

The Report of the Social Protection Task Force

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Summary

- We demonstrate that the introduction of social protection systems as well as their generosity and coverage have significant impacts on health.
- Who receives the benefits within the household affects the health outcomes for the family.
- The eligibility for and administration of benefits matters. We examine the growth of means testing in the UK and its recent modifications.
- We find serious difficulties facing those with long term medical conditions who are on the margins of the labour force. Collaboration between the health and social protection systems is poor.
- We give particular attention to gender and health and the implications this has for the social protection system. We also consider the fate of groups like asylum seekers who are excluded from its normal working.

Policy

A natural question for the Commission to ask is: are benefits adequate to support a healthy life? We are driven to the conclusion that there is no rational basis for the levels of benefit that are supposed to protect UK citizens from financial risk. While some benefits approach adequacy others fall far short. We recommend:

- A more reasoned and open process for benefit setting. An adequate minimum for healthy living should be the prime goal;
- Benefit priorities:
 - Not using the coming financial crisis as an excuse to cut benefits in real terms;
 - Meeting the child poverty targets;
 - Keeping to the government's promise to raise the basic pension in line with earnings;
 - Increasing the role of child benefit in the benefit structure especially for 2nd and subsequent children;
 - Improving income support rates for young pregnant mothers;
 - Meeting the full costs of long term illness, disability and caring.
 - Including asylum seekers in the mainstream income support system.
- Accepting that more tax resources (and a more progressive tax structure) will be needed in the long run to sustain existing benefit levels, given demographic change, and to fund the improvements we think necessary;
- A simplification of the benefit structure.
- Ending the cliff edge distinction between 'in work' and 'out of work' benefits. Closer links between the health and social protection systems to assist those with long term conditions.
- Considerable caution before making any benefits dependent on 'good health behaviour'. The results may well be perverse.

Section 1 Social protection and health

1.1 Social protection and risks over the life course

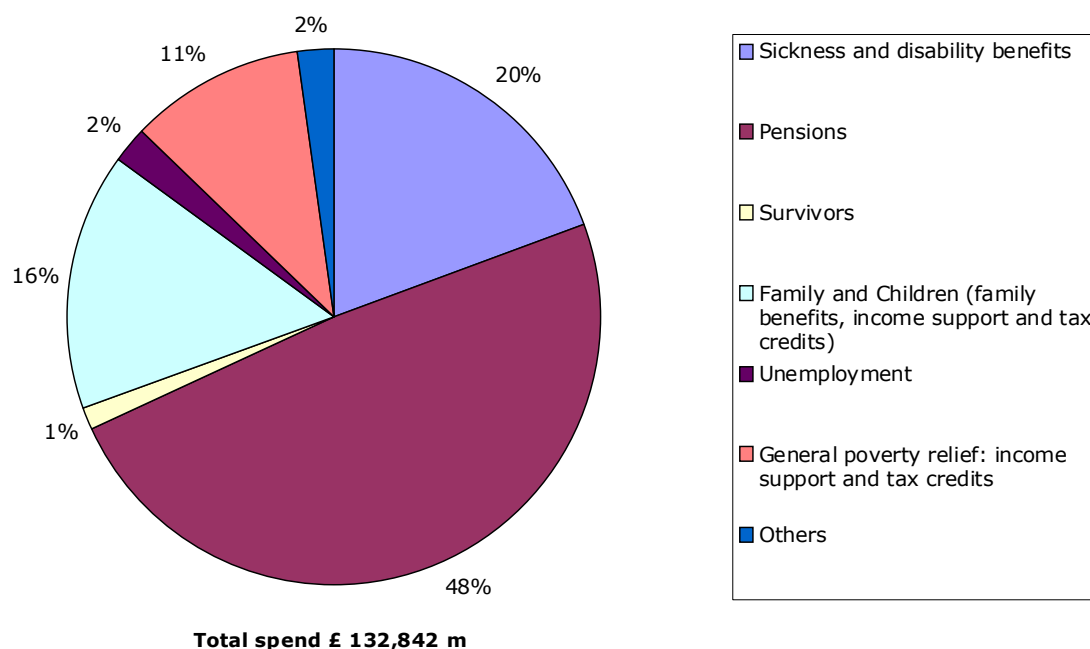
Through their lives individuals and families are prone to a wide range of serious financial risks: of injury or death to the breadwinners or carers, of divorce or separation, of an unplanned child, of unemployment or business failure, retirement, or legal damages following a car accident. In some cases such financial risks can be reduced by prudent individual action - taking out private insurance cover. In others the state can require such action. It may subsidise or 'nudge' individuals into insuring themselves (Thaler and Sunstein 2008). But some risks cannot be fully insured against in any private market (unemployment). Many markets work very inefficiently or can be used only by a fortunate few. (For the formal economic theory underlying these statements see Barr 2004.) As a consequence the state has come to act as a main line insurer against financial risks over the life course.

In the conventions of national accounting free services are not shown as part of the 'social protection' budget though they are also major sources of financial security. The state can remove the necessity of paying for schooling and health care. The importance of this role can be seen clearly in the present economic crisis where in the UK loss of a job does not also mean the loss of health cover. On both counts the broad welfare state smoothes income through the life cycle, from periods of earning and low need to periods of low earning and higher risk. Three quarters of all social welfare effort performs this role for all of us while the rest supports the lifetime poor (Falkingham and Hills 1995). However, to make our task manageable, we have confined our analysis to the role played by cash transfers in mitigating financial risk. The scale and composition of the UK's social protection budget defined in this way is shown below (see Figure 1).

In a model we have found helpful Diderichsen (2001) postulates that individuals' differential susceptibility to ill health, their exposure to risk and their unequal capacity to mitigate the consequences of adverse life events can all affect morbidity and life expectancy. Social protection systems act as just one 'policy entry point' to counter these effects. Nevertheless they are a very important entry point – or, in practice, a series of entry points. In the chart below we set out a series of life events and their attendant risks to health together with the social protection measures that are designed to mitigate those risks.

The causes of health inequalities are varied and complex and go far beyond the consequences of financial insecurity. But as we shall demonstrate the absence of any collective safety net has profound health consequences. The generosity and coverage of established social protection systems and the way they are administered have important implications for a nation's health. The United Kingdom's is seriously deficient in many respects.

Figure 1 Central Government Social Protection expenditure 06/7



Source: Public Expenditure Statistical Analyses 2008, April 2008 H M Treasury

Box 1 Key health risks though life and social protection responses

Life course stage/event	Examples of income maintenance	Risks / evidence
Maternity	Statutory maternity pay (contributions based) Maternity allowance Sure Start maternity grant (conditional) Health in pregnancy grant (universal) NI Credits Healthy Start	Poverty in and soon after childbirth is associated with a much higher risk of a low birth-weight birth, maternal depression in infancy and lower chances that the mother will try breastfeeding. All these are known to be associated with poor outcomes in the rest of childhood and in adulthood (Bradshaw and Mayhew, 2005). Lone parents are particularly at risk of poverty – children born to single parents are 907 times more likely to be born into poverty than children born to employed couples. Alongside level of education, being a young mother, having three or more siblings, ethnicity and geographic location can all impact the likelihood of being born poor (ibid). Babies born in the 20% most deprived areas have on average a 200g lower birth weight and account for one-third of babies with low or very low birth weight (Spencer, 1999).
Child birth / early years	Sure start maternity grant (if not already claimed) Cold weather payment (if child under 5 and parents receiving IS)	Young children in poverty have poorer general health and more specific health problems than their peers, and more admissions to A&E departments. Under 3 year olds in families with income of £10,400 or less are 2.5 times more likely to suffer life-limiting chronic illnesses, and two times more likely to suffer from asthma than under 3 year olds in families with incomes over £52,000 and over (Spencer, 2008 [unpublished]).
Childhood	Child benefit Child tax credits	Almost 3 million children in the UK live in poverty. Risks of childhood poverty have a regional dimension, with the south east having the lowest levels of childhood poverty and

	Child Trust Fund Free school meals	<p>children born in inner London at highest risk where almost half (48%) of children are born poor (CPAG, 2008).</p> <p>Children of lone parents or who do not have a parent in work are most at risk of poverty, however 8 per cent of children living in a household where all adults work live in poverty (ibid). This emphasises the continued problem of in-work poverty amongst those on low wages.</p> <p>Poverty in childhood has been shown to have profound effects on health in adult life (Forsdahl 1977). Higher childhood inadequate nutrition is shown to have a significant affect on adult height in men and women (Berney et al 2000). Childhood socio-economic disadvantage has been shown to heighten the risk of disability in adulthood (Kuh et al 1994). Childhood adversity, including economic disadvantage, has been shown to increase levels of mental ill-health amongst adults (Lundberg 1997).</p>
Young adulthood		
- entering labour market	National Minimum Wage (lower rate) JSA (paid at lower rate) New Deal for Young People Educational Maintenance Allowance	<p>Around 20% of young people aged 20 – 24 in the UK live in poverty. Poverty rates for 16 – 19 year olds are higher and stand at 23% (JRF 2007). The Poverty & Social Exclusion survey found young women were more than four times as likely as young men to be in poverty (Fahmy, 2006) Leaving home increases the risk of poverty while getting – and keeping – a job can protect young people from poverty, but only after they have been in work for around a year (ibid).</p> <p>There are concerns that young people will be the hardest hit in the current recession as youth unemployment in the UK is higher than for other age groups. Unemployment amongst 16 – 24 year olds currently stands at 16.1% (Eurostat, 2009) Young people who make the speediest transitions into a difficult youth labour market, parenthood or independent living are most at risk from the negative outcomes associated with social exclusion (Catan, 2003). Young males face particular mental health risks, with suicide rates amongst this group particularly high.</p>
Working age	National Minimum Wage Housing benefit Council Tax Benefit	<p>In the UK, six in ten poor households have someone at work, while over half of poor children now live in a working poor household. Five million employees, a fifth of the workforce, are 'low paid' earning less than 60 per cent of average earnings (Lawton, 2009). Low income and health can have a cyclical relationship, with low income and poverty raising the risk of poor health – and poor health heightening the chance of low income.</p>
- unemployment	JSA Income Support	<p>Unemployment in the UK now stands at over 2 million (National Statistics 2009). Unemployment rates are highest for those living in the North East of England and Wales, and those aged between 16 and 24 (ibid).</p> <p>Unemployment is the greatest determinant of poverty and exclusion. Around 20% of people in non-working households report being unable to buy some basic food items on most days in 2000 (Vegeris and McKay 2002).</p> <p>The health impacts of unemployment on physical health are significant. Research suggests that some 2,500 deaths per year amongst those aged less than 65 would be prevented were full employment to be achieved. (Mitchell et al, 2000).</p> <p>Unemployment can also have an impact on mental health, with stress related to debt concerns (Payne, 1999). Unemployment can almost triple an individual's suicide risk (Blakley 2003).</p> <p>Unemployment has been shown to be associated with relationships breakdown and lone parenthood (Rowthorn and Webster 2008)</p>
- relationship break up	New deal for lone parents	<p>One parent families live on lower incomes than other families and are more likely to experience poverty. Fifty per cent of children living in one parent families are poor (OPF, 2007).</p> <p>There is also a gender difference in how relationship breakdown impacts lone parents: research shows how 'gender remains a good predictor of whether an adult's income rises or falls after experiencing a marital split' (Jenkins, 2008: 20). Women's debt levels are more affected by the shocks of transition such as relationship breakdown than men's and the effects of such transitions tend to be longer-lasting (Westaway and McKay, 2007).</p> <p>Levels of employment amongst lone parents have increased, however, there is a continuing disparity between employment rates of lone parents and those of partnered Mothers (Barnes et al, 2008).</p> <p>Even when in employment, lone parents remain at risk from poverty: 60% of lone parents over the 1999 – 2003 period worked, but one-third were persistently low paid over this period and 40% were low paid for part of this period (Evans et al, 2004).</p>

