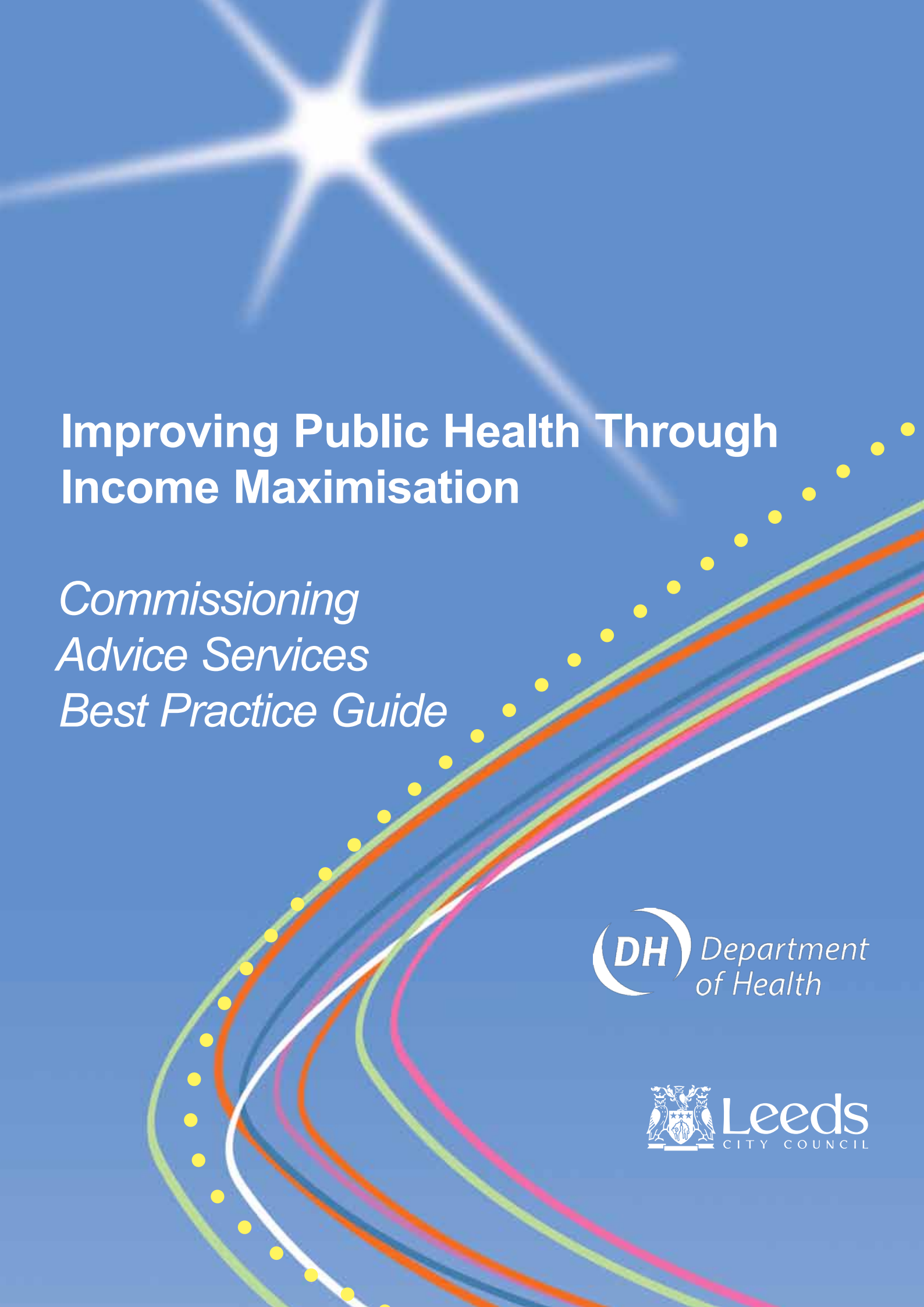
Improving Public Health Through Income Maximisation

Commissioning Advice Services Best Practice Guide



Report of research undertaken by Leeds City Council, Financial Inclusion Team.
Commissioned by Department of Health's Regional Public Health and Social Care Group.

April 2011

Foreword

When this piece of research was commissioned we could not possibly have known how relevant it would be by its date of publication. During the course of this work, a great deal has changed in the realm of public health provision in England. A new government took over in May last year and, with the publication of the Health White Paper in July 2010, announced the abolition of Primary Care Trusts and Strategic Health Authorities. In November 2010 the government published its Public Health White Paper.

Central to the proposals is the return of public health leadership to local government, so that local government and local communities will be at the heart of improving health and wellbeing for their populations and tackling inequalities.

There will be a statutory health and wellbeing board where local public services are able to come together to agree local priorities for commissioning within Health and Wellbeing Plans in response to the priorities set through Joint Strategic Needs Assessments. Partners, including local authorities and the new GP consortia will be expected to commission services in line with those priorities.

For a long time, commentators and professionals have understood and voiced opinion about the clear linkage between increasing the income of those on benefits by the provision of specialist advice services and the health and well-being of those individuals and families. Indeed, the Government's Chief Medical Officer, in his Annual Report published in March 2010, acknowledged the importance of investments in this area of work.

This report pulls together the key evidence to support the need for advice services as an important facility to assist with improving the health of the members of our community who suffer from multiple disadvantage. The Marmot review made clear that if we are to significantly improve the health of those citizens living in more deprived communities, then as a society we must do something to address the inequalities in income which affects our society's ability to deliver health benefits to those in greatest need.

It is one thing to agree the need for appropriate advice provision in helping to address health inequalities but how do authorities go about ensuring that this is provided? The main purpose of this project was to investigate and recommend how commissioning authorities can best address the complex issues faced when looking to secure appropriate services in their area. The research team endeavoured to obtain details of best practice across the whole of the region. In doing so they were able to come up with clear recommendations of methods which could be adopted irrespective of whether the services are being commissioned by a single organisation or a group of organisations acting in partnership.

This piece of work illustrates the linkages between advice provision, income and health; it gives reasoned justification as to why there is a need for this kind of service provision; it looks at the current up-to-date proposals for the changing health delivery systems in this country; it offers a clear route to commissioning organisations to plan and work out how services are delivered. We hope it can be a valuable tool in the armoury of commissioning authorities. What is needed now is for a clear commitment to delivering advice services as a means of improving health. We hope that any new bodies which are established to deliver public health will take on board the information and recommendations in this report and, in so doing, assist in delivering better health outcomes for those in our society who need it most.

Professor Paul Johnstone
Regional Director of Public Health

Councillor Keith Wakefield
Leader Leeds City Council

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Appendices

Attached to this report is Appendix 1 which details all the reference material which has been reviewed as part of this research project. All other appendices can be accessed via Leeds City Council website at www.leeds.gov.uk/fi

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Glossary

BME – Black and Minority Ethnic group

CAB – Citizen Advice Bureau

CLAC – Community Legal Advice Centre

CLAN – Community Legal Advice Network

CLAS – Community Legal Advice Service, brings together individual organisations which deliver core social welfare law services in the form of a CLAC or a CLAN.

CLS – Community Legal Service. A network of LSC funded organisations and advice providers that fund, provide and promote civil legal aid services

CLSP – Community Legal Service Partnership, involve a network of providers, funders and user groups that meet to encourage joined up working.

DH – Department of Health

FIF – Financial Inclusion Fund, currently supports debt advice provision

GP – General Practitioner

IPC – Institute of Public Care

JSNA – Joint Strategic Needs Assessment

LGA – Local Government Association

LSC – Legal Service Commission

LSP - Local Strategic Partnerships

LSRC - Legal Services Research Centre

NHS – National Health Service

NI – National Indicator, performance against each of the 198 indicators are currently reported for every single tier and county council Local Strategic Partnership

PBC – Practice Based Commissioners usually comprise GPs, but can also include other primary care professionals such as nurses, pharmacists etc.

