Welfare to work: the role of general practice

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SUMMARY

This paper considers the potential effects of the government's Welfare to Work policy on general practitioner (GP) working patterns, and aims to explore the relationship between unemployment, ill health, and GP sickness certification. Social security and employment policy initiatives are discussed in relation to the literature on the relationship between unemployment and ill health, sociological and psychological perspectives on work and unemployment, medicalisation of unemployment, adjudication of fitness for work, re-employment and health, and treatment of barriers to employment. The authors postulate that Welfare to Work policy may depend for its success on the crucial role of general practice in sickness certification.

Keywords: welfare; sickness certification; social security; fitness for work.

Introduction

ANNUAL spending on social security benefits is almost three times the cost of the whole of the National Health Service.[1] The government's Welfare to Work policy has the basic aim of targeting the working age population in order to move as many as possible of those financially dependent on state benefits to paid employment and financial independence, and therefore to social inclusion.[2]

Currently, 7% of the working age population of England and Wales are claiming benefits on grounds of incapacity, compared with 5% claiming as unemployed.[3] It is very difficult to anticipate the effects of government welfare policy on these figures and it is possible that there may be both an increase in unemployed people seeking sickness certification and in disabled people seeking work.

The adverse effects of unemployment on health,[5,6] particularly mental health,[7-12] have been well described; those who have been unemployed for more than 12 weeks suffer between four and 10 times the prevalence of depression, anxiety, and somatic illness.[13] There is also a recognised statistical association between unemployment and a raised standardised mortality rate from suicide and accidents.[14,15]

There is evidence to suggest that unemployment increases the workload of primary care, as people who are unemployed have been shown to consult their general practitioners (GPs) more often than average.[16] However, the relationship between unemployment and ill health is a complex one, combining elements of both cause and effect.[17]

A more complete picture may be gained by considering sickness and disability rates alongside unemployment, as people may be transferred from the unemployment register to sickness and disability benefits via a number of different pathways, for political and economic, as well as medical reasons. The GP is the gatekeeper to most of these pathways via sickness certification and therefore has a crucial role to play as signatory to the financially dependent state.

Literature review

Current government social security policy is contained in the Green Paper *A new contract for welfare: principle into practice, the gateway to work and support for disabled people*.[2-4] A search of the British Library and MEDLINE, PsychLIT, and Sociofile databases using the keywords 'unemployment', 'work', '(mental) health', and 'sickness certification' was conducted, and references relevant to primary care and government policy were followed up.

Work and unemployment

Fulfillment of needs. In the 1930s, when mass unemployment was the norm, the sociologist Jahoda, described the benefits of having a job as imposing a time structure, increasing the scope of social relationships, experiencing the greater achievements possible through collective effort, and giving a sense of personal identity and social status.[18,19]

Writing from a psychological perspective in the 1980s, Warr described nine factors affecting the mental health of the unemployed, the most important being financial hardship.[20] The others include anxiety about the future, decreased opportunity to use existing skills or to develop new ones, and an increase in threatening and humiliating experiences associated with a decrease in the quality of interpersonal contacts; for example, signing on for unemployment benefits.

These mediators in the complex association between unemployment and poor mental health can also be used to explain why individuals in unsatisfactory and stressful occupations may feel better if they lose their job,[21] and why those who have found a satisfactory alternative lifestyle without paid employment may feel worse if they are re-employed.[22]

Meaning in life

Rather than regarding the poor mental health of many unemployed people as a result of the failure to satisfy basic needs (for time structure, social status, etc.), Ezzy[23] suggests that the cause may be rooted in a failure to find meaning in life,[24] and that the experience of unemployment is actually a transition phase between the loss of meaning associated with employment, and the reintegration associated with either re-employment or adaptation to an alternative lifestyle.[25]

According to this theory, Welfare to Work policy is likely to improve health if it helps jobless individuals to find meaning and purpose in paid employment. However, there may be many barriers to re-employment, such as successful adaptation to life on benefits, when financial gain from re-employment may be very small compared with the satisfaction of the person's present lifestyle; for example, looking after a family, or pursuing a hobby.[26]

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Submitted: 7 January 1999; Editor's reply: 19 March 1999; final acceptance: 16 June 1999.