		<p>There was a strong association between the experience of material hardship and the development of health problems among lone parents and their children. The most common ailments among children were respiratory problems, such as asthma - suffered by 7 in 10 ill children (Ford et al, 1998).</p>
- disability / long term illness	Employment and Support Allowance DLA	<p>Disabled adults aged 25 to retirement are twice as likely to live in low-income households as their non-disabled adults counterparts: 31% compared with 16% (Parckar, 2008).</p> <p>Disabled people also face extra costs related to managing their impairment that amount, on average, to approximately an extra quarter above normal expenditure compared to non-disabled people. The extra costs can result, for example, from paying for adaptations to the home, social care support, mobility aids or communication aids (ibid). The true extent of poverty amongst people with disabilities or long-term illness is often underestimated when poverty levels fail to take account of the costs of disability. Families dealing with the costs and consequences of disabilities and long term illnesses can require up to 1.9 times the income of families without these considerations (Zaidi, 2008)</p> <p>The employment rate among disabled people remains far below that of non-disabled people, with around 50% of disabled people not in work, compared to around 20% of non-disabled people (DRC 2007).</p> <p>Disabled people who are in work are at a substantially higher risk of in-work poverty, on average earning less than their non-disabled peers and being more likely to work in low skill, low paid jobs (DRC 2007).</p> <p>There is a significant relationship between poverty and long-term illness, with long-term illness increasing the risk of experiencing poverty and poverty increasing risks of long-term illness. In the UK, two-fifths of adults aged 45-64 on below-average incomes have a limiting long term illness or disability, more than twice the rate for those on above average incomes (source General Household Survey, ONS).</p>
Caring	Carer's Allowance Attendance Allowance	<p>The 2001 census recorded almost 6 million carers in the UK. Around 1.25 million of these provide more than 50 hours a week of care (Carers UK et al, 2007a).</p> <p>Caring can have a significant impact on employment, income and well-being for the carer. A survey of 3000 carers undertaken in 2007 found that:</p> <p>72% say they are worse off since they started caring 65% are not in paid work 54% give up work to care 53% say that financial worries are affecting their health 33% are in debt 30% are cutting back on food or heating 10% cannot afford to pay their rent or mortgage (Carers UK, 2007b).</p>
Old age / retirement	State Pension Pension Credit	<p>The risk of poverty among older people in the UK is about three to four times higher than the typical risk of poverty in Europe (Burholt and Windle, 2005).</p> <p>Moving from employment to retirement and the death of a spouse stand out as the biggest factors to impact downward trends in income mobility (Zaidi, 2008). Women who become widowed face an equal chance of experiencing a loss in income as they do an increase in income as a result of changes to benefit receipt on death of their spouse (ibid).</p> <p>Poverty levels are highest for those who have never been married, who do not own their own home, and those aged 80 plus.</p> <p>Although pensioner poverty has reduced overall since 1997, in 2006 /7 (the latest figures) 2.5 million people over 65 were living in poverty, up 300,000 on the previous year (Allen, 2008). There is a strong association between levels of deprivation amongst older people and poor emotional wellbeing and 2.4 million older people suffer from depression that impairs their quality of life (ibid).</p>

1.2 The introduction of social protection and its impact on health

One measure of the importance of social protection is to compare the health of a population before and after such measures have been introduced. Since this mostly takes place in stages this is not easy to do but in some cases major policy changes do give us a chance to calculate their impact on health.

There is a very interesting analysis of changing working class life expectancy in England during the First World War (Winter 1977). Despite the trauma of war, and unlike other European countries, civilian health seems to have improved quite markedly. Winter explains this by reference to higher real wages, especially for unskilled and semi-skilled workers, the growth of women's work in industry, and the provision of separation allowances for soldiers' and sailors' wives. (The latter was a form of family allowance paid to the wives of service men.) It was also a period which saw a significant improvement in older people's incomes following the introduction of old age pensions on 1st Jan 1909. These were means tested pensions which were nevertheless awarded in full in 96% of cases, illustrating the poverty of the million old people who received them (Macnicol 1998). It is difficult not to conclude that the boost to poorer working class family incomes that resulted was a major explanation for the improved health of that population.

Then there are studies of the impact of introducing social protection measures in other countries. One of great interest measured the impact of the New Deal programmes introduced in the US in the 1930s (Fishback et al 2007). These began only after the depression was well underway and were introduced over a short period. Infant mortality had been in long term decline prior to 1930. This positive trend was reversed by 1933. The very weak and patchy state administered poor relief programmes were not designed to cope with long term unemployment. The Federal New Deal programmes put a Federal safety net under families giving them access to food, clothing, housing and health care. The result, the authors show, was a significant reduction both in infant deaths and more generally. A one standard deviation increase in relief spending was associated with a 0.116 deviation reduction in the non-infant death rate. All causes of death were reduced, except for neoplasms and cardiovascular disease. They conclude that the costs associated with saving a life in this way were similar in scale to the costs of saving lives through Medicaid in modern spending terms.

The extension of pension coverage to the black population of South Africa gives other striking evidence (Case 2001; Case and Deaton 1998; Duflo 2003). The South African pension system was designed to benefit a small number of people in the white population. By 1993 it had been extended to all racial groups. On paper the scheme is means tested but 80 per cent of the elderly black population take up benefits and most draw the full pension. Self reported health surveys suggest that not only did pensioners' health improve but so did the health of others in the extended family where the old person lived in a household with a pooled budget. It did not do so where there was no pooling. The effect also differed according to gender: where the pensioner recipient was the grandmother health of children was improved. Children's health was not affected if the

recipient was the grandfather. Overall, daughters' health in the family improved, however, the boys' (presumably already privileged in the family priorities) did not.

There seems clear international evidence that the introduction of social protection has had important and positive effects on health outcomes even within societies that remain highly unequal in other respects. It also suggests that the gender of those who receive financial support has an impact on the health of family members (see also the section on gender below).

This does not tell us how far changes in the generosity of existing social protection systems produce changes in health outcomes. This is a more difficult research question but there is some evidence.

1.3 Generosity and coverage: their impact on health

Lundberg et al (2008) compare trends in life expectancy over the last century in 17 OECD countries and relate them to trends in the generosity and coverage of the social protection systems in each country standardising for the level of the GDP and the impact of war. They, too, find that the initial impact of the early schemes was significant and that the gradient of impact declines as the schemes mature but:

‘at any level of economic development the coverage and generosity of pensions, sickness, unemployment and work accident insurance taken together have a positive impact on life expectancy.’(p. 96).

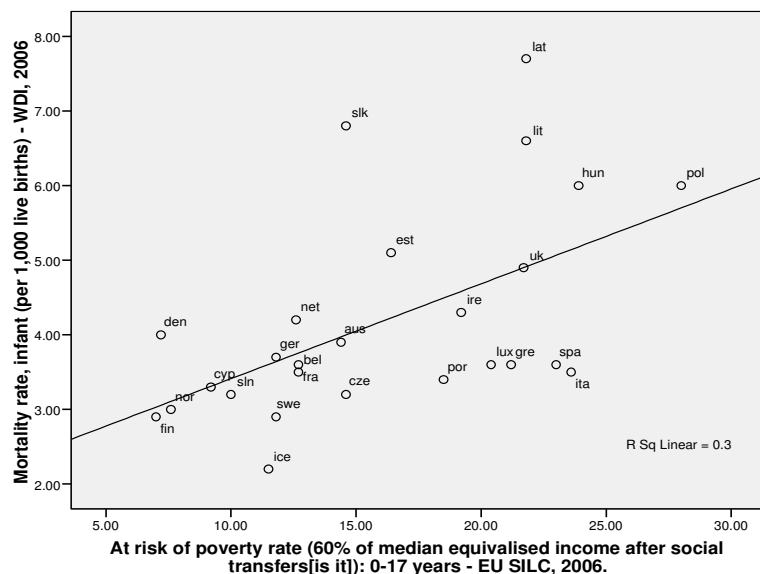
Lundberg and colleagues show the importance of the way programmes for families of elderly people are organised and funded. Using a Social Citizenship Indicator (p158) – a measure of social rights - state pension schemes were ranked by the extent to which they provided basic comprehensive cover for all citizens and the extent to which such benefits secured the relative living standards of the poorest. It also measured the extent to which they provided income security for the average worker through higher replacement rates. The results show that ‘excess old age mortality’ (compared to middle age) falls the more generous the basic citizenship component of the pension scheme. For every 1% improvement in the basic component, old age mortality fell by 0.5% (p163). Though the replacement rates for the average worker were higher in the ‘state corporatist’ models of welfare – Germany and France, Italy and Japan for example – this generosity was not associated with falls in old age mortality.

