

# A citizens' advice service in primary care: improving patient access to benefits

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The links between deprivation, poverty and ill health are well known, but many people with significant health problems do not claim welfare benefits to which they are entitled. Accessing advice within primary health care may be one way of tackling this problem. The aim of this development project was to develop and evaluate over a 3-year period a welfare rights advice and information service that would not only complement the work of the primary health care team, but also target those patients who were most in need. The service was developed using an action research approach. Three models were used with different primary health care teams. The evaluation consisted of both qualitative and quantitative elements. The qualitative study used semi-structured one-to-one interviews with 11 patients who consented to be contacted, two Citizens' Advice Bureau workers and 26 primary health care team members from 10 general practices in Gateshead covering a wide range of practices and patients (approximately 73 000) from all socio-economic groups, and additional focus group interviews with three further primary health care teams. Quantitative data were collected by the Citizens' Advice Bureau on 683 patients and benefits received. A welfare rights service with an attached Citizens' Advice Bureau worker was seen as beneficial by the primary health care team. The work of the primary health care team was complemented by the CAB worker's additional expertise. Many patients entitled to benefits who would not otherwise have sought advice from a Citizens' Advice Bureau worker were referred by primary health care team members. It was found that targeting people unable to access the surgery reached those most in need in the project group. For those referred, a cumulative total of £1 641 865 was gained during the lifetime of the project. Many patients were referred and as a result received benefits. Optimum use of the service was achieved by restricting the service to the housebound. The use of a dedicated telephone line appeared to maximize the use of the workers' time, and also made few demands on the time of the primary health care team.

**Key words:** family practice; social welfare

## Introduction

Deprivation and poverty have been strongly linked to ill health (Department of Health and Social Security, 1980; Townsend *et al.*, 1989; Phillimore

and Beattie, 1994) and are in part addressed by the state welfare benefits system. However, many people do not claim the benefits to which they are entitled. For instance, one-third of about 100 patients who were regularly visited by general practitioners (GPs) at home were not claiming an attendance allowance (Jarman, 1985).

A review of several studies on patients entitled to claim attendance allowance found that many of them could have claimed earlier. Such patients and

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their families felt let down that their doctor had not told them about the appropriate benefits (Buckle, 1986). Despite this view, many doctors appear to feel that welfare rights, social problems and housing problems are inappropriate areas for presentation and management by a GP (Dowrick *et al.*, 1996). Demands on a GP's time cannot be limitless (Chaggar, 1993). Nevertheless, as poverty is linked to ill health, a patient with increased finances is likely to have access to better care and be more mobile, and may well be less demanding of his or her GP's time. Most primary health care team members lack the required expertise to advise patients regarding benefits, and may not consider referral to other agencies, but are often in the unique position of being the only potential source of advice.

Citizens' Advice Bureau sessions held in general practice have been evaluated in Birmingham (Paris and Player, 1993). Not only was a large increase in benefits obtained, but people mentioning health problems were significantly more likely to be entitled to unclaimed benefits. Those whose financial circumstances improved by virtue of assistance given by the Citizens' Advice Bureau had a tendency to have a better health status than those not in receipt of extra money, and those not in work improved more than those in employment (Veitch, 1995). The Birmingham researchers had attempted a formal randomized (at a practice level) controlled trial with intervention and control subjects evaluated using validated quantitative questionnaire instruments. However, recruitment of controls from control practices proved very slow, and the required sample sizes could not be achieved. They therefore concluded that 'the collection of qualitative data could be increased in future research' (Paris and Player, 1993 p. 61).

Our project aimed to find an effective way of providing an advice and information service that would not only complement the work of the primary health care team but also target those patients who were most in need in order to make optimal use of the limited resources available. It was not our intention to link improvements in health to better access to benefits. The mode of delivery of the service evolved during the project according to the participatory philosophy and cyclical approach of action research. The use of some potential patients as 'controls' was not considered to be ethically acceptable by the local Citizens' Advice Bureau,

so formal comparisons were never intended. Funding was obtained to employ a full-time Citizens' Advice Bureau Welfare Officer (WO), to be based initially in seven general practices in Gateshead with the aim of accepting referrals from the primary health care team. The practices were selected pragmatically in conjunction with the then Family Health Services Authority to achieve a spread of type and location. Surgery-based sessions with four or five appointments were offered to each of the participating practices on a fortnightly basis (model 1).