© *British Journal of General Practice,* 2000, **50,** 497-500.

With increasing mechanisation, shorter working hours, and a relatively high proportion of the working age population jobless and dependent on state benefits, it may be that paid employment no longer occupies the central role in some people's lives it did in the past.[27]

Factors moderating psychological distress

A number of factors moderating the effects of unemployment on psychological distress have been identified, including financial problems,[12] social support,[28,29] age and length of unemployment,[30] previous job satisfaction, expectancy of re-employment,[31] and perceived responsibility for job loss.[32-34]

More recent research has concentrated on how individual coping style affects the mental health of the unemployed[35] and Wanberg has found that this is important, particularly when there is low situational control.[36] Four main coping styles identified by Carver[36] have been shown to be associated with different health outcomes:

- active coping style increases the likelihood of re-employment, although it is associated with high levels of initial anxiety after job loss, and does not seem to be protective against the long-term development of depression;
- focus on emotion has been positively related to both depression and anxiety in the unemployed;
- reappraisal seems to be protective;[36] and
- avoidant coping styles are significantly associated with anxiety and depression and a decreased likelihood of re-employment.[35,36]

This may partially explain the avoidance and apathy found in the long-term unemployed by earlier researchers,[38] i.e. those who are more proactive are more likely to have found jobs, leaving the avoidant copers who are more prone to anxiety and depression.

The long-term unemployed may therefore, over time, have become virtually unemployable, owing to poor mental health and low self-esteem, confidence, and motivation. This group is likely to need a period of rehabilitation and training before they can cope with re-employment, even if potentially suitable jobs become available for them.

Medicalisation of unemployment

Unemployment presenting as sickness or disability. Those in stressful or problematic occupational circumstances may be certificated by their GP as suffering from anxiety or depression as a result. After some time off work they may be made redundant by an employer who finds them unsatisfactory as an employee, and continue to receive incapacity benefits when their situation is now one of concealed unemployment.

Job loss may lead to a deterioration in (mental) health to the point where the person becomes incapable of work, even if it were available, and is signed off sick. Socio-economic imperatives, such as the stigma of unemployment, the organisational problem of regular signing on procedures, or the relative financial advantage of different benefits, may encourage people to seek sickness certification.[39]

A hard-pressed GP may view a request for a sick-note as a welcome opportunity to make up time in a busy surgery, and it is much easier to sign patients off work than it is to sign them back in.[40] However, the request for a sick-note can be viewed as an opportunity to discuss work and health related issues, in the same way that a request for antibiotics may lead to health education concerning the aetiology of self-limiting viral illness.[41]

Long-term illness or disability often leads to sickness certification when, under more favourable employment conditions, the person would be able to benefit from having a job. Under the 'New Deal for Disabled People', a number of financial incentives to encourage people on incapacity benefits to return to work will be piloted and there will no longer be a time limit of 16 hours per week voluntary work.[4] GPs will therefore be able to encourage people on benefit to try out new situations without risking the loss of their financial support, but may still be hampered by lack of access to rehabilitation services.

Adjudication of fitness for work

Once an individual becomes unable to do their current job, management of their incapacity falls largely to the GP with follow up adjudication by the Benefits Agency when incapacity exceeds six months.[4] However, by this time the person's employment situation and their mental health may already be compromised and there is a potential conflict of interest between the GP's traditional role of patient advocate and that of adjudication of fitness for work demanded by the benefit system.

The social security medical assessment determines ability to do any work at all, rather than fitness for 'own occupation'. This may cause considerable anger and frustration, often vented on their GP, if a person with a health problem that prevents them from continuing in their own job is found 'fit for work'. Conversely, anyone who is found 'unfit' is no longer obliged to visit their GP for sickness certification. This may lead to acceptance of disability and failure to seek any further medical help, possibly resulting in unnecessary levels of continuing or deteriorating ill health.