The basic citizenship component of social security schemes for all elderly citizens seems to be the element that matters most for their health.

Family policy is more complex than a matter of income. The more time parents can spend with their very young children and the more opportunity there is for the mother to breast feed the better the children's health prospects are, though other co-variables may also be at work (Chen and Rogan 2004.) Lundberg et al (2008) show that generosity of family transfers and wider support for dual earners are associated with lower infant mortality. Our own work suggests that the more successful European countries are in reducing poverty the lower are their infant mortality rates. This is a statistically significant relationship. In Norway and Finland where families have only about a 7% chance of

being poor (60% of median incomes) the infant mortality rate is about 3 per 1000 live births. In the UK, where the chance of a household being poor even after taxes and benefits was more than one in five, the infant mortality rate was nearer 5 per 1000. Both observations are essentially on the regression line that describes the average relationship for all European countries (see Figure 2). Similar results were found for the size of the poverty gap and its relationship with infant mortality.

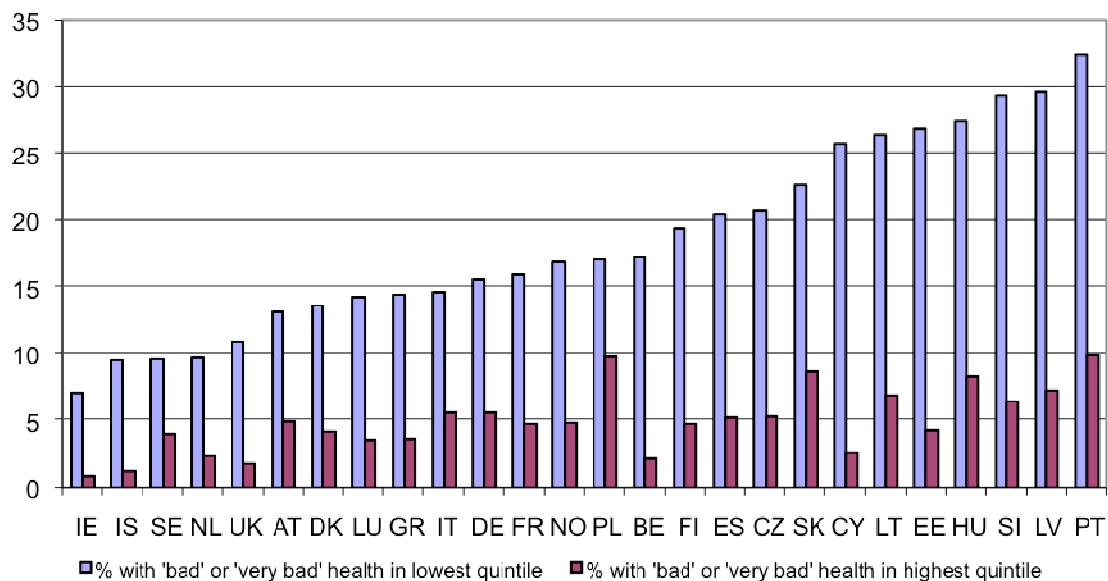
Figure 2 Poverty and infant mortality



More of those in the lowest deciles of household income say they experience poor health everywhere in Europe. But the gradient is generally greater in the UK compared to many other countries. The lowest quintile reports six times as much ill health compared to 2-4 times in a big cluster of other European countries.

However, as a counter to the general pessimism of much of this work we also found that fewer British people, including people experiencing poverty, complain of bad health than in almost all other countries in Europe except Sweden and the Netherlands and Ireland (see Figure 3). This is something for which either the NHS or the stoicism of the British may take credit, perhaps both. The gradient in the reported bad health of poor people across countries is not matched by a similar gradient for the rich.

Figure 3 Self-reported ‘bad’ or ‘very bad’ health by income quintile



Poverty is multi dimensional and its causes and long term consequences go far beyond pure financial stress (Tomlinson and Walker 2009). But financial strain affects all aspects of children’s current well being and their future lives. After analysing the impact of a wide range of deprivation factors these authors conclude:

‘The policy implications of (our) analysis are direct. Improving home life could be achieved by tackling any dimension of poverty but most effectively by reducing financial pressure.’(p4).

In the UK Gregg, Waldfogel and Washbrook (2006) show that the combined measures taken by the present government in the early years of this decade (Working Families Tax Credit, increases in Income Support for children and the Minimum Wage) increased the spending of low income families in ways that should be associated with children’s future health and well-being. Family spending by parents living in poverty rose on items like fruit and vegetables, children’s clothing and footwear, books and newspapers.

Gregg and colleagues (2007) later showed that the introduction of the Working Family Tax Credit was associated with a reduction in single parents’ anxiety and malaise in the period after the onset of single parenthood. Families’ improved income had a particular impact on adolescent children in those families. Gaps between them and other teenagers’ behaviour narrowed. Poor self esteem, unhappiness, truancy, smoking and the desire to leave school at 16 all halved. All these attributes are related to later health.

In another study Gregg and colleagues (2008) were able to confirm the links between family income and later life experiences with children born in Avon in 1991. These associations are strongly mediated through parental behaviour but are highly significant.

‘Holding constant other types of parental capital, income is strongly associated with types of maternal psychological functioning that promote self esteem, positive behaviour and better physical health in children’ (p29.)

There are particularly steep gradients of improvement in these outcomes as income rises at lower levels (Gregg et al 2008 p 44).

All these positive outcomes, however, relate to UK policies introduced in the early part of this decade. There has been no improvement in poor families’ relative income since 2005 and indeed some decline (Stewart 2009)

What this research suggests is that when government throws its weight behind a pro-poor family income strategy the potential implications for child and others health are significant. But these policies need to be sustained. When government takes its foot off this policy accelerator family budget improvements cease and by implication their impact on children’s health. To abandon the goal of largely ending child poverty because of the cost of financing banking failures would have serious repercussions for health inequality.

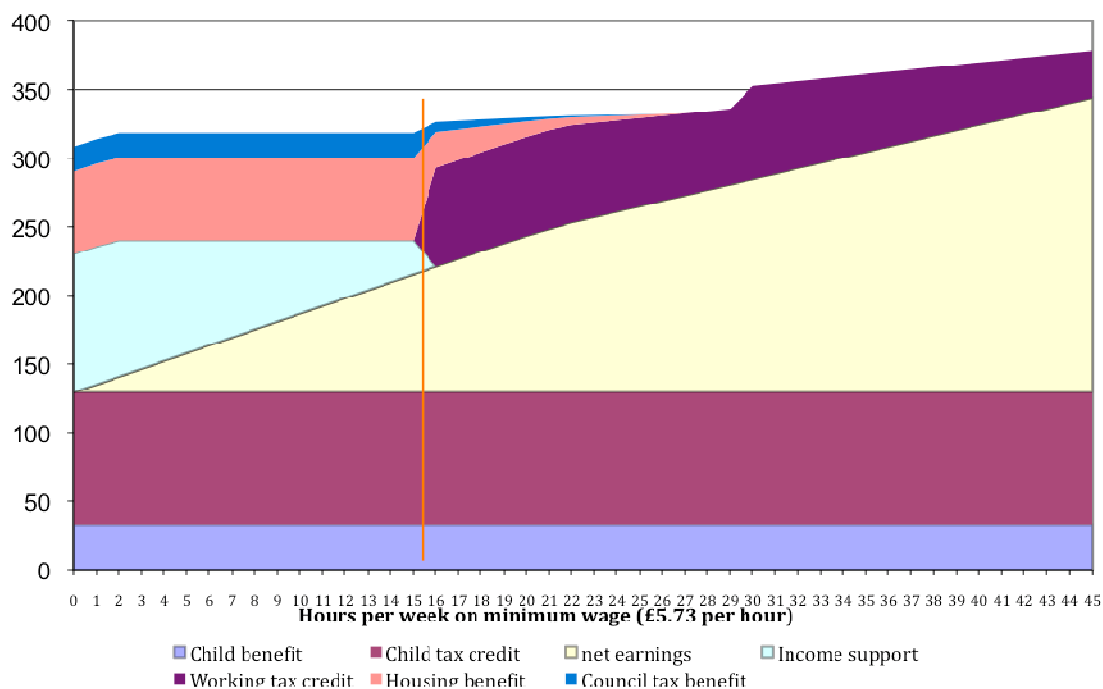
1.4 Targeting and selectivity

The previous Commission on the Social Determinants of Health (CSDH) (2008) concluded from the evidence it received that social protection systems that rely on heavily means tested arrangements have been less successful in reducing poverty, and hence health inequalities, than more inclusive and universal ones (p87-8). However, the United Kingdom case illustrates the complexity of this issue.

The UK moved from having a relatively universal, if rather low, standard of social protection in 1948, to one that has become increasingly means tested (See Table 1). But it has also recently adopted new ways of targeting support to people experiencing poverty making income related benefits for children and the elderly more generous and potentially less stigmatising. The numbers receiving the new tax credits have been extended well up the income range.

As we can see from Figure 4 the receipt of child tax credit extends over a wide range of income that could be earned by an individual on the minimum wage varying her hours of work. It also extends to families earning beyond the average wage. Instead of being used to minimise benefits to low income groups tax credits have been used to make them more generous while not benefiting the highest income groups.

Figure 4 Net disposable income £ per week for a couple plus two children before housing costs by hours supplied at the minimum wage from April 2009. Rent=£60 per week, Council Tax=£18.00 per week.