Some practices made good use of the service, but in others (particularly the smaller practices) appointments were difficult to fill and nonattendance was common. After 1 year, a dedicated telephone line was provided for the four lowest referring practices, by means of which the Citizens' Advice Bureau worker could be accessed directly and easily (model 2). It was still felt that many people were using the service who could have accessed the central bureau, and that people who were housebound and those with mental health problems should be targeted. The reasons behind the non-use of the central bureau were not within the parameters of our project. It was necessary to find ways by which the service could be made available to a wider group of practices, so the project was concentrated on individuals who were housebound in a new sample of three Gateshead practices (model 3). All of those practices within the Gateshead district that were not involved in models 1 and 2 were invited to participate. However, only three of them took up the offer. Building on the Birmingham experience, our quantitative evaluation was limited to simple data on the amount of extra benefit gained for patients but, using qualitative data, the practicalities of the service and the comparative merits of the three models were explored with primary health care professionals and patients where possible.

## Methods

### Qualitative methods

Two workers contributed to the project sequentially changing after about 6 months. The worker was interviewed at 6-monthly intervals to explore the action research cycle of fact-finding, planning, implementation and evaluation (Hart and Bond,

1995). Citizens' Advice Bureau colleagues and the research team contributed to this process. All of the patients who were seen by the worker were informed that they might be invited to an interview to evaluate the project. Patients were interviewed once only, and a random sample of four patients was selected from a list provided monthly by the worker of all closed cases and a standard letter sent asking if the patient would agree to an interview. It was possible to interview in their own homes the majority of those who replied by post in the affirmative. The majority of those who were invited declined to be interviewed, and no follow-up was felt to be acceptable in order to respect confidentiality and sensitivity. However, no new data appeared in the later interviews, so larger numbers might not have revealed much further information. In total, 13 patients were interviewed. Ethical permission to conduct patient interviews was given by the Gateshead local research ethics committee.

The primary health care team members were selected by the worker from different practices in order to gain a wide range of opinions. Most of those who were invited agreed to be interviewed. The following health care professionals were interviewed: five GPs, four practice nurses, two health visitors, four receptionists, six practice managers, three district nurses and two community psychiatric nurses. Some interviews were held after the project's first year, and more during the 18-month to 2-year phase. A list of names was provided by the worker covering all of the practices involved and encompassing a range of roles within the primary health care team. Letters inviting professionals to be interviewed were sent out, and it was generally not difficult to gain their permission. Occasionally, a substitute individual was found in the absence of a primary health care team member. In one practice, only the manager agreed to be interviewed and one or two others who were approached refused permission as they were new to the team and felt that they had little experience of the project. The interviews were semi-structured, exploring as many aspects of the project as possible and allowing the interviewee to talk freely. The relative merits of the three models were explored where relevant.

Three focus groups consisting of a total of 21 health professionals were held, one in each of the practices involved in the third phase of the project,

and three more patient interviews were conducted. All of the interviews and focus groups were recorded, transcribed and analysed for themes using the NUD\*IST qualitative analysis computer software package (QSR NUD\*IST; Qualitative Solutions and Research, 1995).

Interviews were conducted by the two researchers who knew some of the health care workers professionally, but were unknown to the patients. At the beginning of each interview it was explained that the project needed to be evaluated in order to determine whether it was beneficial, and how best such a service should be provided in the future. The fact that both interviewers were not only university researchers but also locally known GPs probably helped to obtain agreement for health professional interviews. No payment was offered to the health care workers for either the individual or focus group interviews. None of the patients interviewed was under the clinical care of either of the interviewers, so the latter were identified only as university research workers.

### **Quantitative methods**

Quantitative data were collected via the Gateshead Citizens' Advice Bureau on the numbers and source of patients referred, together with their type of health problem (if any) and the type and amount of additional resources gained for them from the welfare benefits system.