PCT – Primary Care Trust, the NHS body currently responsible for commissioning healthcare services and, in most cases, providing community-based services
SHA – Strategic Health Authorities, the 10 public bodies which currently oversee commissioning and provision of NHS services at a regional level.

VCO – Voluntary and Community Organisation

Improving Public Health Through Income Maximisation

The Case For Action - Summary Headlines

- Number of clients in receipt of money advice who believed the advice was linked to improvement in their health - **41%**

  (Dayson et al, 2009)

- Number of clients who reported a reduction in stress in response to the advice received - **67%**

  (Dayson et al, 2009)

- Those stating that their health had been affected to some extent as a result of their money worries - **91%**

  (Ministry of Justice Research Series, 2007)

- As a consequence of receiving help and money advice, clients described improvements in their health, in their cancer condition, and potential remission. They felt better; were less anxious, less stressed and less worried about money.

  (Macmillan Cancer Support, 2010)

- Over a three and a half-year research period, it was estimated that the cost of civil justice problems to individuals, health and public services was at least **£13 billion**.

  (Causes of Action: Pleasance et al Legal Services Research Centre 2006)

- During the 12 months up to April 2010 the number of enquiries made to Citizens Advice Bureaux for debt advice increased by **23%** and the increase for welfare benefits advice was **21%.** There were over **2 million** enquiries for debt advice and a similar number seeking benefits advice.

  (Citizens Advice annual advice statistics 2009/10)

- Low income and debt are associated with higher rates of mental illness. The costs associated with face to face debt advice over five years is estimated at £250 million. With this investment, associated **savings** are estimated at around **£300 million** for productivity gains, on legal costs and the NHS.

  (Department of Health, February 2011)

- People with mental health problems are more likely to get into problematic debt. Rates of debt in people with no mental health problems are **8%**. The rates for those with depression and anxiety are **24%**, and for those with psychosis **33%**.

  (Department of Health, February 2011)

Note – Full references appear in Appendix 1

Executive Summary

This report recommends a best practice model for commissioning money advice services. This model will enable local partners to develop advice strategies that can be easily and efficiently adapted to achieve a maximisation of income of their clients, ensuring value for money invested in advice, with the purpose of delivering improvements to health.

Likely implications of Government reforms are acknowledged. There is an overview of all the processes and influence upon current advice strategies, funding and commissioning. The model being proposed takes into account influence and changes following the implementation of any proposals which emanate from the 2010 Health White Paper – Liberating the NHS; the Public Health White Paper – Healthy Lives, Healthy People; the Reform to Legal Aid and Universal Credit – Welfare that Works.

The report highlights the case for action. It draws upon primary and secondary research to evidence the links between money advice and improving health outcomes. A literature review of all available reports and journals was compiled, and evidence gathered on the linkages between inequalities and health and in particular health improvement related to advice provision.

The primary research for this project involved surveys being sent to all local authorities and PCTs in Yorkshire and the Humber to establish how advice services are currently commissioned. Site visits were attended for further exploration of two different commissioning models.

In addition to supporting the view that advice services positively impact health, the surveys explored the ways in which advice is commissioned and formed the basis of the recommendations of best practice.

From the survey results it was apparent that advice is commissioned in a number of different ways within the region. Either through grant funding based on simple outputs, grant funding based on a preferred provider model and also a process of competitive tender via a Community Legal Advice Service.

One of the important aspects of the model being proposed is the involvement of a formal needs analysis. This gives an independent indication of need in particular locations. It encourages active engagement with frontline service providers. The model is dynamic. This allows new areas of demand for services to be recognised as they emerge and gaps in provision identified and filled. Priorities can be set and outcomes determined. This gives a clear indication of level of service provided to ensure that public money is used appropriately and that services meet users needs.

A further positive by-product of the model is that it supports a strong, diverse and vigorous voluntary sector and encourages the development of cooperative working across multiple service providers.

1. Introduction

The aim of this research project is to recommend a model for commissioning money advice services. This will enable local partners to develop advice strategies that can be easily and efficiently adapted to achieve the purpose of maximising the income of their clients, ensuring value for money invested in advice, leading to a maximisation in improvements to health.

The social, economic and health benefits of income maximisation through advice provision have been researched for this project. What is evident is that the problems of society, the economy and health are interlinked. This has emphasised the importance of better co-ordination between services.

These problems have created a demand for high quality advice services. It is essential for local authorities and health services to work together and be able to understand the supply of advice services in order to meet their local demand efficiently and effectively.

2. Current Picture

Advice services are currently commissioned in various ways across the region via the Legal Service Commission (LSC), Local Authorities and the NHS. To achieve the project aim, there is a need to establish best practice in the region to develop a commissioning model that will help local commissioners decide where best to invest in order to most effectively increase income among the most disadvantaged. In 1999 the LSC was established to develop a Community Legal Service (CLS) to focus on the civil justice problems of the 'disadvantaged and socially excluded'.

A number of different mechanisms for advice service delivery have been investigated and information has been obtained from both Local Authorities and Primary Care Trusts (PCTs) describing methods of operation of advice services. There is no consistent approach being followed across the region and most services have come about by a process of organic development over a long period of time.

Emerging Coalition Government policy is changing this landscape. A description of the likely implications of Government reforms, including the proposals in Liberating the NHS, the Health and Social Care Bill, the public health white paper, the Fundamental Review of Legal Aid and the Comprehensive Spending Review, is contained later in this report.

The report provides an overview of influences on the delivery of advice services and their impact on health outcomes. Various appendices are also included which provide information which describes the current state of advice provision across the region. The information has been considered by a Stakeholder Group and a model for delivery of advice services across the region has been recommended. This model can be used by partners to help guide them in providing services in a more coordinated and efficient way.

3. Social and Economic Context

Much of the literature researched for this project highlights that income inequality leads to many problems associated with social exclusion and ill health. For example, the 2006 Causes of Action research by the LSRC explains how vulnerable groups are more prone to social exclusion, and find themselves suffering a combination of social problems. The research revealed those receiving welfare benefits were more likely than others to report homelessness and debt and severe money management problems. Unemployed respondents were also more likely than others to report money/debt and rented housing problems.

'Civil justice problems' include social issues of discrimination, domestic violence, unemployment, homelessness, immigration, mental health, money/debt and welfare benefits. These can be everyday problems which many people struggle with. Often, for vulnerable people who cannot access the right advice, one social problem leads to another and when combined with other problems it leads to broader social, economic and health problems. These broader problems inevitably involve substantial public expenditure.

The Spirit Level by Richard Wilkinson and Kate Pickett (2009) provides evidence on how wealthy societies with growing gaps between rich and poor are in fact worse off in terms of social problems than the less wealthy societies which have narrower gaps between the highest earners and lowest. The book contains numerous graphs, plotting income inequality against a number of variables including life expectancy, health, obesity and stress. It demonstrates how income inequality has led to negative impacts on society including deprivation and the breakdown of communities.

In his speech given at the Hugo Young lecture, in November 2009, David Cameron spoke about The Big Society. In this speech, David Cameron referenced The Spirit Level and recognised a need to:

"focus on the causes of poverty as well as the symptoms because that is the best way to reduce it in the long term. And we should focus on closing the gap between the bottom and the middle, not because that is the easy thing to do, but because focusing on those who do not have the chance of a good life is the most important thing to do."

This report aims to assist in ensuring that those on the lowest incomes do not lose out with the impending reforms and cuts. Advice on income maximisation needs to be recognised as a core part of delivering the Big Society agenda.