The move to use the tax system to target benefits drew heavily on US experience. There the Earned Income Tax Credit (EITC) was successful in reducing family poverty and in doing so in a way that was not stigmatising. Virtually all working families in the US fill in an income tax return and credits are calculated retrospectively. There is a minimum of stigma or additional complexity. One US study has tested the impact of introducing variations in its generosity over time and between states. It also compared that with variations in the traditional means tested welfare system over the same period (Strully, Rehkopf and Xuan, forthcoming). It shows that introducing an EITC programme was associated with higher birth weights for poorer children and less maternal smoking. But there was no association between birth weight and levels of generosity in traditional means tested and stigmatic welfare benefits. Being on 'welfare' was associated with more smoking.

However, in the UK most people do not fill in detailed tax returns annually. Our Child Tax Credit system requires additional, separate and complex form filling and tries to take account of changing family circumstances which the US system does not. It has ended up being complex, too often wrong and therefore worrying to poor families whose circumstances change week by week (Hills, Smithies and McKnight 2006).

The extent of low take up for income related benefits remains worrying. Between 59 and 67 per cent of potential pension credit beneficiaries do not claim. Between 6 and 10 billion pounds of DWP benefits remained unclaimed in 2006/7 (DWP 2008) while an

estimated £4 billion in working tax credits and child tax credits was unclaimed in 2005/6 (HMRC 2008). Thus while an improvement on traditional means testing tax credits are still overly complex.

Despite its disadvantages we do not recommend abandoning child tax credits which have proved instrumental in reducing the level of child poverty within a constrained budget. But we would favour over the long term increasing the role played by child benefit especially for second and subsequent children so as to provide a secure and adequate floor under tax credits. This is particularly important for families whose circumstances fluctuate.

A small example of an attempt to further universalise family support was piloted in Hull from 2004-7. Children in low income families are eligible for free school meals. Hull made all primary school children eligible. The evaluation showed positive impacts on diet, more fruit and vegetables consumed, more children ate breakfast, there was improved dental health and school behaviour (Colquhoun, et al 2008). The scheme was ended in 2007 when party control changed. The government have announced a further experiment in three poorer areas in England. Scotland has also experimented and as a result proposed free meals for those in the first three years of primary school from August 2010.

Table 1 British benefit expenditure 1948/9-2007/8

	1948/9	1958/9	1968/9	1978/9	1988/9	1998/9	2003/4	2007/8
	(percentages)							
Contributory ¹	53	67	69	66	55	47	45	45
Non contributory, Non income related ²	34	23	17	17	17	20	21	21
Means tested benefits ³	13	10	14	17	28	33	27	25
Tax credits ⁴							7	9
Total income related	13	10	14	17	28	33	34	34
All benefit spending	100	100	100	100	100	100	100	100
(£000s)	(471)	(1,287)	(3,172)	(15,837)	(47,315)	(95,557)	(124,511)	(150,580)

Source: DWP Benefit spending tables historical series (www.dwp.gov.uk);
H.M. Treasury Public Expenditure Statistical Analyses 2008.

¹ Retirement pension, widows, sickness, unemployment benefit, Job Seekers Allowance contribution based, maternity benefits.

² Family Allowance, Child Benefit, disability benefits, death grant etc. Child Benefit spending was excluded from the DWP series from 2003/4 as responsibility transferred to HMRC. HC Supply Estimates give totals for Child Benefit and Child Trust Fund.

³ National Assistance, Supplementary Benefit, Income Support, Family Income Support, Family Credit, Pension Credit, Housing Benefit, Rate Rebate, Council Tax Benefit, Job Seekers Allowance (Income Based). Some DWP means tested benefits are replaced by tax credits after 2003.

⁴ Working Families Tax Credit, Child Tax Credit, Working Tax Credit. (GB est.)

House of Commons Supply Estimates 2003/4; 2007/8

How people access social protection services matters. (Also see the section on gender below.) Targeting by income always creates problems. Some can be mitigated by the nature of targeting. There are other ways of prioritising those at most risk, for example responding adequately to the particular contingencies households face.

Universal benefits can be the most effective way of reaching poorer families.

Section 2 How much is adequate?

2.1 The present rules

The very term social protection implies that it is the state's intention to protect its citizens from starvation or from falling below some level of wellbeing deemed to be morally or politically unacceptable. As Jose Harris (2007) has argued 'entitlement to public relief in case of need had been a common law right in England and Scotland since the 14th century (long before the statutory formalisation of the Poor Law under the Tudors).' (p29) However, determination of need was for many centuries a local responsibility. During the Second World War Beveridge (1942) recommended that there should be a national determination of what constituted a 'minimum', or in his terms, a 'subsistence' level that should inform the setting of social insurance benefit rates and the national safety net that was to catch those not fully eligible for such benefits.

The concept of subsistence may have been flawed (Veit-Wilson 1994; Townsend 1979) but from the perspective of the Commission the natural question to ask is 'do people on benefit have enough money to live a healthy life?' This is not a question asked by governments: none of the endless reviews of social security in recent decades has addressed the fundamental question as to whether benefits are adequate. In many respects the UK has been moving steadily away from any notion of a common minimum standard of wellbeing. Some benefits are currently up rated in line with inflation, some with average earnings, some not at all. (See Table 2).

Table 2 Benefit up rating rules 2009

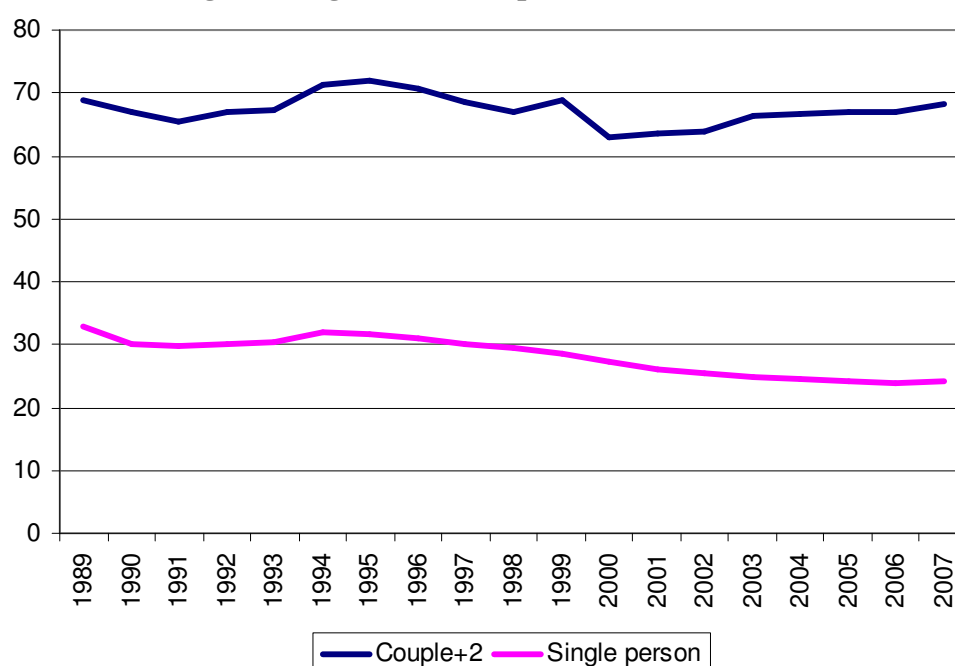
Type of Benefit	Up rating rules
Retirement pension	Retail price index (RPI)
Pension credit	Average earnings
Child benefit	RPI (but more for 1 st child this year)
Employment and support allowance (Incapacity benefit)	Rossi index (RPI less certain housing costs)
Child tax credit <ul style="list-style-type: none"> • child element • family element 	Average earnings none
Working tax credit	Prices
Income support and other means tested	Rossi index

Adult rates have been left to fall behind those for children relative to living standards. Those out of work without children have steadily fallen behind (see Figure 5 below). With each rise in average earnings compared to inflation the relative gaps widen. They are the consequence of policy allowing purely accidental variations between economic indicators to determine the living standards of people on low incomes. Reviewing the outcomes of this situation Sefton et al (2009) conclude:

‘The large and widening differential in means-tested support for different family types raises serious questions about the horizontal equity of the benefits system and, in particular, the sustainability of further selective increases in benefits for pensioners and families with children’ (p 31.)

We are driven to the conclusion that there is no rational coherent basis for the levels of benefit that are supposed to ‘protect’ UK citizens, at least looked at from the perspective of a commission charged with considering the health of the nation.

Figure 5: Income Support as a proportion of net in work income of one earner on two-thirds average earnings (notional replacement rate)



Source: DWP (2008) *The abstract of Statistics for benefits, national insurance contributions and indices of prices and earnings*, 2007 edition

2.2 A Minimum Income Standard?

There is a long tradition in the UK of measuring poverty by setting a household budget that is deemed by experts to be sufficient to purchase all ‘physical necessities’ (Rowntree 1901; Glennerster et al 2004). Modern usage refers to a ‘minimum income’ needed to support a ‘minimum healthy life style.’ This approach was re-established in the UK with

the work of the Family Budget Unit (Bradshaw 1993; Parker 1998; 2000). Middleton and colleagues at the Centre for Research in Social Policy (CRSP) developed a consensual approach to budget standards relying on the wider public's view about what constituted necessities (Middleton et al 1997; Smith et al 2004). If a family does not possess enough income to buy both the items that are commonly viewed as important for child's self esteem and food necessary to provide what an expert might view as a healthy diet, then the former - clothing or a mobile phone, for example - may take precedence. The latest work in this tradition therefore combines the two approaches (Bradshaw, et al 2008). This produces minimum income standards for a range of household types. They are derived from an iterative process that involves focus groups representing these household types and experts. The level was described for participants as:

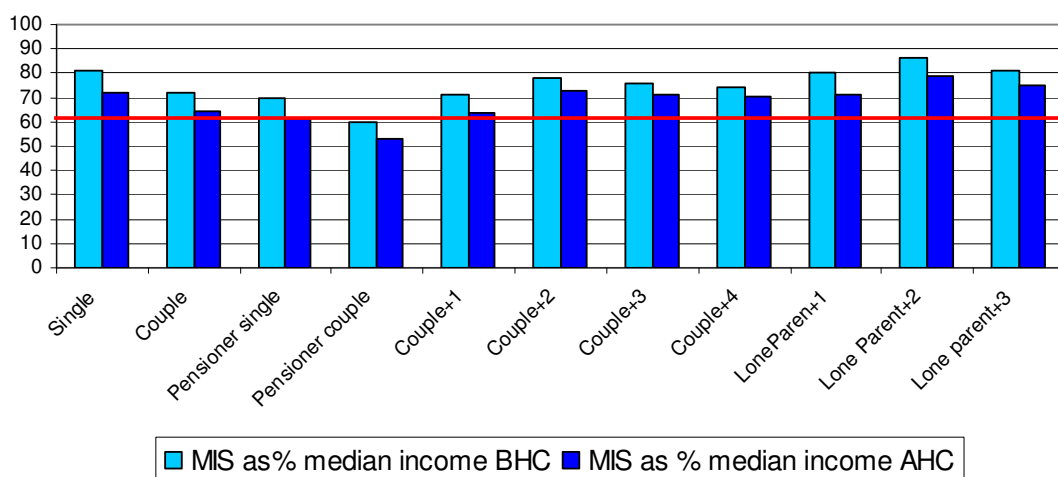
‘A minimum standard of living in Britain today includes but is more than just food, clothes, and shelter. It is about having what you need in order to have the opportunities and choices necessary to participate in society.’