## **Results**

### **Qualitative methods**

The advice worker believed from the start that the links with the primary health care team were a great advantage that would hopefully lead to greater confidence in the service and more referrals. The primary health care team felt that the advice worker would be undertaking work outwith their role:

we get lots of people with lots of problems . . . not particularly medical problems but . . . social problems . . . housing, etc., and GPs aren't always the best people to answer those sort of questions you know . . . and the Citizens' Advice Bureau have the knowledge basically and it's saving GP time and it's getting patients the best advice. (Practice manager)

The worker had time to listen to the patients' problems, which were seen as basically non-medical. For example, a district nurse felt that:

the forms are just a nightmare . . . patients don't understand them so they give them to you, and really at times you haven't got time to fill them in . . . (the worker) will go out and visit the patients and he'll fill them in for us and he knows how to get through the system, which is very good because we've had a few returned from cancer patients and we don't understand why they are not getting the allowances when they are obviously terminally ill and he goes out and they get the allowances. (District nurse)

There were other advantages, too. Patients, professionals and workers all welcomed the opportunity to make a Citizens' Advice Bureau appointment within the near future with no anticipated delays. The surgery setting was also more familiar, it was not usually far to travel, and it was less stigmatized than a bureau attendance.

I wouldn't have gone to the advice bureau, but being in the surgery was different. (Patient)

By 'kind of prescribing it to them', as a worker commented, the service was legitimized. GPs commented that the referral could be seen as part of a 'total package of care', an 'extension of our services', and the fact that it was initiated by the doctor removed barriers and could be perceived as making it more confidential. It was considered advantageous that people were being helped to get the benefits that they needed.

I still had a hard enough time just to get that money back, but if I hadn't have come up here I wouldn't have gotten it at all. (Patient)

He's getting them a lot of money, that's the biggest advantage, he's winning the appeals and he's getting the money, he's getting the claims put right, and it's all because he knows what to put on the forms. (GP)

[the worker] got me the mobility and incapacity, you see, and the mobility I wouldn't have known anything about. (Patient)

Practices varied in the ways in which their staff were informed about the service – some organizing meetings, while others made little effort to impart information. People were especially keen to learn about what would be an appropriate referral, the range of assistance that the Citizens' Advice Bureau could provide, and what was expected of them. Those in the practices that had arranged meetings incorporating training felt that they had been well informed. There was no organized feedback, although it was generally felt that this would have been useful. It was suggested that a standard letter listing patients seen or referred each month would not breach confidentiality.

The service was found to be very valuable, fulfilling a real need and complementing the existing service by almost all of the primary health care team members interviewed.

I thought it was an excellent idea, very innovative, proactive rather than reactive, [a] quality service and also a degree of empowerment involved in actually having a client come here to see someone to discuss issues, it's very positive. (Health visitor)

Well, I certainly think it should continue, I think it would be really beneficial to clients and members of staff as well. If it wasn't to continue, I think it would be a shame . . . have a word with clients to get their feedback.

(Community psychiatric nurse)

### Housebound service (model 3)

A GP felt that it was advantageous to initiate the referrals personally rather than have a surgery-based session where patients could self-refer:

By us offering it we've had to be more proactive so we've had to think more about the patients, but if there was someone sitting there, you may rely on patients to initiate referrals. (GP)

Those who were interviewed who already had a surgery-based service were emphatic that a housebound service should be provided as well as, not instead of, their current service. Practices that were only offered this service were satisfied, as were the patients who would not have thought of using the service themselves. One GP said:

I'm quite happy not to have anything to do with benefits . . . to refer to people who have all that information . . . at the end of the day, I'm a doctor – I've got enough to deal with.  
(GP)

Referral was simple and quick:

there was no referral letter, didn't have to come back, trawl the notes out, I was just in the house, phone call to the answering machine, takes less than a minute. (GP)

The importance of the service was emphasized by one GP, who reported:

[almost] everyone referred got a considerable increase in benefit – this almost implies that we didn't refer enough people. There are other people who could have done with it.  
(GP)

### Quantitative methods

The cumulative total of additional benefits gained for patients during the study period was £1 641 865. The type and amount of specific benefits are shown in Table 1. The majority (54%) of the 683 referrals came from GPs, with 16% from nurses and 10% by self-referral (see Table 2). More than half had physical illnesses, either alone (47%) or with mental health problems (14%). Mental health problems alone were reported in