Research on financial inclusion interventions by Dayson et al (2009) highlighted changes in general health after people accessed financial inclusion advice, with clients receiving debt and benefits advice noticing they were less stressed, making fewer trips to the doctor, needed fewer prescriptions, and using the additional income to spend on food, paying bills and saving. These suggest clear implications for improving health.

From the literature in Appendix 1, many papers conclude that financial inclusion services positively impact health, including research by Balmer et al (2005). This paper highlighted the link between civil justice problems and health and the

importance of debt advice intervention within healthcare settings, stating debt advice services not only

'...provide solutions to patients problems, but can also improve patients' health.'

4. Health Context

Life expectancy has grown for us all, on average, but the gap between rich and poor has grown wider. In Fair Society, Healthy Lives: the Strategic Review of Health Inequalities in England (2009), Sir Michael Marmot and colleagues identified six priority policy objectives to tackle inequalities, Objective Four – Ensure a healthy standard of living for all – included recommendations to:-

1. Establish a minimum income for healthy living for people of all ages.
2. Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies.
3. Reduce the cliff edges faced by people moving between benefits and work.

The Government's response to the Marmot Report is built into its proposals for the reform of health and welfare systems, and the public health white paper.

In the Annual report of the Chief Medical Officer, 2009, Professor Sir Liam Donaldson, On the state of public health: (March 2010) recognised how financial inclusion can help reduce health inequalities. Professor Donaldson stated that money needs investing in these services because research is continuing to prove the benefits of the services outweigh the cost.

JSNA - Local authorities and the NHS have a statutory duty to produce a Joint Strategic Needs Assessment (JSNA) that identifies currently unmet and future health, social care and wellbeing needs for their population. The JSNA is intended to inform the plans, targets, priorities and actions necessary in reducing identified inequalities and achieving the desired health and wellbeing outcomes.

Subject to Parliamentary approval, the new proposals for health and for public health will see the JSNA take on greater significance, with a duty on local commissions in local authorities and the NHS (eg local GP Consortia) to take account of the JSNA and the new health and wellbeing strategies, when commissioning services.

5. Background to advice funding

Legal Aid, to understand fully how commissioning relates to debt and benefit advice, it's important to understand how advice services have been funded over the years, and why it is evolving. An LGA report by Tribal Group (2010) offers a thorough account of the existing provision of legal advice services to recent changes to funding.

The LGA report explains that provision of free legal advice allows all people access to justice and secures people's civil liberties. Debt and benefit advice falls into the legal advice category of social welfare law. Voluntary sector organisations are the biggest providers of this type of generalist advice.

Citizens Advice Bureaux (CABx) are Voluntary Community Organisations (VCOs), and one of the biggest networks of providers which cover all aspects of social welfare law at the generalist level as well as specialist services. There are many other independent VCOs providing generalist services and some also focus on specific areas or clients such as the elderly or BME groups.

Local authorities are one of the main funders of generalist social welfare advice. Their funding is allocated in the form of grants, service level agreements or contracts. Some organisations may have received funding from their local authority for many years and are often reliant on it to continue offering a service to the local community.

The LSC funds specialist level advice (such as court representation or higher level casework by qualified lawyers and not for profit organisations) for those eligible for legal aid. The LSC previously only required providers to meet their quality standards before allocating funding. The LSC moved away from this system and towards competitive tendering, where providers currently compete for fixed rate contracts. However there are now proposals to cut debt and benefits advice from the legal aid budget. This was announced in November 2010 in the Ministry of Justice's Reform to Legal Aid Green paper and is discussed in detail later in this report.

The Financial Inclusion Fund (FIF) is a separate debt advice fund established in 2004 by the last government. Initially, £45 million was allocated for the first three years, a further £85 million was allocated in 2008. The funding was confirmed to end 31st March 2011, redundancy letters had been sent out, and advisers were reducing case loads.

The FIF has been supporting 500 face to face specialist debt advisers based in CABx and other not for profit advice centres over the last seven years.
Although CABx delivered the vast proportion of the work, a small number of other advice providers also delivered debt advice through the fund including special projects aimed at rural communities and disabled people. The fund was used to train specialist advisers to deal with complex cases and to represent clients to their lenders.

Around 100,000 people a year are assisted by the money advisers paid for by the fund. A survey of 1,300 clients in the North East in 2009 found that 95 per cent of CAB respondents reported a high level of satisfaction with the service and felt it had made a real difference to their lives. In a similar survey in Swansea, 86.7 per cent of respondents felt that the advice given to them made a lot, or some, difference to their health.

With this evidence, a further £27 million has been allocated to maintain FIF for one more year. The Department for Business announced it had found the money from a contingency fund but an alternative source of funding will need to be sought to sustain the service after next year. In a press statement announcing the funding, Secretary of State for Business Vince Cable said:

"While the Government has maintained funding for this programme, it provides only a small part of the revenue necessary to keep the Citizens Advice network fully functioning. I would like to take this opportunity to call on the other funding streams, such as from local authorities, to help provide whatever support they can to keep this excellent service going."

With possible cuts in provision of legal aid, and uncertainty on the FIF after 2012, commissioning debt and welfare benefits advice for the future will require service providers to work closer together on tighter budgets with increased demand as wider services will be lost and unemployment and the cost of living are expected to rise. However, reforms to Public Health (discussed in more detail later in this report) suggest Health Commissioning be split between GP Consortia and the Local Authority. Given the linkages between advice provision and health improvement, there is potential for local authorities to continue the fund for specialist debt advice.

6. Community Legal Advice Services (CLAS)

In 2000 the LSC, in conjunction with councils, not for profit organisations and local solicitors, attempted to co-ordinate funding and to understand supply and demand of legal and advice services by creating Community Legal Service Partnerships (CLSPs). CLSPs involved a network of providers, funders and user groups that would meet to encourage joined up working.

The LSCs withdrew support from CLSPs in 2006 and switched their resource to administering legal aid, although in some areas CLSPs have continued without LSC input. With the dissolution of CLSPs, in which local authorities played a major role, it became more difficult for local areas to understand, on a strategic level, the need and supply of advice services in their area and therefore could not always assess whether funding levels and delivery of services were appropriate.

Since 2006, the LSC has been looking to change the way it funds legal advice. Upon reviewing its current process, the LSC decided competition between providers over funding would increase value for money. In a small number of areas, they proposed joint funding with the local authority into one funding pot. They would then invite providers to bid for this one contract to run a Community Legal Advice Service (CLAS).

A CLAS can take the form of one centre and is known as a Community Legal Advice Centre (CLAC), or from a range of centres and are known as Community Legal Advice Networks (CLANs).

In effect, the CLAS brings together individual organisations which deliver core social welfare law services. The organisations are required to form a single legal entity in order to become a CLAS.

Commissioning of generalist social welfare advice services has not traditionally happened within most local authorities but has in recent years been associated with the NHS and other Government Agencies. With this shift towards competitive tendering, VCOs are expected to provide evidence of value for money and the financial impact of their service. Not all VCOs are well placed or equipped to record outcome data. They risk losing funds to other providers, often from the private sector that can offer services at a reduced cost, although this can often initially be as a “loss leader”.

7. Commissioning

Commissioning is a cycle of activity at a strategic level. It includes:

- assessing the needs of a population;
- assessing existing supply and whether it is fit for purpose
- setting priorities and developing commissioning strategies to meet those needs in line with local and national targets;
- securing services from providers to meet those needs and targets;
- monitoring and evaluating outcomes and then using this data to inform future commissioning rounds; and
- the above combined with an explicit requirement to consult and involve a range of stakeholders, patients/service users and carers in the process.

Procurement is not the same as commissioning. Procurement, purchasing and contracting are activities that focus on a specific part of the wider commissioning process – the selection, negotiation and agreement with the provider of what service is to be supplied. Procurement or purchasing usually refers to the process of finding and deciding on a provider. Contracting usually refers to the negotiation and letting of a contract and its subsequent monitoring.