The food budget was assessed for nutritional adequacy and guidelines for healthy eating. The fuel budget was designed to enable the household to have adequate levels of warmth for a healthy life given that the dwelling was of adequate size and had been made thermally efficient. Other, if less elaborate, estimates have been made by Morris and colleagues (Morris et al 2004).

Living in the cold is clearly a health risk. A household is said to be in fuel poverty if it needs to spend more than 10% of its income on fuel to sustain satisfactory heating (21 degrees in the main living room and lower elsewhere.) In 2005/6 only 7% of families were spending more than this. Over half were in single person households. But by November 2008 the price of domestic fuel had risen by over half compared to 2005. This will have increased fuel poverty substantially probably to more than 15 %. Over half of single pensioners and two thirds of workless households are now in this position (Bradshaw 2008). The marked excess of deaths in the March quarter is thought to be in part caused by heating problems. The Winter Fuel Payment is a response but it is only available to those over 60. The allowance is increased on an ad hoc basis and does not reflect the costs to those on benefit who spend more of their budget on fuel. Water charges have also been rising fast. Water debts and the anxiety they cause may have an impact on health (Huby 1995; House of Commons Environment Food and Rural Affairs Committee 2003).

Though it is not inevitable that households living below a MIS level will have unhealthy diets, homes that are too cold and resources that do not enable them to participate in society in a healthy way, the risks are clearly higher. The minimum income approach seems, intuitively, to be an appropriate way to begin to judge what levels of income might be taken as the basis for healthy living. When we compare the income ‘needed’ on this basis by each family type we can see that it is in many cases higher than that implied even by a poverty line set at 60% of median income (Figure 6.) That is not true for pensioner couples or single pensioners after housing costs.

Figure 6: Minimum Income Standard as a % of median income April 2008



If we use MIS levels as a yardstick of adequacy for those with no children we find it corresponds to only two fifths of UK income support levels. For couples and single parents with children income support levels are roughly two thirds of MIS levels and 80% of the poverty line.

Whatever measure we choose the striking result is how different is the scale of social 'protection' for different groups in the population.

Table 3 Income Support levels in relation to poverty thresholds and Minimum Income Standards by family type 2008/9

	% of poverty line	% of MIS
Single aged 25 no children	50	42
Couple working age no children	46	42
Couple 1 child age 3	66	62
Couple 2 children aged 4, 6	75	62
Couple children aged 3, 8, 11	81	61
Single parent 1 child aged 3	81	67
Pensioner couple aged 60 – 74	94	106
Single pensioner aged 60 - 74	107	109

Source: Sefton et al 2009

2.3 Barriers to improvement

There are of course difficulties in simply reading off from such studies a level of benefit that should be paid. While it is true that representative samples and focus groups discussing income adequacy produce the kinds of levels suggested above other equally representative samples asked about desirable levels of taxation give different replies. They suggest a reluctance to pay the taxes needed to fund such benefits.

When samples of the British population were asked if they were prepared to pay more taxes to fund better services a majority replied 'yes' through the 1990s and up to 2002. However, this reply turned out to mean 'only very little more' (Taylor-Gooby and Hastie 2002). Now only a minority of those questioned in the most recent British Social Attitudes Survey say they wish to pay more taxes for pay for better services and by 'services' they mean health and education not social protection for the non elderly (Sefton 2009). This gets scant support.

The budget standards approach gives us an initial way to discuss adequacy across the full range of social benefits in a way that ordinary people can engage in. But it has to be accompanied by an open discussion of the costs and possible trade offs. In the setting of the minimum wage such a weighing of the evidence is regularly undertaken by a panel representing employer and employee interests. Nothing equivalent exists in the case of social security benefits.

2.4 The costs of long term illness.

For those in the population who suffer from long term illness the costs imposed on the family can be high. Disability similarly adds to the costs a family faces and this differs by the kind and severity of the condition. Family members may experience a lower standard of living for any income they earn or receive in benefit compared to others (Smith et al 2004). Zaidi (2008) found that the costs varied with income and produced equivalisation factors that could be applied to adjust a family's income to take account of their differential needs. These varied from the lowest income group at 1.9 to that for the highest at 1.3. Saunders (2006) used a similar methodology in Australia with similar results.

2.5 Time costs.

Burchardt (2008) shows that the time costs of caring, looking after children and other family activities which have to go on even if people are in work can tip people into time poverty and affect the quality of care and /or the wellbeing of the household (see also the section on gender below)

At present levels of benefit many more families with long term sick or disabled members will fall into poverty when measured in a way that takes into account the differential costs these conditions bring. Present approaches to determining financial need do not take account of the time costs of caring. They should. Methods now exist to enable that to be done.

Section 3 Eligibility for and the administration of social protection

3.1 Excluded groups

Some groups face both serious health risks and find access to social protection difficult. Almost all migrant groups have lower life expectancy than the UK-born population, with some diseases, such as cardio-vascular disease, more prominent amongst certain minority ethnic groups. Asylum seekers and refugees experience higher levels of mental ill-health than the general population (Taylor and Gair 1999). Pakistani or Bangladeshi women are 1.5 times more likely to suffer from a long-term illness or disability than their white counterparts (Mizra and Sheridan, 2003) while gypsy and traveller groups are more prone to ill-health than the most disadvantaged socio-economic groups, with a strong likelihood of experiencing long-term illnesses, health problems or disability (CRE 2004).

Despite high levels of poverty, take up of benefits amongst excluded groups can be low. Excluded groups can experience difficulties in accessing benefits due to a number of factors including lack of information and awareness of the system. This varies by ethnic group. Bangladeshis have particularly low levels of benefit receipt alongside the highest levels of poverty whereas Pakistani local networks stand out as being particularly well-informed about the benefit system (Salway et al 2007). Lack of knowledge and high levels of illiteracy are also thought to partly account for low-take up amongst Gypsies and Irish Travellers (CRE 2004). There can also be cultural resistance to taking up benefits. Amongst Black Africans there is a strong reluctance to assume a disabled identity, for example (Salway et al 2007). Many minority ethnic groups tend only to be eligible for means tested benefits because their shorter working histories mean fewer national insurance contributions. Two-fifths of Pakistani and Bangladeshi working couples with children are on means tested benefits compared with 8% of white families. Minority ethnic women are likely to experience poverty later in life because they are less likely to have a state or private pension (Mizra and Sheridan, 2003).

Asylum seekers Strict eligibility rules mean that asylum seekers can be at further risk of poverty and destitution as they are not entitled to mainstream welfare benefits or to be in paid work. Those deemed destitute are supported by the National Asylum Support Service (NASS). Destitute asylum seekers include pregnant women and people suffering from physical and mental illness (Asylum Commission, 2008). The Refugee Council and the Independent Asylum Commission have also found that asylum seekers face significant difficulties in buying enough food and essential non-food items. As a result, many find it difficult to maintain good physical and mental health (Sellen 2000).

Difficulty in accessing health services has been thought to have an impact on levels of infectious diseases. Asylum seekers and 'over stayers' can be much more reticent to seek health care compromising the prevention of infectious diseases such as TB and HIV / AIDs. The number of recorded TB cases rose by over 10% in just one year across England, Wales and Ireland. This could have an undoubted impact on wider population health.

Making access to social protection difficult for asylum seekers and other new entrants to the UK is counterproductive and can endanger the health of the host community. Asylum seekers should be included in the standard system of income maintenance.

3.2 Sustaining work

There is strong evidence of a link between unemployment and poorer general health, longstanding illness and disability. It can aggravate adverse health outcomes. A stable work environment that is appropriately flexible can also contribute to health and wellbeing. This is especially true of many who are at risk of poor mental health. There is much evidence that unemployment can cause or aggravate adverse health outcomes (Bartley 1994; Janlert 1997; Shortt 1996; Murphy and Athanasou 1999). This is especially true for lower income groups (Saunders and Taylor 2002; Brenner 2002; Fryers et al 2003). Unemployment also increases the chances of relationship breakdown, whether loss of employment impacts upon men or women (Blekesaune, 2008) in turn increasing risks of poverty (OPF 2009) and poor health (Bleksaune, 2008).

However, the beneficial impacts of work (i.e. gaining adequate economic resources, improved self-esteem, improved general and mental health) depend on the nature and quality of that work. People can and do experience contrary health effects from work (Waddell and Burton 2008). Physical working conditions constitute a major cause of health inequality (Lundberg et al 2007). Moreover, those who are encouraged to enter work, then leave it and continuously re-cycle in and out of work, face more hardship and uncertainty for their family (Middleton 2004).

Poor links between health and social protection

Despite this, the links between the health service and employment-related services have been poor (Black 2008). The NHS lacks a tradition of vocational rehabilitation (Rankin, 2005) and has previously offered occupational health only for NHS employees (Black, 2008). The number of occupational therapists is relatively low in the UK, with only one for every 43,000 workers (Henderson et al, 2005). Occupational health has tended to be limited to helping people retain employment rather than for those seeking to re-enter work but even this provision is limited and varies widely in different industries. Only three percent of firms have a comprehensive occupational health service, although fifteen percent have more basic support (Royal College of Psychiatrists, 2008).