**Table 1** Specific types and amounts of benefits gained from March 1995 to March 1998

Type of benefit	Total gained by March 1998
Attendance allowance	£135 216.80
Invalid care allowance	£26 742.25
Disability living allowance	£421 773.70
Severe disablement allowance	£82 761.88
Income support	£302 199.00
Council tax benefit	£10 187.78
Family credit	£17 691.75
Housing benefit	£40 541.82
Overpayment of benefits reclaimed	£588.37
Other benefits, including charities	£513 541.60
Road tax exemption	£1863.64
Incapacity benefit	£88 405.21
Child benefit	£2351.97
<b>Total</b>	<b>£1 641 866.00</b>

**Table 2** Sources of referral

	Number referred	Percentage of total
General practitioner	364	53
Self	67	10
District nurse	42	6
Health visitor	29	4
Community psychiatric nurse	26	4
Practice nurse	11	2
Other	144	21
<b>Total</b>	<b>683</b>	<b>100</b>

29% of cases, and only 10% had no health difficulties. The proportion of those referred who received additional benefit was higher in the housebound-only model compared to the surgery-based sessions and dedicated line models (55% of 42 referred vs. 32% of 641 referred).

### Advantages and disadvantages of the three models

#### *Model 1 – surgery-based sessions*

Despite success in obtaining benefits for patients (see quantitative results section), there were drawbacks with the surgery-based sessions. Some surgeries were either unable to fill appointment times or filled them inappropriately. Some had experienced difficulty in finding space for the worker. Return appointments were not taking up their allocated time, and non-attendance was problematic. The doctor could use the service to offload supposedly demanding patients. In places where the service had been well used, the worker found that he started to receive a much larger proportion of 'word-of-mouth' self-referrals which were often inappropriate. Such people could equally well have attended the bureau.

#### *Model 2 – dedicated telephone line model*

The dedicated line model offered several advantages. Surgeries did not have to struggle to find space for the worker. They could also refer if and when required – there was no pressure to fill appointments. Communication with the primary health care team was increased. For example, the referrer was usually the one who had identified the problem and who had to use the telephone to leave

a message. This meant that more thought had gone into the referral, instead of merely telling the patient to make an appointment at the desk.

### *Model 3 – dedicated telephone line and restriction to the housebound*

There were quite specific criteria in the third model, so referrals were appropriate and there was no duplication of work in the central bureau. The worker felt that the third model was the way forward for the future:

We've got a system that's easy to work to, doesn't impose too many pressures on practices, and one worker could cope with a lot of surgeries. (Worker)

## **Discussion**

It is clear from our results that the primary care-based Citizens' Advice Bureau service was welcomed, much needed, valued and effective. It enabled the expertise of the Citizens' Advice Bureau to reach a cohort of patients who would not otherwise have received it or derived financial advantage from it. Moreover, primary health care team members felt better able to cope with benefit problems presented by their patients, and they welcomed the initial training.

Although surgery-based sessions worked well in some of the practices, it became obvious that such a method of delivering the service was open to misuse, and did not always make the best use of the worker's time. A dedicated telephone line improved the quality of the referrals, and when this was combined with targeting individuals who were housebound, it appeared that this was the best way of maximizing the effective use of limited resources. The implementation of this method meant that patients who could never access the central service were prioritized, all referrals were appropriate, the worker's time was not wasted and the service could be offered to a larger number of practices.

We believe that the number and spectrum of health care professionals interviewed was sufficient to elucidate in detail the groundswell of support for the new services offered in our study. More interviews might have produced some dissonant voices, but we consider this unlikely. Patient inter-

views were continued until no new messages emerged, but we acknowledge that the sample may have been biased. Many patients, particularly those with mental health problems, declined to take part in an interview, so other issues (both positive and negative) may have remained hidden. The involvement of a community psychiatric nurse with such patients may have boosted the uptake of interviews, but was not logistically possible.

The quantitative data on health problems were obviously rather superficial, and the cash sums cited may be an underestimate, as some payments continued beyond the end of the study. We chose a cumulative figure to represent moneys gained over the 3-year project. Patients entered the project at different times; some benefits won were recurrent, but for an unknown period, while others were 'one-off' payments. Extrapolating a figure to represent moneys gained over a 5- or 10-year period would thus not have been an accurate representation.

