and second at the level of the physical environment. The second pair includes the impact of psychological factors on health, first at individual level, and second, at the level of the social environment.

**Individual material factors**

These include:

1. the effects on health when basic physical needs are not met (malnutrition, lack of protection against climate, etc.);
2. the effects on health throughout life when the basic physical needs of an individual’s mother before and/or during pregnancy were not met;
3. the effect of an individual’s health-damaging behaviour such as smoking, lack of exercise or an unbalanced diet. Such behaviours are more prevalent among groups with lower socio-economic status.

Self-evidently, the inability to feed, clothe and shelter oneself is certain to reduce one’s chances of good health. In the developed world, such an inability is sufficiently unusual that it cannot be used to explain the burden of ill-health, most of which is now experienced by those with above-subsistence incomes. However, it must not be assumed that only the destitute are unable to provide adequately for themselves: Stitt and Grant and Morris et al. calculated a minimum cost of living that was higher than some existing levels of welfare benefits. Whether or not welfare benefits are adequate, it is clear that helping all deprived individuals to maximize their income by taking up benefits to which they are entitled is a crucial way of protecting them from the negative effects on health of inadequate food, clothing and shelter.

Individual poverty may directly cause individual ill health in other ways. For example, research has shown how inadequate housing may directly affect health. Increased income may enable individuals to afford more domestic heating, which may reduce respiratory symptoms in those living in previously damp housing. The purchase of aids and adaptations may make daily life less arduous for those with disabilities or chronic conditions, reducing stress and depression, and allowing more participation in social networks.

However, there are significant limitations in how income increases can be expected to have an impact on individual physical health. Many diseases and disabilities develop slowly over time, and many causal factors, psychological, biological and social, influence health only slowly. The effect of childhood circumstances on health can be lifelong, however modified by subsequent factors and influences; early unemployment has long-term health effects on men; most environmental hazards take effect slowly. An income increase cannot quickly reverse or modify such processes. For these reasons, one might expect WBAPC to relieve psychological rather than physical morbidity, at least in the short term (see below), although advice given to younger clients, or the parents of children, is more likely to have a preventive effect over time.

Some health care professionals fear that WBAPC might encourage health-damaging behaviours by providing individuals with more resources to fund these, although there are examples of smoking reduction or cessation as a result of WBAPC.
Environmental material factors

These include:

1. the effect on health of environmental features such as pollution, dangerous work environments, traffic accident black spots;
2. the effect on health of the absence or inadequacy of services that support health. Self-evidently, unequal access to health care will reduce opportunities for the reduction or cure of diseases and symptoms.33

Clearly, WBAPC will not reduce pollution, traffic accidents, occupational health hazards, etc. However, it may have a role in enhancing access to services. It is in itself an attempt to improve access to advice services. Service users appear to find it easier to access the service in a setting that is familiar, unstigmatizing and nearer to home;32,34,35 premises may be better than those of High Street services.36 Appointment systems are judged to be more efficient and waiting times shorter.32,35 Service users have reported various barriers to using High Street services: geographical distance, especially in rural areas, lack of clarity about how to access the service, long waiting times, and lack of continuity in advisers.37 One service in primary care reports that two out of three of its users would not have sought help in High Street services.38 To make WBAPC available to people not currently in contact with primary health care, some schemes use mailshots to offer welfare benefits checks to patients registered at the practices.8

Beneficiaries of WBAPC may also have enhanced access to other services affecting health. For example, WBAPC clients in one study31 said that they had used their increased income to pay for transport, home maintenance, incontinence products and/or extra laundry.

Individual psychological factors

Unemployment and work insecurity are both bad for health.39,40 and worry about money can affect psychological well-being.31,42 Weich and Lewis43 found that self-reported financial strain was strongly associated with both the onset and the maintenance of episodes of mental illness. Financial strain makes people more vulnerable to psychological stress after major life changes,44 and mortgage indebtedness increased men’s visits to general practitioners (GPs).45

However, such worries do not affect psychological health alone. Chronic stress has physiological effects associated with lower SES.46,47 For example, the Whitehall study has shown that less control over one’s job in civil servants of lower ranks is associated with lower physical health status.48 Such stress typically causes physiological damage over long periods of time:49 the chronic, persistent, inescapable dissonance between what a person would like to do or become and what seems accomplishable triggers biological signals that are antecedent of chronic disease development. The disease becomes clinically manifest only after decades of persistent signals. The biological signals are probably subtle, but steady and long-term.9

Impairments to health may be made worse where health-damaging behaviours such as smoking are adopted as a means of dealing with stress.50

WBAPC is a potential means of relieving the psychological effects of money-related worry. For younger beneficiaries of WBAPC, freedom from financial worry may also contribute to the long-term reduction of physical ill-health related to such worry. For older clients, income increase is more likely to be a way of reducing current financial strain and improving current quality of life than of preventing future morbidity and mortality. Blaxter41 showed that, although most inequalities in physical health decrease after 60, those in psychosocial health increase. The promotion of psychosocial health among older people may therefore have a small part to play in the reduction of health inequalities.