There are cultural, institutional and economic reasons for this situation. At a national level the split of responsibilities between health and social protection and employment services has been inimical to developing appropriate means to manage long term conditions, particularly mental ill health (Royal College of Psychiatrists 2008). This also applies to local service delivery. NHS providers of primary care have no incentive to invest in interventions that result in savings to other government agencies let alone private firms' productivity and profit. Reviews of welfare to work initiatives, such as Pathways to Work, have identified cultural clashes between Jobcentre Plus employees and NHS staff: the former having a more 'directive' approach as opposed to an 'empowerment' approach offered by the latter (Barnes and Hudson, 2006)

Recently there have been attempts to tackle these issues notably in the ‘Pathways to Work’ experiments’. The Gregg Report (2008) lays great stress on a ‘personalised approach’ with those who have a good chance to return to work in the longer term. The follow up white paper (DWP 2008) said they should have ‘access to a wide range of personal support’. Any agreed programme should include ‘managing their health for work, condition management, programmes for drug and alcohol rehabilitation, therapy or physiotherapy for a common health condition’. (p69). It also says that the process will ‘provide better support for those who have poor mental health in and out of work, including those who have fluctuating conditions’ (p83). But this depends on good collaboration between health and social care.

Twelve primary care trusts have been chosen to pilot an experiment in which they appoint employment advisors to people access the Psychological Therapies Programme. But, there is disagreement about the role GPs and other clinicians should play. The Black Review (Black 2008) put the GP firmly at the centre of promoting a return to work – ‘fit notes’ will assess what patients can reasonably do despite ill-health. But GPs and the Royal College of Psychiatrists see conflicts with their role as patients’ advisers (Sainsbury et al 2008; Royal College 2008).

The extreme complexity of the social protection system means uncertainty. This leads to fear about people changing their status – particularly moving into work (Work and Pensions Select Committee 2007; evidence to us from the Disability Alliance). The rules do not reflect how swiftly people’s circumstances change and how medical conditions fluctuate. There is too sharp a distinction between ‘in work’ and ‘out of work’ rules - the ‘cliff-edge nature’ of benefit conditionality (OPF 2007; JRF 2007; Disability Alliance 2009). Mind (2009) have suggested an ‘annualised hours allowance’: a system which allows individuals to work up to a certain number of hours each year before losing access to certain benefits, rather than the current system which allows work of less than 16 hours a week. Similar comments were received from Arthritis Care.

Complexity also leads to misconceptions. Many people believe that Housing Benefit will be lost when they enter work (DWP 2007a). They may be right. Difficulty with ‘passporting’ benefits means that it can be stopped if an associated benefit ceases (CAB; Disability Alliance; CPAG). Undertaking ‘Better Off Calculations’ should be done by Job Centre Plus advisers but this is time consuming and people often rely on mistaken local knowledge. Moreover, as unemployment rises, these calculations are less likely to be done by overworked officials (Toynbee, 2009). Recipients of housing benefit and council tax benefit who move into work can be subject to steep marginal deduction rates – up to 85% (DWP 2007b).

Parents or carers of disabled children face even greater disincentives. The Carers Allowance is lost once a carer earns over £84 a week and there is a disincentive to work more hours up to £131 per week. The costs of child care for such families is high and is not taken into account in the Working Tax Credit. This prevents most of these families being able to work (EDCM 2007). In work incentives overall have grown worse since 2000 (Adams, Brewer and Shepherd 2006).

Rules that apply to periods of incapacity to work, permitted work, ‘linking rules’ and other benefit complexities are difficult for anyone even in good health to understand. Staying out of work may easily become the preferred and rational option.

3.3 More positive links between health care professionals and social protection

There have been a number of pilots exploring the effectiveness of GPs acting as ‘gateways’ to further advice and work-related support. Under the Pathways to Work initiative, employment advisers were placed in a number of surgeries with generally positive results recorded from GPs, employment advisers and service users (Sainsbury et al, 2008).

A number of GPs also took part in early piloting of a National Education Programme to improve GPs knowledge, skills and confidence when dealing with health and work issues. Evaluations showed improved confidence to provide advice regarding fitness to work, but GPs emphasised time constraints on patient consultations and a lack of suitable back to work schemes in the locality (Chang and Irving, 2008).

Low take up of pension credit and other benefits by pensioners is particularly concerning, given levels of pensioner poverty. Over one third (36%) of pensioners fail to claim entitlements to at least one benefit (Hancock et al, 2008).

There have been a number of pilot studies exploring the effectiveness of welfare rights advice being provided in primary health care settings. They show that these arrangements did result in financial gains for patients. This resulted in more peace of mind, less stress, capacity to buy necessities and perceived independence as expressed in follow up interviews. Even though there was no evidence that this translated into improved physical health outcomes at least during the relatively short follow up periods (Abbott and Hobby, 2006; Mackintosh et al, 2006; Adams et al 2006), the improvement in well-being was sufficient to indicate the value of such initiatives from a health perspective.

This evidence suggests that there is scope for more positive relations between the health and social protection systems both helping people into work and in giving them access to benefits.

Section 4 Gender and health

‘Gender inequities are pervasive in all societies. Gender inequities damage the health of millions of girls and women. They influence health through, among other routes, discriminatory feeding patterns, violence against women, lack of access to resources and opportunities, and lack of decision-making power over one’s own health...In daily life, gender relations of power often underpin unequal access to and control over material and non-material resources and unfair divisions of work, leisure, and possibilities of improving one’s life’ (CSDH, 2008: 145).

The Commission on the Social Determinants of Health paints a stark picture of the continued impact of gender inequalities on health worldwide. In England, it has been argued that gender represents ‘a fundamental determinant of health status’ (Wilkins et al., 2008: 102). Gender differences in living and working conditions mean that men and women face different health risks (Doyal and Cameron, 2003). Nevertheless, the gendered patterns of physical ill health are not uniform and vary according to the condition (Payne 2006a; Wilkins et al., 2008).

4.1 Poverty, gender and mental health

The damaging effects of gender inequities are clearer and generally more consistent with regard to mental health, in particular depression and anxiety (Payne 2006a; Wilkins et al., 2008). According to the Royal College of Psychiatrists, those with a mental disorder are more likely to be women (59%), aged 35-54 and to be socially disadvantaged (www.workingforhealth.gov.uk/documents/mental-health-and-work.pdf). Women, people with low levels of social support and from poorer backgrounds are less likely than others to recover from suicidal thoughts (Singleton and Lewis, 2003). Poverty is associated with depression among new mothers (Mayhew and Bradshaw, 2005). The former Social Exclusion Unit observes that women generally are more likely than men to experience common mental health problems and longer-term episodes of depression. In particular, it highlights that ‘levels of depression are highest among the mothers of young children, lone parents and those who are economically inactive’ (2004: 75). A qualitative livelihoods study of 24 low income households found that ‘depression had impacted on virtually all of the women spoken to and a third of the men. There were clear gender-related catalysts that led to the depression for both women and men’ (Orr et al., 2006: 32; see also Women’s Budget Group, 2008).

However, the Poverty and Social Exclusion (PSE) Survey did not confirm a differential impact of poverty on women and men’s mental health. Instead, Sarah Payne suggests that there may be gendered differences in the ways in which poverty impacts on mental health, ‘associated with, for men, stresses related to self-esteem in the role of breadwinner or primary earner...and for women, stress revolving around caring responsibilities and managing a family budget on a low income’ (Payne, 2006b: 291). Possible support for this interpretation comes from a Swedish study (albeit couched in slightly different terms). This found a stronger relationship between measures of relative deprivation and self reported health and anxiety for men than women but the reverse for self-rated deprivation based on consumption items. The authors suggest that the impact of relative deprivation on men might reflect a greater concern among men with their relative social status, whereas the impact of self-related deprivation on women might reflect their ‘responsibility for everyday consumption’ and ‘internalised norms of everyday consumption’ (Yngwe and Lundberg, 2007: 155).

The PSE survey did find a gender gap in levels of common mental disorders among those in paid work, particularly part-time work. Payne suggests that ‘clearly the double burden of paid and unpaid work is likely to be of significance in explaining these figures for women’ (2006b: 299-3000). This double burden is also likely to be particularly stressful for low income women who are more vulnerable than men to a combination of time and income poverty (Burchardt, 2008).

Doyal and Cameron comment that ‘the higher levels of depression and anxiety reported by women have been explained in part by reference to their work in caring for others with what may be insufficient amounts of time, money and other resources. This is especially true for those women raising their families in poverty’ (2003: 9). Women typically act as the shock-absorbers of poverty (Lister, 2003; Women’s Budget Group, 2005). The associated stress is particularly acute where there is debt: women tend to be the primary managers of debt also. People with psychiatric disorders are much more likely to be in debt than others; according to McKay and Collard, ‘in general poverty and debt tend to cause mental health problems rather than be a consequence of them’ (2006: 206). Debt has been shown to have ‘a detrimental effect on people’s mental and physical well-being due to stress, stigma and fewer associated life opportunities’ (Sharpe and Bostock, 2002: 10; see also Balmer et al., 2006). This is graphically illustrated in Orr et al’s livelihoods study where women talked about debt as being ‘depressing’, ‘devastating’, ‘demoralising’: ‘When added to the high number of women depressed in our sample, a connection between debt, isolation, shame and depression is clear’ (2006: 22). Some of the women also talked about how debt affected their sleep.

Arber et al argue that good sleep is fundamental to good health. Their own analysis found that living in adverse material circumstances affects sleep quality adversely. Moreover, ‘women’s sleep is more likely to be disturbed by worries, particularly associated with their gender role as mothers or wives, and their concern for the well-being of family members’ (Arber et al., 2009: 287).