8. Health Commissioning

The main commissioners of NHS services are currently PCTs. However, the NHS White Paper sets out major changes to the way NHS services will be commissioned and delivered in the future. A new National Health Service Commissioning Board will commission services in two ways.

- some specialist services will be commissioned nationally
- but the majority of services will be commissioned locally by GP consortia.

Similarly, at local level, public health commissioning will be the responsibility of local government.

9. Health and Local Authority Commissioning

Local authorities and PCTs work as key partners in Local Strategic Partnerships (LSPs). LSPs bring together different sectors of the community – public, private and voluntary – to work effectively in identifying and agreeing priorities and instigating and developing new initiatives that improve performance, linked to Local Area Agreement targets.

Some services may form legal partnerships with PCTs to provide services jointly. Funding can be pooled between health bodies and health-related local authority services, functions can be delegated and resources and management structures can be integrated.

10. Possible Implications from policy changes

Equity and Excellence: Liberating the NHS was the Government White Paper issued on 14 July 2010. Subject to Parliamentary approval, the paper is committed to driving cultural change within the NHS.

The reforms include abolishing PCTs and Strategic Health Authorities (SHAs) and aim to make the NHS more responsive, transparent and better able to withstand the funding pressures of the future. Once in place, it will be the responsibility of government, commissioners, healthcare providers and GP practices to ensure that public funding is used to achieve the best possible outcomes for patients and communities.

Healthy Lives Healthy People is the Public Health White Paper released on 30 November 2010. The strategy builds on the proposals to abolish PCTs and SHAs as stated in the NHS White Paper. Leadership for public health will return to local authorities. In principal, the majority of services will be commissioned locally, either by local authorities or by local GP consortia.

Statutory Health and wellbeing boards in every upper tier local authority will be where this comes together. Local authorities and GP consortia will have an equal obligation to prepare the JSNA and to do so through the health and wellbeing boards. This will inform a local health and wellbeing strategy that in turn will provide the framework for what is commissioned. Commissioners will have a duty to have regard to the JSNA and Health and Wellbeing strategy.

Many of the reforms will have an impact on current advice provision. Potentially commissioning routes are more straightforward: through local authorities, for communities/citizens and through GP consortia, for example for services supporting patients with mental health issues or cancer or contributing to wider commissions as part of their support for public health. There is also the opportunity for these issues to be considered as part of the JSNA and strategy development process.

The Comprehensive Spending Review, October 2010, announced that councils will need to find savings through smarter procurement, increased collaboration, streamlining and merging operations. There was also mention of ending ring fencing of all revenue grants from 2011-12, except simplified school grants, and a new public health grant from 2013. This includes a single un-ring fenced Early Intervention Grant worth around £2 billion. The Cabinet Office new responsibilities around the Big Society and funding will include:

- Around £470 million support for the Civic Society organisations sector, including a £100 million fund to help charities, voluntary groups and social enterprises make the transition to a tougher funding environment, to build a big society, and make the most of the opportunities it will bring;
- A National Citizen Service which will support young people from a mix of different backgrounds to develop skills and engage with their communities – sufficient to fund 10,000 places in 2011/12 and 30,000 in 2012/13;
- The Community First Fund which will support new and existing small organisations in the most deprived areas.

Universal Credit: Welfare that works, was the Government's White Paper released November 2010. This reform will impact upon the current welfare rights advice provision. The key elements of the reform include:

- bringing together different forms of income-related support and provide one integrated benefit for people in or out of work.
- will consist of a basic personal amount (similar to the current Jobseeker's Allowance) with additional amounts for disability, caring responsibilities, housing costs and children.
- ensuring that no-one loses as a direct result of these reforms.
  imposing sanctions and cease benefits to those who fail to actively look for work

The Government has indicated its commitment to ensuring that no-one loses as a direct result of these reforms. If the amount of Universal Credit a person is entitled to is less than the amount they were getting under the old system, an additional amount will be paid to ensure that they will be no worse off in cash terms.

However there are concerns over how those most vulnerable will be affected when sanctions are placed on benefit recipients who, it is judged, fail to look for work. If benefit payments cease, this could adversely affect individuals with severe debt problems, cause payments to fail and incur further charges.

Proposals for the Reform of Legal Aid in England and Wales was released by the Ministry of Justice in November 2010.

With regards LSC funding for debt advice, this green paper proposes to exclude all legal aid for debt issues, including cases relating to insolvency loans, credit card debts, overdrafts, utility bills, court fines, or hire purchase debts. Legal aid will be retained for debt cases where, as a result of rent or mortgage arrears, the client's home is at immediate risk of repossession. With regards welfare rights advice, the paper proposes to exclude all welfare benefits issues from the scope of civil legal aid.

It was noted throughout the green paper that these decisions were made on the basis that free advice is available through the Department for Work and Pensions, Jobcentre Plus, National Debt Line, Money Advice Trust etc. However with uncertainty on the continuation of FIF after 2012, and funding being squeezed across the board, financial exclusion and its negative social, health and economic impact is likely to grow.

11. Research Method and Analysis

In order to research this project surveys were sent across all local authorities and PCTs in Yorkshire and the Humber to establish how advice services are commissioned. Site visits were attended for further exploration of two different commissioning models.

A literature review of all available reports and journals was compiled, and evidence gathered on the linkages between inequalities and health and in particular health improvement related to advice provision. Appendix 1 contains a literature review of evidence.

Survey Findings

From the research and surveys of PCTs and Local Authorities in the region there was a strong consensus that advice has a positive impact on health.
Seven local authorities responded, with four authorities providing details on their advice strategies. For a full review of survey responses see Appendix 3.
One local authority surveyed revealed that the advice they commissioned contributed to their Health and Wellbeing indicators –

- Helping people maintain their independence and wellbeing at a difficult time: develop information, advice and advocacy services to support people's needs, including the use of campaigns to encourage take up of benefits and pensions.
- Contribute to reducing health inequalities
- NI 119: Self-reported measure of people's overall health and well being
- Reducing health inequalities by providing access to welfare advice in primary care settings.

Seven PCTs responded in total, five PCTs currently commission income maximisation related advice service. The following reasons were given as to why the PCT commission advice:

- Tackle and reduce health inequalities
- To address health inequalities, and in particular to improve access to benefits for those with long term illness and the elderly
- Primary care advice service addresses socio-economic influences on patients' health and contributes to reducing health inequalities. It complements the work of primary care staff and provides an opportunity to signpost patients to a venue which is local, familiar, non-stigmatising, and where pre-booked appointments are offered.
- Mental health users are significantly more likely to rely on benefits and to experience debt.

12. Site Visit Findings

In addition to supporting the view that advice services positively impact health, the surveys explored the ways in which advice is commissioned and formed the basis of the recommendations of best practice.

From the survey results it was apparent that advice is commissioned in a number of different ways within the region. Either through grant funding based on simple outputs, grant funding based on a preferred provider model and also a process of competitive tender via the Community Legal Service.

Hull City Council which commission advice in this way were unable to complete the survey due to the nature of some questions offering insight into their commissioning techniques. They believed that this insight could potentially undermine the competitive process when the tender is re-let. Instead Hull agreed to take part in a site visit so that we could compare their model to the Preferred Provider Model which is used by Bradford Council. The full result of this study can be found in Appendix 2.

Both models were reported to work well for their authorities. The Hull CLAC model

set new standards which they hoped would drive change and secure improvements. The competitive tender process resulted in a private sector provider of advice services receiving funding in place of the previous provider, Hull CAB. However, the CAB operating in the area has not seen demand drop as a result of the CLAC. This shows the high level of demand in the city for advice and the two organisations are now working together to try to support the need for advice in the city.