Despite this, the moneys gained during the project markedly exceed those produced in earlier work (Paris and Player, 1993; Veitch, 1995). It would have been interesting to explore the types of benefits gained in more detail, particularly the large sum labelled 'other benefits including charities', but the data held by the Citizens' Advice Bureau did not permit this. The increased proportion of successfully benefited patients in the housebound cohort indicates both their greater need and the effectiveness of this model of primary health care linkage. The fear of a 'burden GPs could do without' (Chaggar, 1993: 261) can be alleviated. If the amount of benefit gained for our sample of practices in all three models was extrapolated to the whole country, the additional welfare bill would be enormous, but restricting the service to the housebound would appear to provide the opportunity to tackle need in a targeted fashion.

### **Guidance for those wishing to implement a similar service in their primary care group**

On the basis of our work, we suggest the following model to improve patient access to benefits and to allow such a valued service to continue (see Box 1). All practices within a primary care group should be invited to participate. The referral process should be restricted to members of the primary health care team, using a dedicated line and limited to those who are unable to access a central bureau

**Box 1 Practice points**

- The provision of Citizens' Advice Bureau services linked to primary health care would appear to be an effective means of securing and maintaining very necessary benefits for those most in need and most at risk.
- All practices within a primary care group should be invited to participate, with preference given where appropriate to those in deprived areas.
- The referral process should be restricted to members of the primary health care team using a dedicated telephone line, and limited to those unable to access a central bureau (e.g. individuals who are housebound, the terminally ill and those with mental health problems).
- Practices should start to access the service in a staged fashion. This would allow the worker initially to spend time with as many members of each primary health care team as possible, informing them about who and how to refer, and the range of services offered.
- A feedback session after the first month may be helpful, followed by monthly written updates on referrals received and dealt with.
- Using the above model, one worker could cover the patients of the average primary care group on a continuing basis.

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Since the government is set on reducing the overall welfare budget as a matter of urgency, the provision of Citizens' Advice Bureau services linked to primary health care would appear to be an effective means of securing and maintaining very necessary benefits for those most in need and most at risk from any proposed changes within the context of the government's drive to reduce inappropriate benefit claims (Department of Social Security, 1998). Since tighter controls on welfare spending will inevitably put more barriers in the

way of the needy and the undeserving alike, we strongly recommend further consideration of Citizens' Advice Bureau workers in primary health care services in order to protect the disadvantaged. The latter are surely not the intended target of the Government's welfare reforms.

**Recommendations for further study**

A larger study targeting individuals who were housebound that investigated the use of the worker's time, type and amount of financial benefits gained, and methods of introduction of the scheme into a primary care group, would be valuable. A study designed to investigate whether an improvement in health follows successful benefit claims would be interesting. It would also be useful to investigate the reasons behind the nonuse of the Central Bureau.

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**References**

- Buckle, J.** 1986: Informing patients about attendance and mobility allowances. *British Medical Journal* 293, 1077-78.
- Chaggar, J.S.** 1993: Letter: Citizens' Advice in general practice. A burden GPs could do without. *British Medical Journal* 307, 261.
- Department of Health and Social Security** 1980: Inequalities in health: report of a research working group (Black Report). London: HMSO.

- Department of Social Security** 1998: *New ambitions for our country: a new contract for welfare*. London: Department of Social Security.
- Dowrick, C., May, C., Richardson, M. and Bundred, P.** 1996: The biopsychosocial model of general practice: rhetoric or reality? *British Journal of General Practice* 46, 105–107.
- Hart, E. and Bond, M.** 1995: *Action research for health and social care. A guide to practice*. Buckingham: Open University Press.
- Jarman, B.** 1985: Giving advice about welfare benefits in general practice. *British Medical Journal* 290, 522–24.
- Paris, J.A.G. and Player, D.** 1993: Citizens' advice in general practice. *British Medical Journal* 306, 1518–20.
- Phillimore, P. and Beattie, A.** 1994: Health and inequality in the Northern Region, 1981–1991. Newcastle upon Tyne: Department of Social Policy, University of Newcastle upon Tyne.
- Qualitative Solutions and Research** 1995: *QSR NUD\*IST* (Application Software Package). Melbourne: Qualitative Solutions and Research.
- Townsend, P., Phillimore, P. and Beattie, A.** 1989: *Health and deprivation. Inequality and the north*. London: Routledge.
- Veitch, D.** 1995: *Prescribing Citizens' Advice. An evaluation of the work of the Citizens' Advice Bureau with Health and Social Services in Birmingham*. Birmingham: Birmingham District Citizens' Advice Bureau Ltd.