4.2 An intra-household and life-course perspective

To understand women’s poverty and its impact on health, it is necessary to adopt both an intra-household and a life course perspective. Intra-household analysis reveals that resources are not always shared fairly within families to the detriment of women and children (even though the evidence also indicates that women tend to put their children’s needs before their own) (Goode et al, 1998; Rake and Jayatilaka, 2002) This can result in hidden poverty and deprivation – not reflected in official statistics, which assume that income is shared fairly within households. The PSE survey found that when members of couples were asked whether ‘they/and or their partner went without certain items and activities in the previous year due to lack of money’, 21% of women answered yes compared with 17% of men. In poor-income households 27% of women and 11 per cent of men reported that their partners lack fewer items than they themselves did (Pantazis and Ruspini, 2006: 383). Payne (2006a) argues that these inequalities contribute to gender differences in women and men’s health.

An important factor in intra-household analysis is domestic violence. Recent qualitative studies of poverty have documented how domestic violence looms large in the lives of low income women, with adverse effects on their health (Orr et al., 2006; Hooper et al., 2007). A study of women’s financial assets also underlines the link between domestic violence and debt (Westaway and McKay, 2007). Cathy Humphries (2007) argues that violence against women is a key determinant of their mental and physical health and is therefore an issue of health inequality particularly for low income women who are at greatest risk of domestic violence. She cites studies that ‘hypothesise that financial

resources and employment provide a number of protections for women that prevent domestic violence or the entrapment of women in relationships of abuse' (Humphries, 2007: 123).

Humphries' argument underlines how a dynamic life-course perspective reinforces intra-household analysis because women's access to resources within a partnership affects their ability to cope should that partnership end for whatever reason. Recent research shows how 'gender remains a good predictor of whether an adult's income rises or falls after experiencing a marital split' (Jenkins, 2008: 20). Women's debt levels are more affected by the shocks of transition such as relationship breakdown than men's and the effects of such transitions tend to be longer-lasting (Westaway and McKay, 2007). A study of the financial implications of the death of a partner found marked gender differences with regard to the impact on psychological health. Women who felt that their financial situation had worsened following their partner's death were more than twice as likely to report high levels of emotional distress as those who did not feel financially worse off. There was no significant correlation for men. Moreover, the impact of a perceived worsening financial situation on women's psychological health continued over several years (Corden et al, 2008).

According to the former Social Exclusion Unit, 'twenty eight per cent of lone parents have common mental health problems' (2004: 75). In a Voices of Experience workshop run with mainly lone mothers by the Women's Budget Group 'depression emerged powerfully as a link between women's and children's poverty' (WBG, 2005: 4). A qualitative longitudinal study of lone mothers who had elected to move into employment after a period on benefit found that

poor health was a significant issue throughout the study. 19 mothers [out of 34 in the third wave] reported some significant period of illness since they were last interviewed in 2005. The women were suffering from a range of conditions that affected their capacity to work to varying degrees, including stress and depression...Several factors had precipitated a period of stress or depression, including the onset of physical ill health, caring responsibilities in relation to parental bereavement, pressures at work, and debt (Ridge and Millar, 2008: 3).

Health was also an important factor in whether the mothers felt themselves to be better off in work. This suggests that attention needs to be paid to the health implications of the increasingly stringent rules that are being applied to lone parents in order to enforce labour market obligations.

A key point in the life-course for women's health and that of their children is maternity. Harker and Kendall observe that 'the health of the mother-to-be is particularly important during pregnancy' (2003: iii). On the basis of their analysis of the effects of poverty on childbirth, using the Millennium Cohort Study, Mayhew and Bradshaw (2005) draw attention to the high proportion of lone mothers who have their first child while reliant on income support.

Later in the life course, care for adults becomes an important factor in the lives of many women and men, with women supplying around 70% of caring hours overall (Work and Pensions Committee, 2008). The Carers, Employment and Services (CES) study confirmed earlier research demonstrating the ‘the very clear relationship between health, caring and the hours of care given’ for both men and women (Yeandle et al., 2007: 22). ‘Carers who provide care for 35 or more hours each week are considerably more likely than other carers to report being in poor health’ (*ibid.*). Carers in poor health were more likely to be ‘struggling financially’ than other carers, regardless of employment status (*op cit: v*). Although, overall, male carers were slightly more likely than female to report poor health in the CES survey, the fact that women are more likely to care for longer hours makes them particularly vulnerable to poor health.

Women and men are exposed to different kinds of health risks but women are particularly exposed to the mental health problems associated with poverty because of their role in handling the family budget and in caring responsibilities. Social protection policy has to be sensitive to these differences and needs.

Section 5 Conditionality and health

We have already seen that work seeking conditions are increasingly being applied to the receipt of social protection benefits in the UK and elsewhere (OECD 2007; Greenberg 2006). But the idea of conditionality is also beginning to creep into preventative health care. Perhaps, it is increasingly argued, social security benefits should be tied to good health promoting behaviour. The idea originated in programmes for middle income and transitional economies.

A number of countries have introduced Conditional Cash Transfer programmes (CCTs) with the aim of providing financial assistance to parents in exchange for their investment in the human capital of their children. Typically, CCTs offer payments for attendance at health clinics, adherence to vaccination programmes and school attendance of younger children.

Evaluations of one of the earliest schemes, Opportunades (formerly Progresá), in Mexico recorded positive changes in behaviour. Beneficiary families visited the health facilities twice as frequently as non-beneficiary families (Gertler 2000). Intervention also led to a decrease in reported prevalence of childhood illness: within less than a year of exposure, children aged under 3 at the beginning of the programme were 25% less likely to be reported as having been ill. After 20 months, this figure rose to 40%. Children born to mothers on the program were 25% less likely than those born in non-beneficiary households to be reported as having been ill in the previous 4 weeks (Gertler, 2004). However, evidence for measurable medical changes in outcomes is less significant. This pattern is repeated across schemes in other countries (Morris et al, 2004; Attansio et al, 2005; Maluccio et al 2004).

The potential of CCTs has been noticed by the developed world with Mayor Bloomberg introducing the Opportunity NYC scheme in New York, USA. This scheme extends the

typical model. So for instance, parents will receive greater cash payouts should their child not only attend school but also see improvements in their academic performance.

There are concerns regarding the soundness of the evaluations of schemes. Legarde et al (2008) found that independent analysis of Progresia by a number of different investigators of the same data gave rise to different conclusions. There have been reports of inaccurate recording of results, for instance anecdotal evidence of schools automatically promoting children to the next grade in Nicaragua, grade promotion being one of the conditions of continued cash transfer (Bastagli, 2008). Some schemes are also thought to have produced unintended consequences, for instance increased fertility rates in Honduras where only pregnant women were eligible for subsidy (Stecklov et al, 2006), and further child malnutrition in Brazil where beneficiaries are thought to have mistakenly believed that having at least one malnourished child was necessary for continued membership of the program (Morris et al 2004).

There are difficulties in disaggregating the impact of the conditional component from effect of increases in income on its own with differing conclusions (Bourguignon et al 2003; Todd and Wolpin 2007). The impact of the unconditional Child Support Grant in South Africa showed that more generous grants in early life significantly boosted child height (Aguero et al, 2006). Similarly the introduction of a Basic Income Grant in one experiment in Namibia (N\$ 100 a month per person) was followed by a 42% fall in the number of underweight children and attendance at local children's clinics rose (BIG 2009). As Popay (2008) suggests, "when extra cash is available and people are able to make healthier choices, they often do so".

The government here is watching the New York experience closely and Child Development Grants are being piloted from 2008-11. Low income eligible parents who have not been in touch with Children's Centres will be given £200 if they 'engage or re-engage' with the advice and help available there (DCSF 2009). Although up-to-date information on the impact of introducing such conditionality into the Sure Start maternity grant scheme is not available, we do know that in 2001-2 over 8,000 claims were disallowed because of the failure to attend a child health clinic (Dwyer, 2008). This kind of programme needs more evaluation and discussion.

In short, evidence from the developing world about making social benefits conditional on healthy behaviour needs to be approached with caution. It is unclear how far applying such conditions to cash grants changes behaviour and it carries the danger of producing perverse results.

Section 6 Policy implications

Throughout we have argued that social protection has a part to play at every stage in the life course and that the UK system leaves some groups at particular risk. This leads us to the following conclusions.

A more reasoned and open process of benefit setting.

We have argued that there is no rational basis for the divergent and widening gaps that exist between the standards of financial protection afforded to different UK citizens at different stages in their life cycle. That is certainly true if we begin with the objective of providing a healthy living standard for all.

An assessment of the minimum standard of income that is required to sustain a healthy lifestyle should inform all benefit strategies and up-rating policies. Such an across the board assessment could be undertaken at regular periods by an expert panel drawing on evidence submitted to it and commissioned by it. The final decisions on levels of benefit must clearly be made by government, taking account of ‘affordability’ but these judgements should follow a more open and informed public debate and be informed by a long term strategy for all groups.

Benefit priorities based on health gain

- The government has promised to pursue its goal of ending child poverty by 2020. This should continue to be given high priority. Evidence suggests past interventions have been effective but need to be sustained.
- We have cited work which shows that to whom benefits are paid determines how family budgets are spent and who in the family benefits. Bennett (forthcoming) argues that social protection policies should take account of their impact on ‘the degree of autonomy enjoyed by men and women, and in the way in which within-household inequalities may be affected, both immediately and over the life cycle’. Child Benefit, which mothers largely draw, affects the child centred nature of family budgets. This argues for greater emphasis on child benefit as the vehicle for reducing child poverty and for an increase in child benefit especially for second and subsequent children who now attract a substantially lower rate of benefit.
- Adult out of work safety net benefits (income support, income related jobseeker’s allowance/employment and support allowance) have not been improved at all in real terms in recent years and are falling increasingly behind average incomes (Sutherland et al 2008). These need improving as a matter of urgency.
- The inadequacy of the adult benefit rate has particularly serious implications for first time pregnant mothers dependent on income support (Mayhew and Bradshaw 2005). The government has responded to concerns about pregnant women’s health with a new universal health in pregnancy grant of £190 from April 2009. The Healthy Start scheme provides milk/fruit vouchers for women who are 10 weeks pregnant or with under five children, in receipt of certain means tested out of work benefits or receiving child tax credit. Despite these moves pregnant women in receipt of benefit remain vulnerable especially if they are under 25 and therefore only receive lower age benefit rates for themselves. This makes no sense from a health perspective.
- To the extent that women take the main responsibility for managing inadequate benefits on a day to day basis their physical and mental health is most at risk as a

result of benefits being too low to sustain a healthy life. In addition to improving weekly benefits, the strain of juggling could be eased somewhat by the introduction of seasonal grants to help with one off expenses – such as new bedding or equipment. Research carried out for Save the Children (2007) found a preference for seasonal grants over an equivalent increase in weekly benefits among low income families.