Due to the cuts to Legal Aid, Hull City Council is likely to lose its LSC funding for debt advice and welfare rights advice. This leaves the CLAC model potentially vulnerable and it may be subject to reform. The funding cuts are forcing a move for better efficiencies and joint working.

The Bradford model supports a thriving voluntary sector. Their good level of communication between providers, commissioners and funders allow them to adapt to changes in accordance to client need. The Preferred Provider Model has been chosen as a recommendation of best practice for commissioning advice services to best meet client need, to maximise their income and improve health.

13. Best Practice Model

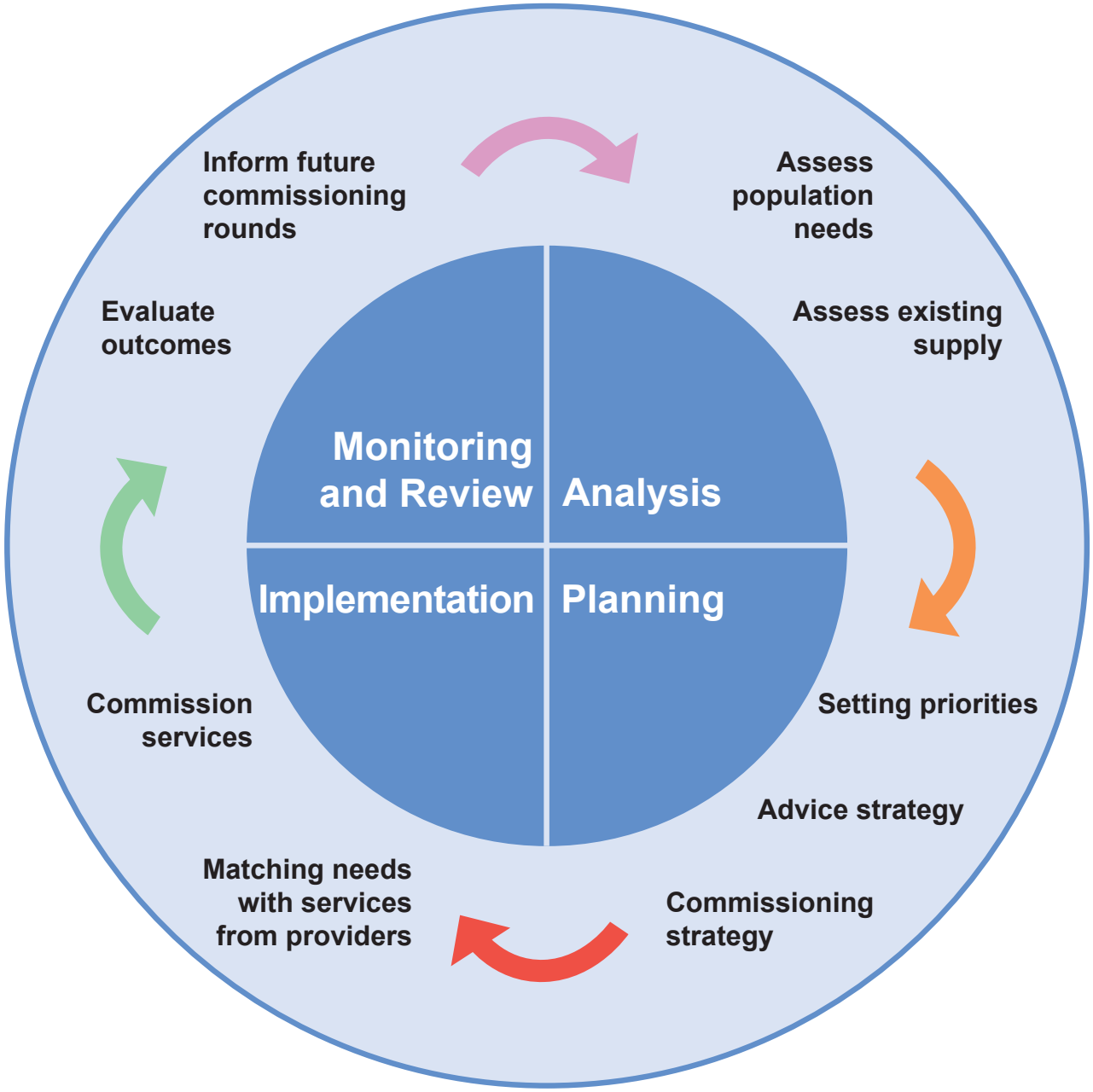
The best practice examples have been sourced from the research surveys and site visits. This research can be found in full in Appendices 2 and 3. The table below sets out a model of good practice which could be adopted by either a single commissioner or a group of commissioning organisations.

Preferred Provider Best Practice Model			
Commissioning Stage	**Best Practice**	**Impact**	**Action**
Stage 1 Assessing the needs of a population	Need is assessed by the commissioning organisation in the following ways • Needs analysis • Monitoring data • Provider intelligence The needs analysis uses a range of proxy indicators which can include: • Sum of Unemployed people aged 16-74, who have never worked and who are long term unemployed, • Households in receipt of Income Support • People aged 16-74, Economically Inactive, Permanently sick/ disabled to determine the need for advice based on deprivation In addition monitoring data from funded groups can be used to give an indication of high areas of demand by geographical area and area of law. With regard to new and emerging demand, providers provide information at regular Advice Partnership meetings	Undertaking a formal needs analysis gives an independent indication of need. By actively engaging with frontline service providers, new areas of demand for services can be recognised as they emerge	Analysis Stages
Stage 2 Assessing existing supply and whether it is fit for purpose	Existing supply of CLS quality marked advice services across the district is mapped against the needs assessment undertaken under stage 1. Services are judged against set eligibility criteria, including quality, and financial management. Those organisations who do not hold the CLS quality mark must evidence their current practices against this standard and must achieve the standard within an agreed period, if funding is awarded.	This allows gaps in provision to be identified and where possible filled.	

Stage 3 Setting priorities and developing commissioning strategies to meet those needs in line with local and national targets	Organise stakeholders into a relevant group with representatives to inform supply and demand, i.e. Commissioners, Funders, Advice Providers, Community. Establish commissioning time scales. Three years is a likely appropriate period for commissioning rounds. Identify staff to undertake this work and have clearly defined roles. Priorities are agreed through consultation with the Advice Partnership to determine the Advice Strategy, taking into account key local and national priorities. The Advice Partnership can include the advice sector, solicitors, elected members, council and health officers and professionals. The Advice Strategy is linked to other key strategies across the commissioning organisations such as regeneration, cohesion, health, equality, financial inclusion, homelessness etc. as appropriate to the organisations strategic framework. A commissioning document is published detailing the expectations of commissioned providers, with separate service specifications for generalist, specialist and services provided for specific communities eg BME.	Clear priority setting. Clear understanding of expectation from services.	Planning Stage
Stage 4 Securing services from providers to meet those needs and targets	Advice organisations which meet the eligibility criteria are considered for funding, according to the criteria laid out in the commissioning document – those that are successful are issued contracts for a fixed time period, perhaps three years, with clear expectations and monitoring required in relation to outcomes, outputs and milestones.	Clear communication with providers on expectations and outcomes allows information to flow and needs to be met.	Imple-men-tation Stage

Stage 5 Monitoring and evaluating outcomes and then using this data to review ongoing performance and to inform future commissioning rounds	These are then monitored through quarterly reporting. Monitoring should include both quantitative and qualitative data. Outputs and outcomes are linked to higher level outcomes in the commissioners strategic delivery plans, as indicated in Stage 3 above. Outcome data collected can be level of debt, debt situations stabilised, and income raised. Outputs include numbers of people seen. Case studies and customer satisfaction surveys are collected. If advice services are not meeting outcomes, outputs and milestones, then the commissioning organisations officers would work with the organisation to resolve any issues where possible. If an organisation was consistently underperforming and all attempts to remedy the situation had failed then would dispute procedures within the contract can be instigated.	These give a clear indication of level of service provided to ensure that public money is used appropriately and that services meet users needs	Monitoring and Review Stages
Stage 6 An ongoing requirement through the life of the contract to consult and involve a range of stakeholders, patients/service users and carers in the process	Advice Partnership meets regularly, perhaps quarterly, to monitor the implementation of the Advice Strategy in order to ensure that key stakeholders are actively involved. Annual user surveys used to give an indication of service users needs	This leads to continuous development and improvement.	

