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**[Doctors are key to welfare reform.](#)**

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## Care not cuts: NHS key to healthy welfare reform

Clare Bamba

Professor of Public Health Policy

Wolfson Research Institute

Durham University

clare.bamba@durham.ac.uk

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## Care not cuts: NHS key to healthy welfare reform

The Comprehensive Spending Review (CSR) has set out plans for unprecedented public sector funding cuts. There has been a particular focus on cutting the Department of Work and Pensions budget and the £192 billion paid out annually in welfare benefits. Most attention has been paid to incapacity related benefits (Incapacity Benefit, Disability Living Allowance, and Employment Support Allowance) which account for £12.5 billion of the welfare bill. The Coalition government intends to move the current 2.6 million incapacity benefit (IB) recipients onto lower paying benefits (such as Job Seekers Allowance – JSA, or Employment Support Allowance - ESA). This will be done by using private sector agencies, such as A4E, to reassess the health and fitness of all recipients over the next four years. Those deemed ‘fit for work’ will be immediately transferred onto the lower paying JSA (see Box), those deemed to be too ‘incapacitated’ for work will be placed on the ESA with a ‘support’ premium and with no conditionality, whilst those considered ‘sick but able to work’ will be placed on ESA with a ‘work-related activity’ premium. Failure to engage in compulsory ‘work-related activity’ would result in a loss of this premium and placement on the ESA basic rate. The reforms announced in the CSR mean that this latter group will now also see their entitlement to ESA limited to one year. After a year they will have no right to benefits (not even JSA) and will therefore become reliant on family support, charities or means-tested assistance (Income Support). Of the 1.5 million IB claimants currently being reassessed, it is expected that more than half will be placed into this group.

Clearly these reforms have significant implications for IB patients, and potentially for their relationship with GPs and other health care providers. On the one hand, the increase in surveillance, the uncertainty about benefit entitlement, and the stigma attached to being marked out by politicians and the press as “*welfare scroungers*” may well have negative effects on recipients’ self-esteem and mental wellbeing. Further, the income reductions that they will experience (see Box), is also likely to have a detrimental impact on their health and wellbeing. Further, IB recipients may be less willing to access their GPs and other health professionals as they may begin to perceive them as instruments of this renewed state surveillance. IB patients often have complex and multiple chronic health conditions and they have been out of the labour market and dependent on low value state benefits for

a long time. They did not benefit from the economic boom but the Coalition government seems determined that they will bare the brunt of the bust.

<b>Weekly Benefit Rates 2010</b>
£115 UK Poverty Line
£91.40 Incapacity Benefit
£91.40 Employment and Support Allowance (work related activity premium)
£96.85 Employment and Support Allowance (support premium)
£65.45 Employment and Support Allowance (basic)
£65.45 Job Seekers Allowance
£65.45 Income Support
Sources: Department of Work and Pensions 2010; The Poverty Site 2010.

Such welfare reforms may cut central government costs but they are highly unlikely to be health promoting and they are also unlikely to actually be effective in terms of getting people back into work. In our recession economy, there are few job suitable vacancies (even if recipients “*get on the bus*” as Iain Duncan-Smith suggests), and those that do exist are more likely to be filled by the newly unemployed than the long-term sick. In addition, the welfare reforms are clearly not based on evidence of ‘what works’ but on an ideological desire to shrink the state, combined with the view that those in receipt of IB related benefits are work shy rather than chronically ill. This is in contrast to the research evidence which shows that people in receipt of IB related benefits have multiple and complicated long term illnesses and that the vast majority (up to 95% in a recent study of IB recipients in Easington, County Durham) cite ill health as their biggest barrier to gaining employment. GPs and other primary health care providers therefore hold the key to reducing IB receipt by tackling the root cause: ill health. If welfare reform is actually about getting people into work (rather than just cutting

expenditure, shrinking the state and stigmatising the poor) then improving health is the most important first step in this process.

However, in all of the Coalition's talk of welfare reform, there has been very little mention of illness or of the potential role of health professionals in the process of return to work. In contrast, the research evidence suggests that a 'health first' approach to welfare reform is the most effective. In 2009, the National Institute for Health and Clinical Excellence (NICE) released evidence based guidance on managing long-term sickness absence and incapacity for work. It recommended that integrated programmes, which combine traditional vocational training approaches, financial support, and health support on an ongoing case management basis, should be commissioned to help IB recipients enter or return to work. NICE considers these integrated approaches to be the most effective way of enhancing the employment of people in long term receipt of IB.

This approach is being piloted by County Durham and Darlington PCT who have commissioned SALUS (NHS Lanarkshire) to provide a 'health first' case management approach for long-term IB recipients (3 years or more). This pilot programme uses telephone and face to face case management programmes to identify individual health needs and any other related barriers to employment (such as debt or housing). The scheme is intended to complement mainstream services with case-managers signposting the patients to NHS, DWP and other health and welfare services. Patients are referred onto the programme by other NHS services (such as the Alcohol Service), their GPs, or they can self-refer. The pilot is being evaluated by a multi-disciplinary team of researchers based at the Wolfson Research Institute, Durham University.

Clearly abandoning millions of people in deprived communities to a life on benefits is not desirable, but for welfare reform to be effective it needs to be considered outside the ideological box of expenditure cuts, and to be actively based on the available research evidence. This clearly shows that the health care sector, particularly GPs and case management techniques, holds the key to successful social inclusion and a healthy return to work. This is something that could be taken on board by those running the new Public Health Service, and involving GPs in welfare services could form part of the new system of GP commissioning: Care not cuts.