- An improvement in carer's allowance could play an important part in improving the health of carers. The Work and Pensions Committee (2007) has called for a two tier scheme which combines income replacement for carers unable to work full time and compensation for the additional costs involved in intensive caring.
- The costs of long term illness and disability to a family are not fully recognised in the benefit rates such families receive. They should be reviewed.
- The time costs of caring and parenting are not adequately taken into account in setting benefit standards.
- At the other end of life growing uncertainty surrounds people's pension income especially if they are dependent on private defined contribution pensions that reflect financial market conditions. The government's commitment to raise the basic pension in line with earnings in the next parliament is therefore even more important than it was.
- Asylum seekers should be included in the mainstream income maintenance system. This should include entitlement to health related benefits such as sure start maternity grant and the new health in pregnancy grant.
- Based on the evidence of positive results from the Hull experiment, free school meals should be extended to all primary school children.

More tax resources will be needed.

Barriers

This is not a propitious time to suggest more public funding. Because of demographic changes merely to sustain present benefit levels relative to earnings will require devoting a higher share of the GDP to social protection. That is true even after taking into account the later age at which the full state pension is now to be awarded following the Pension Commission (2005). Current government estimates of future public spending still assume that all benefits to the non elderly will continue to fall relative to the incomes of rest of the population. To keep benefits at their present values relative to average earnings and sustain other service standards in the face of demographic change, may take 5 % more of the GDP in the next two decades (Glennister 2009) or 6% over four (Hills 2009). For the government to raise the current child cash support levels sufficiently to lift nearly all children out of poverty on the government's own measures by 2020 would cost £37 billion in current prices (or £28 billion in GDP adjusted prices) (Brewer et al 2009). The cost of meeting the half way targets for 2010 is much less – about £ 4.2 or 4.7 (depending on the assumptions) for the cheapest child tax credit option. To attempt to raise all benefits to MIS levels would clearly be far more expensive.

Yet, as we have argued, to abandon long term and achievable goals such as eliminating child poverty, raising basic pension and disability benefits to widely agreed levels of adequacy would be a bad mistake if we are serious about health inequalities.

Whatever the immediate constraints this seems to us an inevitable long term conclusion from our evidence.

Nearly a decade ago the public were convinced that the NHS lacked the resources it needed to provide prompt and high quality care. To raise social protection levels to anything near the standards necessary to create greater equality in health outcomes will similarly require higher levels of tax, preferably within a more progressive tax system. The case will have to be won and won in difficult times. But because people realise that times are special they may be more prepared to accept the logic.

We are told we are entering ‘a time of austerity’ with the implication that social ambitions must be curbed. Those who say so clearly have little experience of the 1940s. This was a time of very limited resources including food and fuel, both of which were fiercely rationed. There was a decline in the then much lower standard of living. It fell by 15 per cent in the years 1939 to 1942. Consumption did not recover to its 1938 levels until 1954. Yet it was precisely in those days of real austerity that the nation found the resources to found the National Health Service and put in place a comprehensive system of social protection. As a result of food rationing under scarcity differences in the quality of diet linked to incomes and social class essentially disappeared in this same period - the in take of protein, fat, vitamins and minerals, for example (Zweiniger-Bargielowska 2000). Austerity involved sharing the pain equally and planning for a new tomorrow. It could mean that again.

Other routes to an improved minimum income

There are other ways to raise the lowest incomes over the longer term other than raising tax or insurance contributions:

- reducing the numbers of people not earning through an extension of current into work policies;
- pushing up the minimum wage to the extent that it does not endanger the first goal;
- improving educational levels and skills, thus raising the long term rewards to work especially for the poorest;
- raising the levels of private pensions individuals save to acquire.
- encouraging and enabling a longer working life.
- enabling a higher proportion of the working age population to enter the labour force.

All these strategies are to be found in government policies but progress has been slow.

Simplification of the benefit structure

We have argued that the complexity and means tested nature of the social protection system has steadily grown since 1948 and is now in need of reassessment and simplification. There are three major routes that could take.

Citizens' Income entitlement

The enticingly simple solution offered by advocates of the Citizens' Income (www.citizensincome.org) is that the state provides everyone with a minimum income on which they build at their discretion. Critics argue that it would not merely require very high tax rates but raise major work incentive issues (Commission on Social Justice 1994 pp261-5 for a discussion and some answers). Yet for children, for the retired and for those too sick or disabled to work long term this latter argument has less force. The Pension Commission (2005) suggested the UK follow the example of the Netherlands and New Zealand in gradually transforming our basic pension from an insurance contribution basis to one derived from residence. The higher rates of benefit to be paid to those incapable of work under the government's new arrangements might be seen as a move in this direction. Child benefit can be seen as a means of ensuring that every family has the resources to ensure a minimum healthy standard of living for each child. A gradual move to the ideal of a citizen's income for these three groups does not seem to us an unrealistic goal. But to ensure healthy lives, it must be an *adequate* citizen's income. The government's lowering of the contribution period for full state pension and the extension of the principle of crediting contributions for periods of caring is a partial acceptance of this strategy.

Minimising means testing

This could be done by scaling up the importance of the child benefit component of the present support for children, notably by increasing benefits for second and later children as discussed above.

Improvements to benefits discussed already would also help achieve this goal.

We think the government's current policy to reduce means testing in old age and raise the basic pension in line with earnings is right and its time table for doing so should be kept to despite current financial difficulties which in many ways will increase old peoples' sense of financial insecurity.

Simplifying means testing

There are several proposals that come under this heading. The government's own welfare reform green paper (DWP 2006) suggested moving 'towards a single system of benefits for all people of working age.'

Sainsbury and Stanley (2007) suggested replacing IS, JSA, ESA/IB with a single working age benefit that dealt with income replacement. Extra financial needs would be transferred to need based benefits. It would be calculated at an individual level. It would not be based on any contribution record for 12 weeks and then means tested.

The IFS (Brewer et al 2008) have proposed An Integrated Family Support model. It would replace child and working tax credits, IS, JSA, child benefit, and housing benefit and council tax benefit. It would have different 'components' - family situation, numbers and age of children and housing. But they would be dealt with as one benefit. It would be paid by central government and withdrawal or tapering done through the tax system. The administrative detail remains to be worked out! The costs are kept down by means testing

child benefit, setting child and family entitlements below current rates of JSA/IS and by a rise in income tax of one per cent on the basic rate.

The ending of the as of right child benefit is a move away from the one universal cash benefit families have. Critics from some of the vulnerable groups concerned think that both attempts to merge the different schemes into one will merely move the complexity under one roof and the price to pay would be a further extension of means testing (Work and Pensions Committee 2007 paras 333, 334, 335)

We favour adapting the present rules in line with four principles:

- Improving the security of benefits when people's situations change, at least over an extended transition period;
- Maximising take up;
- Making sure that mothers actually receive the benefits where at all possible;
- Fuller consideration of the interaction between benefits.

Making it easier to move in and out of work for the long term sick and disabled

We have argued that the current rules do not take account of how quickly people's health circumstances can change. There is too sharp a distinction between 'in work' and 'out of work' rules. Some organisations have suggested to us an *annualised* hours allowance within which people can earn income before losing access to certain benefits, as opposed to the *weekly* 16 hour limit currently in place, alongside much more flexible treatment of individual cases.

Another possible way forward would be for GPs or consultants to identify people who are at risk of intermittent periods of sickness and thus likely to be repeatedly reliant on social protection benefits. Such people could, for example, be those who have a care plan in existence. The social protection system would then be alerted. An email from the responsible medical advisor (lead GP or consultant) to the designated social protection office would restart a full range of agreed benefits immediately.

This would clearly require checks against abuse and regular reviews. Experiments to work out the details and variants would be advisable. But some changes are necessary. The present system is neither helpful to those suffering nor to the taxpayer.

Parents and carers of disabled children face even more disincentives to work than lone parents. We have not been convinced that any single solution exists but we think it is a significant problem that needs examining with some urgency. The fact that the social protection system is often a barrier to resuming working life especially in cases where this would be especially helpful to individuals' health and wellbeing is regrettable.

Better links between the health and social protection systems

Such links are currently poor. Many in the medical profession see their role as patient advisors conflicting with any attempt to act as agents of the social security state. Yet if we are to rely on a 'more personalised' approach to helping people move from being long term sick to full contributing members of society good medical advice is crucial. There are no incentives for the medical profession to do this now. We welcome experiments

underway to integrate staff from the employment service into local health care agencies and attempts to reward local PCTs and GPs who succeed in reducing long term sickness. We strongly endorse the extension of occupational health services as the best way to provide skilled advice to those who are finding difficulty adapting to work again or holding down a job and managing a serious long term condition.

GP practices have been shown to be good places to site welfare benefit advice. Benefit take up increased as did patients' quality of life and social interaction even if long term health gain has been difficult to demonstrate. This suggests to us it is something that should be extended.

Healthy behaviour conditionality

There has been some discussion of making various benefits conditional on undertaking some kind of healthy behaviour notably on behalf of children. Experiments have been undertaken abroad and one, 'Sure Start Maternity Grant', has been introduced here. We advise considerable care in going further down this route as overseas evidence shows perverse consequences are all too easy to occur. The application of conditionality to the maternity grant appears to have excluded some potential recipients. But we do not know who they are. Are they those who might need them most or not? We require up-to-date information to evaluate such schemes effectively.

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Disability Alliance

Arthritis Care

St Mungo's

Cardio and Vascular Coalition