Diagrammatic Plan of the Recommended Commissioning Model



Conclusion

The objective of the recommended model is to enable local partners to develop advice strategies that can be easily and efficiently adapted to achieve a maximisation of income for clients, ensuring value for money invested in advice, with the purpose of delivering improvements to health. Although the research focuses on Income Maximisation advice services, the findings and recommendations in the Best Practice Commissioning Model can be transferable and adapted for wider advice services.

With funds for advice services at risk of being cut, it has been important to state the case for action, to ensure commissioners within Health and Local Authorities are aware of the cost and health benefits of investing in advice services. Therefore, a literature review was undertaken to produce evidence of where advice services had positively impacted health. The primary research involved surveying Health and Local Authority Commissioners and an analysis of the survey findings acknowledged advice is commissioned because it contributes to a range of national indicators, but particularly health and wellbeing indicators, and helps to tackle and reduce health inequalities.

The funding cuts are forcing a move for better efficiencies and joint working. Our findings reveal the CLAC model to be potentially vulnerable to reform in this current climate. In contrast to the CLAC model, the preferred provider model is dynamic and adaptable. It supports a thriving voluntary sector and encourages a good level of communication between providers, commissioners and funders, allowing them to adapt to changes in accordance to client need.

The model presented in the report explains each stage of the commissioning process, and aligns each step with examples of best practice. Central to the model is the development of an Advice Strategy and a Commissioning Document which sets out clearly defined priorities, which are consulted upon and agreed by Commissioning, Funding, Advice and Community stakeholders. Another component is the involvement of a formal needs analysis. This gives an independent indication of need in particular locations. It encourages active engagement with frontline service providers. This allows new areas of demand for services to be recognised as they emerge and gaps in provision identified and filled. Priorities can be set and outcomes determined. Combined, the model recommends a clear indication of level of service provided to ensure that public money is used appropriately and that services meet user needs.

Appendix 1 – Literature and Research

Note – References in bold provide details of the headline data at the start of this report.

Source/Reference	Title	Summary/ Quotes	Notes
Balmer N, et al Legal Services Research Centre, Legal Services Commission, UK (2005)	Worried Sick: The Experience of Debt Problems and their Relationship with Health, Illness and Disability	Highlights the importance of advice interventions that recognise the link between civil justice problems and health, illness or disability. 'Evidence is now emerging that the provision of advice services in healthcare settings cannot only provide solutions to patients' problems, but can also improve patients' health.'	Supports view that financial inclusion advice positively impacts health inequalities
Beckfield, J (2004)	Does Income Inequality Harm Health? New Cross-National Evidence	Questions the hypothesis that income inequality impacts health. Critiques Wilkinson (1992) research. The most important methodological difference between this study and previous work is that this study accounts for unobserved between-country differences with fixed-effects models. Using a larger sample, better (though still imperfect) income inequality data, and more statistical controls reduces support for the inequality-health hypothesis, but accounting for unmeasured heterogeneity with a fixed-effects approach eliminates support. This suggests that heterogeneity bias may be the most serious limitation of the "classic" cross-national work in this area. ' Using a larger sample and multivariate methods with appropriates statistical controls, I find some evidence of a statistically significant but small harmful effect of income inequality on population health'.	Opposes the view that income inequality harms health. Suggests other inequalities could be more detrimental to health.
Citizens Advice (May, 2010)	**Citizens Advice annual advice statistics 2009/10**	**Bureaux across England and Wales advised people on 7.1 million new issues in the 2009/10 period, up 18% on the previous year (April 2008 - March 2009). Debt is still the biggest area of advice, making up 34% of all enquiries, closely followed by Benefits at 29%. Both issues saw an increase in enquiries compared to last year: Debt was up 23% (2.4 million enquiries) and Benefits up 21% (2 million enquiries).**	**Highlights the demand and need for advice**

Dayson, K et al (2009)	**Financial Inclusion Initiatives, Economic impact and regeneration in city economies. The case for Leeds**	**527 service users of debt and money advice providers, welfare rights and benefit support services and Leeds City Credit Union were surveyed. The surveys revealed an economic impact is produced from total operating costs of £3.3 million. This means that for every £1 invested in financial inclusion initiatives £8.40 is generated for the regional economy. In addition to the economic and social benefits to such initiatives, the surveys revealed benefits associated with health:** • **41% of clients in receipt of money advice believed the advice was linked to improvement in their health** • **67% of clients had noticed a reduction in stress in response to the advice received**. **The research shows that every year, £26 million additional income is generated in the local economy in Leeds with an impact on the regional economy of over £28 million.** **This economic impact is produced from total operating costs of £3.3 million, which means that for every £1 invested in financial inclusion initiatives £8.40 is generated for the regional economy.**	**Some evidence from surveys reveal link to health benefit:** **Where people were helped directly to increase their incomes, they spent the extra money mainly on food, paying bills, their children and saving. As well as feeling better off, a substantial number of people also reported that their health improved: they made fewer visits to the doctor and needed fewer prescriptions.**

Department of Health **No Health without Mental Health, Supporting Document (February 2011)**	**A Cross-Government Mental Health Outcomes Strategy for People of All Ages** **The economic case for improving efficiency and quality in mental health**	**Low income and debt are associated with higher rates of mental illness. Studies suggest that the effect of low income on mental health may largely be explained by the effect of debt. Moreover, people with mental health problems are more likely to get into problematic debt. Rates of debt in people with no mental health problems are 8%. The rates for those with depression and anxiety are 24%, and for those with psychosis 33%.** **The Impact Assessment gives estimates of the costs associated with face-to-face debt advice over 5 years as around £250 million. Associated savings are estimated at around £30 million to the NHS, and around £50 million on legal costs with around £220 million from productivity gains. However, these figures exclude several important benefits such as debt repayments to creditors and health and wellbeing gains to individuals.**	**Cost benefit evidence - investing £250 million in advice brings savings of £300 million.**
Department of Health No Health without Mental Health, Supporting Document (February 2011)	A Cross-Government Mental Health Outcomes Strategy for People of All Ages Impact Assessment	Costs are assumed to be incurred for contact with a debt service in the first year. the level of need varies by client and may affect number of visits per client. The modelling results assume face-to-face advice, at a cost of £270 per person. The costs and benefits of a face-to-face intervention costing £270 per person have been estimated at an England level.	Cost-benefit impact assessment contains background to the figures used.
Department of Health CMO Annual Report (March 2009)	Department of Health, 2009 Annual Report of the Chief Medical Officer	The annual report of the Chief Medical Officer, Professor Sir Liam Donaldson, contains a statement of the state of Public Health with reference to financial inclusion work and its effect of health. Quotes statistics from Leeds City Council's economic impact evaluation on financial inclusion work.	National recognition from the Health sector that financial inclusion can impact on health inequalities

Department of Health, NHS White Paper. (July 2010)	Equity and Excellence: Liberating the NHS	The strategy for the NHS contains four themes, Putting patients and the public first, Improving healthcare outcomes, Autonomy, accountability and democratic legitimacy and Cutting bureaucracy and improving efficiency.	The reforms include abolishing Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) and aim to make the NHS more responsive, transparent and better able to withstand the funding pressures of the future.
Department of Health, Third Sector Partnership Team (March 2010)	The NHS commission-ing environ-ment: : A guide for organisations in the third sector	Contained within the guide are four main components to commissioning: Identify need, Identify demand, Identify who can meet demand and Monitor and review	National recognition of the impact the third sector can have on health and a guide to encourage third sector to enter NHS markets.
Dorling, D. National Health Executive, May/ June, pp.18-19. (2009)	Healthy, wealthy but not wise	The latest [2009] House of Commons Health Committee report on health inequalities ignores what is the fundamental determinant of inequalities in health – inequalities in income and wealth. Reduce social inequalities and you reduce the need people have to do things like smoke, including smoking illegally smuggled tobacco and many much more health damaging activities, just to get through the day.	Commentary on how health inequalities can be reduced if the focus is on social inequalities
Dorling, D. (2010).	Injustice: Why Social Inequality Persists,	Discusses five sets of beliefs – elitism, exclusion, prejudice, greed and despair and how they contribute to the growing gap between rich and poor.	Quantitative facts to evidence how social and income inequality impacts on health. A broad overview of the whole subject of inequality.

