Tackling the Failures of the Welfare State –
“Thinking the Do-able”
A Paper For Policy Makers

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Foreword: Eddie Barnes
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1. Foreword

The failings of Britain's benefits system have been well documented and nowadays are the subject of broad political consensus. Less well covered, and more controversial, however, are the attempts to try and fix it. This paper proposes a new solution.

I first became interested in the problems with Britain's Welfare State after reading articles on the dependency trap by John Bird, the founder of the Big Issue magazine. Living in Glasgow, where one in seven people of working age are deemed too ill to work, I did not have to go far to see matters for myself. When I first visited a welfare-to-work scheme in the east end of the city, I was amazed at the lengths they were going to. Advisers from the company running the scheme were taking shopping trolleys around the high rises, promising claimants free groceries if they came in for an appointment. Those claimants were then being taken for free meals to Chinese Restaurants in town, to get a sense of life outside their estate. Just getting incapacity benefit claimants to partake in their programme took a huge effort, never mind finding them a job.

But there could be little arguing with it all. The advisers spoke of how, corroded by unemployment, the area had become crushed by low self-esteem, a lack of confidence, and a sense of fatalism. “It's like there's a moat around here,” said one, of the isolation people felt. Breaking through that sense of despair was the most difficult thing of all - hence the extraordinary efforts.

That most difficult task is where this paper comes in. How do you get people stuck on sickness benefit back to the work place? This paper does not consider the question of disincentives within the benefits system. Rather it examines how the State can improve and better co-ordinate its many arms to meet the needs of benefit claimants and of working age people in general. And it suggests a way of doing it which is achievable and affordable.

The paper is based on the underlying belief that the system at present does not adequately respond to the complex needs of individuals. Workless people present with a cocktail of social, medical and psychological problems. But, working in silos, the NHS, education and social services, and the benefits system do not grasp this. That failure compounds ill health, causes needless expense for the public purse, and locks in welfare dependency.
Breaking through that sense of despair is the most difficult thing of all, but when it is successful, it is genuinely inspiring. One such organization which does this on a daily basis is Salus, part of NHS Lanarkshire. Case managers take on people out of work and, using newly honed techniques, attempt to understand their full needs, so as to guide them on the path back to the job market. At its most fundamental, Salus strives to hand people control over their lives at the moment when they feel they have none. Forty percent of clients either return to work or end up in education. This is the personalized, empowering State at its best.

This paper has grown out of that work, and from related research by Glasgow University’s Healthy Working Lives Group. Having witnessed the results from Salus, it takes the results from Salus to their logical conclusion – showing how a de-medicalised, person-centred Welfare State will turn lives around. And it suggests a way of doing it which is achievable and affordable.

This paper proposes a way to unlock the cycle. At its core is a proposal to create a unifying purpose for the entire public sector – to define and improve the functional capacity of each individual. It argues that there should be an obligation on the NHS and all public servants to screen for the full needs of the people they deal with, so they are able to signpost them properly towards the services they require, i.e., become proactive rather than reactive. To do this, the paper will propose wider use of the case management approach and of the bio-psychosocial model of health. It promotes this model as the best way to root out the obstacles which prevent people from developing their potential and getting back to work and progressing in their lives. It argues that this both works and saves money.

Frank Field, the Labour MP now advising the Coalition Government, has declared that he is no longer “thinking the unthinkable”, so much as “thinking the do-able”. A better description of this work would be hard to find.

Eddie Barnes, Political Editor, The Scotsman

2. Introduction

• The United Kingdom is facing an unprecedented situation in terms of public debt. The public purse can no longer afford to meet the financial burden of the current provision of services.

• Ill health is one of the biggest costs of all. Dame Carol Black’s Review of the Health of the Working Age Population – Working for a Healthier Tomorrow estimated that ill-health is costing the British economy £100 billion per year.

• Ill-health is often self-reinforcing. Unable to work, peoples’ health declines further; those not in work and on benefits have significantly poorer health and higher mortality than those in a job.

• The Centre for Policy Research has identified perceptions of the ‘benefits trap’ as a reason why some benefits claimants are unwilling to return to work

• Worklessness is now the principal cause of health inequalities and social exclusion in this country.