Environmental psychological factors

Three distinct arguments, often linked and sometimes confused, need to be distinguished here. First, the experience of living in a hierarchy is taken to have an impact on health. Wilkinson46 argues that ‘the psychosocial effects of social position account for the larger part of health inequalities’, and draws analogies between hierarchical arrangements in communities of primates and of humans.51 The gradient of improving health as one ascends the elaborate hierarchy of the Civil Service is also used to support this argument.

Second, Wilkinson argues that it is social inequalities, rather than social conditions themselves, that cause ill health. Health status, he argues, is lower in societies or parts of societies where social inequalities between population groups are more extreme.48 He points out that general levels of health are better in Scandinavian states, where social attitudes and welfare programmes result in reduced social and economic inequalities compared with Britain or the United States. (However, health inequalities persist in Scandinavia.52,53)

Third, Wilkinson46 and others55,56 argue that the psychosocial effects on health of social position can be reduced by the protective effects of high levels of social capital: communities where there are high levels of trust, of participation in civic life, and of social support are healthier than those where levels are low, although it is unclear which elements of social capital affect health the most.57

The literature that has resulted from Wilkinson’s work has shown that the relationships between socio-economic inequalities and health are very complex.58–63 We do not know which geographical or social units are the point of impact of SES inequalities on health.64,65 is it inequality or low status within the peer group, the work place, the neighbourhood, the town or county, the region, the nation? Furthermore, little work has been done to investigate individual perceptions of inequality and how these affect individual health.66

The role of WBAPC in reducing inequalities and improving the social capital of whole communities is likely to be small, focused as it is on individuals. It is possible that the conse-
quencies of increased income help to build social capital, for example, if new income is spent on social activities such as has been reported by Abbott and Hobby.31 The manager of the service examined in that study pointed out (unpublished data) that her scheme had raised £600,000 for the local economy, a contribution that was regarded by the regeneration partnership that funded the scheme as the equivalent of six additional full-time jobs in the local community.

Discussion

WBAPC as a health intervention is most likely to improve the psychological status of its beneficiaries. There is some potential for longer-term impacts on individual physical health and on the social and material circumstances of the community in which individuals live. However, the longer-term effects on individual health would operate most powerfully on younger clients, whereas in reality service users tend to be older.5

The importance of WBAPC to individuals should not be underestimated. Those using the service may be suffering considerable health disadvantage; in one study,31 service users had an average age of 57, and reported high levels of chronic morbidity: half or more reported each of three conditions (arthritis, physical disability or sensory impairment), and half reported that arthritis or physical disability had worsened during the study. These high morbidity levels were confirmed by SF-36 scores. Improvements in the psychosocial aspects of life are likely to be of considerable importance to individuals enduring chronic co-morbidity.

The value of siting such services in primary care needs some discussion. There is no reason to suppose that service users would experience fewer benefits to SES and health if they used services in other settings. Partly, the choice of setting reflects changes in funding; local authorities have been disinvesting in welfare advice services and in grants to voluntary organizations such as Citizens Advice Bureaux, and Health Authorities, Primary Care Groups and Trusts and Health Action Zones have been prepared to take over funding.

Primary care locations also appear to add value to such services, not only saving the primary care health team time,34,36,67 but reaching people with particular needs (e.g. older people,31,32 people with depression37 or those with complex problems68). Collaboration between NHS and advice staff facilitates case-finding.34,35,69

Many health professionals are glad to be able to refer their patients to relevant non-medical services with easy access.2,70 Those who believe in a biopsychosocial model of primary health care will welcome the bringing together of diverse services. Evidence suggests, however, that such GPs are a minority,71 and indeed some GPs explicitly oppose the idea that they have a major responsibility to improve access to such services in this way.72

Belief in the health impact of such schemes is therefore based on anecdote rather than evidence. It has proved challenging to measure clear improvements in health attributable to WBAPC. Veitch5 showed a range of improvements in health, although these lacked statistical significance. Abbott and Hobby31 measured statistically significant improvements in psychosocial health in WBAPC clients whose income increased. Other studies7,32 had less encouraging results. Small improvements in individual health may not be apparent to primary health care staff, as the instruments used in these studies (the Nottingham Health Profile,3 SF-366 and the Hospital Anxiety and Depression Scale35) are not used routinely in primary care. Nor is WBAPC likely to reduce noticeably the work-load of primary care significantly. One study of a general advice/signposting service in primary care for deprived patients did find that visits to the GP by the service’s users reduced by two a year,73 but it is unlikely that GPs would notice such reductions in use by a small number of patients.

However, having access to such services may help to improve the overall quality of health care. Abbott and Davidson73 found that prescribing patterns changed for patients who had been referred to a general advice/signposting service based in the same health centre. The number of prescriptions for drugs new to the patient significantly decreased, whereas the number of repeat prescriptions increased. This suggests that once social and medical problems had been disentangled and dealt with separately, GPs found it easier to prescribe appropriately and patients to comply with drug regimes.

In short, there is evidence to support the proposition that WBAPC is a limited but none the less valuable component of health care for deprived patients. It should not be forgotten, either, that, in addition to any argument from evidence, there is also a strong ethical argument that gross income inequalities are in themselves unacceptable, regardless of their health consequences; that public policy should aim to reduce them; and that health services have a contribution to make to the implementation of that policy.

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