DWP Universal Credit: welfare that works (November 2010)	Universal Credit: welfare that works	The White Paper "Universal Credit: welfare that works", published on 11 November 2010, sets out the Coalition Government's plans to introduce legislation to reform the welfare system by creating a new Universal Credit. Universal Credit aims to simplify the system to make work pay and combat worklessness and poverty.	Will impact upon the current welfare rights advice provision.
Friends Provident (January 2008)	Intelligence on financial inclusion: Funding ideas to overcome the impact of ill health on financial exclusion	Department of Health support for a new 'information prescription', designed to improve information for patients, creates an opportunity to press for a more effective response to their financial advice needs. Most major illnesses have their own advocacy and support organization, many of which come together in the Long Term Conditions Alliance. Funding either directly or through the Alliance would help such representative agencies to explore these needs and to pilot innovative and practical ways of meeting them.	Paper summarises funding ideas related to improving the financial circumstances of those affected by ill health
Greasley, P, Small, N School of Health Studies, University of Bradford (2002)	Welfare advice in primary care	The following advantages of providing advice services within general practices have been identified in the literature: Improvement in the health and quality of life of patients may lead to a reduction in patients' use of NHS resources, e.g. consultations, prescriptions.	This paper contains evidence to show the advantages of financial inclusion services to health.
Harding, R et al (May, 2002)	Evaluation of welfare rights advice in primary care: the general practice perspective	GP perspective: Lack of funding and space were the principal reasons for not having in-house advice. Surgeries wish provision to be expanded within practices. Welfare rights advice in surgeries improves ability to meet welfare needs via specialist advisers. Referral processes are simplified, enabling general practitioners to ensure that relevant advice is provided without the need for welfare knowledge themselves. General practices welcome the expansion of provision, with the proviso that adequate resources are identified. The current lack of basic information in surgeries must be addressed (e.g. information on local providers, printed information detailing range and eligibility criteria of welfare benefits)	GPs support idea of having inhouse welfare rights advice. Report supports view that income maximisation via financial inclusion advice positively impacts health

HM Government Healthy Lives Healthy People: Our Strategy for Public Health in England (November 2010)	Healthy Lives Healthy People: Our Strategy for Public Health in England	In the new vision, each local authority and their individual director of public health will act as strategic public health leaders for their local population. They will lead discussions about how their ring-fenced money should be spent to improve outcomes for people's health and well-being locally. They should be in a position to ensure public health is always considered when local authorities, GP consortia and the NHS make decisions.	Local authorities will hold the funds, and have overall responsibility for commissioning all public health services that are proposed to be delivered at a local level
HM Government (February 2011)	No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages	Broadening the approach taken to tackle the wider social determinants and consequences of mental health problems one example of this approach is providing face-to-face debt advice. Evidence suggests that this can be cost-beneficial within five years. The upfront cost of debt advice is more than offset by savings to the nhs, savings in legal aid, and gains in terms of employment productivity, even before taking into account savings for creditors.	Points to the cost benefit of investing in advice services. Further details in supporting Department of Health documents; The economic case for improving efficiency and quality in mental health, and its accompanying Impact Assessment, both are referenced in this appendix.
HM Treasury Spending Review (October 2010)	Spending Review 2010	The Chancellor, George Osborne, presented the Government's Spending Review on 20 October 2010, which fixes spending budgets for each Government department up to 2014-15. The Spending Review set a clear direction for reform, focused on shifting power away from central government to the local level. The Government will announce further details of its reform programme in a White Paper in early 2011.	Priorities are growth, fairness and reform

Jean Adams et al, (2006)	A systematic review of the health, social and financial impacts of welfare rights advice delivered in healthcare settings	Socio-economic variations in health, including variations in health according to wealth and income, have been widely reported. A potential method of improving the health of the most deprived groups is to increase their income. State funded welfare programmes of financial benefits and benefits in kind are common in developed countries. However, there is evidence of widespread under claiming of welfare benefits by those eligible for them. One method of exploring the health effects of income supplementation is, therefore, to measure the health effects of welfare benefit maximisation programmes. Conducted a systematic review of the health, social and financial impacts of welfare rights advice delivered in healthcare settings.	Good theoretical reasons why income maximisation should improve health, but currently little evidence of adequate robustness and quality to indicate that the impact goes beyond increasing income. Evidence to prove financial inclusion advice improves health is difficult to quantify, but theories and qualitative, anecdotal evidence all acknowledge the link.
JSNA (2009)	Joint Strategic Needs Assessment	Local authorities and NHS have a statutory duty to produce a Joint Strategic Needs Assessment (JSNA) that identifies the currently unmet and future health, social care and wellbeing needs of the local population. The legislation intends that the JSNA will inform the plans, targets, priorities and actions necessary in reducing identified inequalities and achieving the desired health and wellbeing outcomes. Core to JSNA is a data pack that provides a comprehensive profile across a number of areas crucial to the health and well-being of the population such as • Demography • Socio-economic and environmental factors • Lifestyle (particularly 'healthy living' issues • Ill heath • Health and Social care service provision	Will highlight areas of deprivation and needs analysis

Kondo, N et al BMJ (August 2009)	Income inequality, mortality, and self rated health: meta-analysis of multilevel studies	Provide quantitative evaluations of the income inequality by conducting a analysis of on the association of income inequality with mortality and self rated health. Results: 60 million participants found that people living in regions with high income inequality have an excess risk for premature mortality independent of their socioeconomic status, age, and sex. A similar conclusion was supported by our meta-analysis of cross sectional studies with poor self rated health as the outcome.	Quantitative results analysis. Supports view that income inequalities lead to health inequalities.
Macmillan Cancer Support (2010)	**Local financial support and advice services - an evidence review**	**Debt can be a major problem during illness, causing deteriorating mental and physical health. The effect on carers can also be substantial. There is therefore a positive knock-on effect to health and well-being from being able to resolve debt and ease financial burden. As a consequence of receiving help and advice from Citizens Advice Bureaux, clients described improvements in their health. They felt better; were less anxious, less stressed and less worried about money.**	**Macmillan has developed financial support and advice services in partnership with the NHS, local authorities and Citizens Advice Bureaux among others. These services provide specially trained benefits advisers who can promote and support people to access appropriate financial help.**
Macmillan Cancer Support (2010)	Economic Impact Case Study: Financial Advice for People Affected by Cancer in Lanarkshire	Evidence from clients in receipt of money advice suggests a positive impact on the following: • Alleviate anxiety and stress around financial circumstances • Greater independence due to being able to afford appropriate help and care • Improve wellbeing and quality of life • Improvement in cancer condition, and potential remission	Qualitative, case study evidence.