• This paper contends that much of this need not happen, and amounts to a massive waste of human, social and financial capital.
The current situation can be summarised as follows:

- 20% of school leavers have poor literacy and vocational potential
- In the UK 2.6 million people of working age are apparently unfit to work. (A higher proportion than in any other developed country.)
- The majority of the working age people do not have access to competent advice on vocational rehabilitation, or workplace health
- Most people's work-related ill-health is largely ignored
- Once out of work, the NHS does not consider returning people to employment or to maximum function as a priority
- While 2.5% of workers in Scotland leave the workplace each year through ill health, many of these are in their 40’s and 50’s and for many of these, they are not actually sick. The following figures show the percentage of patients with medically unexplained symptoms:
  - GP attendances 30–50%
  - Gastroenterology outpatients 73%
  - Neurology OP for headaches 63%
  - Orthopaedics OP-for Back pain 69%
  - Gynaecology for pelvic pain 25%
  - Cardiology 32%

Demand for services is now certain to grow. The fastest population increase has been in the number of people aged 85. It more than doubled between 1983 and 2008 (600,000 to 1.3 million) and is expected to reach 3.2 million by 2033. But putting ever more resources into this system is neither desirable nor viable.

3. The capacity to function

- Dame Carol Black's review clearly demonstrated that there is the need for urgent action to improve the functional capacity of the working age population.
- Existing services tend to be delivered from silos, delivering only what they know how to deliver. There is a need for a paradigm shift to one where the focus across the public sector is more integrated. The focus would not be just on the individual's medical condition, or their housing problem, or their educational needs, or on a population based health promotion programme, but would be to ensure that individuals are routinely screened for their individual needs, and can then be signposted onwards.
- Any public sector intervention should have as its fundamental purpose that of improving an individual's capacity or potential capacity to function
4. What is functional capacity and how do we measure it?

- The functional capacity of an individual is defined as their ability to manage their lives physically, mentally, socially, vocationally, and spiritually. It is the ability of an individual to do as much as possible, for as long as possible, or as long as they want, in both their working and non-working life.

- Functional capacity is measurable. The key components on which an individuals’ functional capacity depend are as follows:
  - **Educational attainment** – the illiterate are poor and unhealthy and PhD’s live the longest.
  - **Effective rehabilitation** when ill or injured. This does not happen in the NHS where the focus is on treatment of the condition. (We will know this has been solved when professional footballers and athletes rely on the NHS to speedily regain optimal function after injury).
  - **Access to healthy lifestyle advice** which is tailored to the individual rather than just driven by central diktat.
  - **Safe and healthy workplaces and communities.**
  - **Ready access to employability advice** and modification of work for those who are struggling in work as well as those on benefit.

5. Progress to date

There are a number of examples of good initiatives being delivered throughout Scotland and the United Kingdom however, as a nation there is piecemeal delivery.

- The Health, Work and Wellbeing initiatives are improving focus on this area. The Healthy Working Lives Service in Scotland provides free health and safety, occupational health and health promotion advice to both employees and employers, thus improving access.

- The Fit for Work pilots will support people with health conditions or impairment to enter or remain in employment.

- The introduction of the GP ‘Fit Note’ as opposed to ‘Sick Note’ will increase focus on what an individual is fit to do, and on return to work.

However, overall there is piecemeal and uncoordinated delivery.

6. What needs to be done?

As we have argued, the nation simply cannot afford to continue to deliver public services in their current costly form. We have also argued that this approach is not improving the UK’s record on ill health. Instead, we argue that we require services which focus on the needs of the individual.

Experience from programmes in Scotland and elsewhere demonstrates that in many cases, workless individuals with ill-health do not require access to specialised care and expensive treatments. They require a competent case manager who can provide appropriate support and coordinate interventions. Recent research has shown that this can be effectively delivered by telephone, at very little cost. Most of the services clients require are already there. This approach could easily be extended to needs other than health.
So a system has to be created that ensures that every individual who requires help receives a systematic assessment of his/her holistic needs to help boost their functional capacity.

7. Conclusions and Recommendations

• Much health care usage masks bio-psychosocial problems which the medical model of care fails to identify or deal with.