Marmot (2009)	Fair Society, Healthy Lives The Marmot Review	This Review has twin aims: to improve health and well-being for all and to reduce health inequalities. Two policy goals: To create an enabling society that maximises individual and community potential To ensure social justice, health and sustainability are at the heart of all policies. Reducing health inequalities will require action on six policy objectives: Policy object 4 is the one most applicable to income inequalities effecting health: Ensure healthy standard of living for all – Inequalities in income Having insufficient money to lead a healthy life is a highly significant cause of health inequalities. As a society becomes richer, the levels of income and resources that are considered to be adequate also rise. The calculation of Minimum Income for Healthy Living (MIHL) includes the level of income needed for adequate nutrition, physical activity, housing, social interactions, transport, medical care and hygiene. In England there are gaps between a minimum income for healthy living and the level of state benefit payments that many groups receive.	A review of current practice to propose evidence-based strategies for reducing health inequalities.
Ministry of Justice (November 2010)	Proposals for the Reform of Legal Aid in England and Wales	With regards LSC funding for debt advice, this green paper proposes to exclude all legal aid for debt issues, including cases relating to insolvency loans, credit card debts, overdrafts, utility bills, court fines, or hire purchase debts. Legal aid will be retained for debt cases where, as a result of rent or mortgage arrears, the client's home is at immediate risk of repossession. With regards welfare rights advice, the paper proposes to exclude all welfare benefits issues from the scope of civil legal aid.	Will effect LSC funding for Debt advice and Welfare Rights advice.

Ministry of Justice Research Series (2007)	**12 months later – does advice help? The impact of debt advice – advice agency clients study**	**Money worries affected respondents' lives in a number of ways. For instance, the respondents in this study reported finding it difficult to live normally with their current problems (87%), and found themselves spending much of their time worrying about their money problems (95 % spent some to all of their time worrying).**	**The results show the impact of this on their health, with 91% stating that their health had been affected to some extent as a result of their money worries – which includes 48% whose health had been affected to a great extent.**
Moffatt, S et al. (2006)	The acceptability and impact of a randomised controlled trial of welfare rights advice accessed via primary health care: qualitative study	Qualitative research to test impact of welfare rights advice. Welfare rights advice targeted at people aged 60 years or over and accessed via primary care had a positive impact on quality of life and resulted in increased and social participation. Impact of additional finances was considerable and included: increased affordability of necessities and occasional expenses; increased capacity to deal with emergencies; and a reduction in stress related to financial worries. Overall, perceived independence and ability to participate in society increased. Most participants perceived benefits to their mental well-being, but no-one reported an improvement in physical health.	Further qualitative evidence to prove financial inclusion service impact health positively.
Pascoe Pleasance et al LSRC (2004)	Causes of Action: Civil Law and Social Justice The Final Report of the First LSRC Survey of Justiciable Problems	Key findings from report, taking health as an example: 16% of civil justice problems lead to physical ill-health, four in five of these people need medical treatment, two in three who are treated by their GPs need, on average, six appointments one in ten who are hospitalised spend, on average, 9.5 days as in-patients. 27% of civil justice problems lead to stress-related illness for a quarter of people affected, this leads to medical treatment.	The report demonstrates the knock on effect social inequalities can lead to.

Pascoe Pleasance et al LSRC (2006)	**Causes of Action: Civil Law and Social Justice Second Edition**	**The most exciting contribution that this study makes to the debate is to give the first clear evidence that advice services improve peoples' chances of resolving their problems. High street advice centres, telephone helplines, solicitors, and the whole civil legal aid system play their part in helping people resolve their problems.** **Indeed those who are unable to access advice services find their problems persisting. On the other hand advice not only reduces the distress of individuals it also reduces costs for them, for government and for society. Investment in early advice clearly brings benefits for us all. Reducing social exclusion is a priority across Government. Access to advice services is vital to this. This book helps us understand more about how we can help people with their problems, help them get the advice they need and, critically, help them out of social exclusion. Continued research in this area is vital to enable us to develop our understanding of the problems people face and to assess the impact that advice services make on the resolution of those problems.** **People who are vulnerable to social exclusion are most likely to experience civil justice problems. These problems rarely occur in isolation, but in clusters, often triggering one another:** **• 15% of civil justice problems lead to physical ill-health** **• 28% lead to stress related illness** **• 13% lead to loss of income** **Over a three and a half-year research period between 2001 – 2004, it was estimated that the cost of these problems to individuals, health and other public services was at least £13 billion.**	**This report found experience of civil justice problems can lead to substantial public expenditure and personal loss. Civil justice problems include issues of debt, welfare benefits, and finances.**

Pascoe Pleasance et al LSRC (2007)	Report of the 2007 English and Welsh Civil and Social Justice Survey	Civil justice problems can bring about a range of social, economic and health problems. Table 22 sets out the percentage of problems for which respondents to the CSJS reported having experienced a range of adverse consequences. Over half of problems (51 per cent) were reported to have led to at least one adverse consequence in the 2007 survey, similar to that in the 2004 and 2006 surveys. As can be seen, over a quarter of problems in both surveys led to stress related illness, with physical ill health, loss of confidence and loss of income also being reported to follow from more than one in eight problems.	Main Consequences: Physical ill health -14% Stress related illness -28% Loss of income – 13% Loss of confidence – 15%
Powell, J.E. et al (June 2004)	Welfare rights services for people disabled with arthritis integrated in primary care and hospital settings: set-up costs and monetary benefits	Conclusions. Welfare rights advice received during a visit to a GP practice substantially reduces the level of unclaimed benefit in arthritic populations including the elderly; with mobility and care difficulties. A welfare rights service integrated within a GP practice and encourages those in need to see a Welfare Rights Officer for help with welfare benefit confers monetary benefits for service users that substantially outweigh set-up costs.	Supports view that financial inclusion advice positively impacts health inequalities
Smith, Michael P et al Office for National Statistics (Summer 2010)	Monitoring inequalities in health expectancies in England – small area analyses from the Census 2001 and General Household Survey 2001–05	Study explores the potential of the General Household Survey (GHS) to provide a measure of health expectancies in small areas experiencing differing degrees of deprivation. Reports of ‘good’ and ‘fairly good’ health fell and health expectancies declined as deprivation increased.	Statistical evidence to support the view that deprivation harms health. These findings serve as a useful measure and benchmark in the targeting and assessment of interventions designed to ameliorate health inequalities.

Tribal Group, LGA (March 2010)	Early lessons from changes to legal advice provision and funding the local authority experience	Community Legal Advice Centres (CLACs) and Networks (CLANs) have recently been proposed by the Legal Services Commission (LSC) as new arrangements for providing advice in all categories of social welfare law. They are jointly funded by the LSC and local authorities and so far 5 CLACs have been opened.	Good overview on how funding process of legal advice has evolved. Useful case studies.
Wilkinson, R. G. (1992)	Income distribution and life expectancy	It is not only the scale of the health benefits which suggest that income distribution may improve the health of the majority of the population. The least well off 60-70% of the population may benefit from income redistribution.	Early research into income inequality and health.
Wilkinson, R. G., & Pickett, K. E (2009)	The Spirit Level	Provides evidence on how wealthy societies with growing gaps between rich and poor are in fact worse off than less wealthy societies with smaller gaps. The book highlights and evidences that it is in fact inequality that has led to negative impacts on society including increases in crime, poor mental health, obesity, teenage pregnancy, deprivation and the breakdown of communities.	Quantitative facts to evidence how social and income inequality impacts on health. A broad overview of the whole subject of inequality.
Wilkinson, R. G., & Pickett, K. E. (2006).	Income inequality and population health: A review and explanation of the evidence.	Interpretation of 169 analyses of the relationship between income inequality and health is that income distribution is related to health where it serves as a measure of the scale of social class differences in a society.	Supports view that income inequalities lead to health inequalities.

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