• Experience from Equally Well and other initiatives is that the numerous service providers in the public sector are not comfortable asking a client about potential needs which are outwith their area of expertise.

• Much of health service activity needs to be de-medicalised in view of the high percentage of medically unexplained conditions as described above, with greater use of case managers. Individuals with these problems often are repeat attendees in primary and secondary care. Experience of rehabilitating long term IB recipients has shown that in a population of 5,500 receiving case or condition management biopsychosocial, de-medicalised interventions (in NHS Lanarkshire) only 3% needed to see a doctor. The most effective condition management programmes in Pathways to Work (eg: Salus, NHS Lanarkshire) return 30% of clients to work and 10% into education without any “medical” health intervention.

• This can be achieved at minimal cost, with average case managed interventions costing £200 – £500 per client.

It is recommended that:

• Every Individual should have a Functional Capacity or “Wellbeing” Account with access to assessment and advice, similar in concept to the Personal Development Plans available to those in large organisations. Functional Capacity or “Wellbeing” Accounts should be much broader in scope and should assess the five domains of Functional Capacity. The aim would be to facilitate and signpost to the numerous support services already available to improve health and wellbeing, skills and competencies.

• The competence and confidence of the professionals who interact with individuals needs to be developed through further training so that they understand how to assess functional capacity, and the process of sign-posting to holistic care

• Every individual should be able to assess their functional capacity regularly by simple questionnaire, and know how to access support to improve it. This tool should also be used by those working in all parts of the public sector which interact with the individual. (A research based simple questionnaire has been developed at the University of Glasgow)

• Recurrent attendees in the NHS should routinely be referred to a case manager as part of their care plan. This can be delivered by telephone at low cost.

• The case management approach, using cognitive behavioural techniques can better move on those with chronic health problems. This approach will reduce the major cause of inequalities-worklessness.
8. What would this mean for the individual?

- They would not leave the educational system till they have achieved their potential in basic literacy and numeracy and have some occupational competence.

- All of working age would participate in a life long learning programme, either through their employers programmes for continuing personal/professional development, or if unemployed / self employed would require to have a life long learning appraisal and action plan supported by the state to ensure continuing skill development

- When ill or injured the objective of therapy would be a restoration of maximal function including return to work.

- Every individual would have access to lifestyle risk factor assessment and health improvement advice.

- The ageing worker would have access to programmes to enhance and maintain their fitness, capacity for work and independence. They would receive pro-active employment advice to diminish the likelihood of falling out of employment in their late 40’s and 50’s and would be able to maintain functional independence for longer

- They would have a personal functional capacity (or “Wellbeing”) account, or passport, with regular self assessment of their functional capacity by questionnaire, and systematic access to telephone based case management

9. What would it mean for the NHS?

- All patients and clients of the NHS would have return to maximal function, including work if possible, as part of their care plan.

- There would be a redesign of low cost rehabilitative services.

- Those with well managed chronic conditions, and those with medically unexplained symptoms/ repeat attendees would routinely be referred to a case manager skilled in the bio-psychosocial model of care.

- There would be a reduction in drug costs and inappropriate medical referrals and investigations, with reduction in the growth rate of health care budgets.

- The NHS would focus on functional capacity as well as disease management and re-orientate more to the bio-psychosocial model of care.
10. What would it mean for employers?

• Sickness absence rates will be reduced across the UK.

• Employees would return to work sooner and health care professionals would have an objective to work towards that end.

• Employers would be more flexible about modifying work, providing phased return to work, and accommodating the needs of the ageing worker, and retaining skills. This should be selectively supported by the state on a spend to save basis.

• Employees would be fitter and better trained.

• There would be improved health and safety at work with increased support to employers and employees; eg the Healthy Working Lives service in Scotland and equivalent services in Wales and England. Through these employers would be supported to prevent work-related ill health arising and recognise the benefits of supporting workers to return to work.

11. What would this mean for the country?

• The public sector would have a common purpose: to enhance and maintain the functional capacity of our citizens.

• There would be an integrated approach to dealing with the needs of the individual.

• A greater proportion of the working age population able to enter into sustained employment.

• Increased productivity and economic competitiveness.

• Reduction in healthcare and welfare benefit costs.

• Reduction in health and social inequalities.

• A healthier population.

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