Reform to the 'all work test' in April 2000 introduced an emphasis on capacity for work in addition to benefit entitlement.[2] GPs are encouraged to provide certification for relative disability or ability and to take a more active role in certifying limited fitness for light duties or short hours. While this might be beneficial for occupational rehabilitation, the extra work would not be popular with most GPs and could increase the potential for conflict between advocacy and adjudication roles. However, these problems might be solved by earlier professional consideration of (relative) fitness by social security assessors.

Re-employment and health

Kessler *et al,* in a study of an area of Michigan with a high unemployment rate, showed that adverse health effects of unemployment (high levels of depression, anxiety, and physical illness) were largely reversed by re-employment.[42] Two mediating processes were identified: financial strain and heightened vulnerability to other life events.

In the case of those whose health has suffered from unemployment, it is likely that improving their psychological wellbeing will lead to a greater chance of re-employment and improvement in overall health. Price *et al* have pioneered a job search intervention based on these principles,[43] and clinical psychologists in London have shown that cognitive behavioural therapy for the long-term unemployed results in improved mental health and job-finding success.[44] A pilot of a nurse-led psychoeducational intervention[45,46] for unemployed people with psychological symptoms is currently taking place in Merseyside. If this study shows worthwhile results, such interventions could be offered by suitably trained nurses/counsellors in a general practice setting.

Treatment of health barriers to employment

Approximately 50% of recipients of incapacity benefits have a diagnosis of musculoskeletal or mental health problems.[3] Many of these are suffering from depression and anxiety and chronic

conditions such as back pain and arthritis that have rendered them unfit for their previous occupation.

These groups will be treated largely in general practice[47] and may need referral for other services, such as counselling and psychology, physiotherapy, or back schools. Many people will need a period of retraining following medical management before they are able to successfully gain employment.

The process of occupational rehabilitation could function more successfully if links can be developed between local GPs and personal advisors (PAs) established by the Department for Education and Employment at job centres, as part of the ONE project, formerly known as the 'single gateway'.[4] The March 2000 budget statement announced the introduction of a limited number of Job Retention pilots to test the relative effectiveness of different employment and health strategies in reducing numbers of people off sick long term. Rehabilitation programmes providing health interventions alongside retraining packages, with access jointly via GPs/health centres and job centres, could theoretically provide seamless working and greater cost-effectiveness with improved outcomes in both health and employment.

In order to function effectively in this role, GPs may need more training in the recognition and management of occupational issues. Some GPs already have skills in this field through part-time work as social security assessors or occupational health physicians. These doctors could be a useful resource to link primary care groups (PCGs), PAs, and the Benefits Agency. The Chief Medical Officer's review of continuing professional development in general practice may provide the appropriate climate for such a multi-professional educational collaboration.

Conclusions

The government promises: 'Work for those who can: security for those who can't'.[48] In the majority of cases, re-employment and ensuing economic independence will be as beneficial to the individual and their family as it is to the taxpayer. Work may also give meaning and structure to people's lives. However, inappropriate pressure on those frail in body or mind, or who have adapted well to a life dependent on benefits, may be harmful to the individual.

Successful mobilisation of the potential workforce will depend on the active participation of the country's GPs, and the development of good working relationships between social security assessors, PAs, and GPs. This could be fostered locally by co-operation between the job centre, the social security office, and the PCG.

There is a need for co-ordination and development of easily accessible interventions to rehabilitate those who are unable to work owing to illness or disability, particularly back pain and anxiety/depression. These interventions should be easily accessible from, or provided within, general practice and be made available to the patient before the condition becomes chronic or as part of a retraining package for the long-term unemployed.

While it is probably true that in the right circumstances almost everyone can work,[48] it can equally be said that in the wrong circumstances almost nobody will. It will remain the responsibility of GPs to mobilise resources to benefit their patients' health, while protecting them against unreasonable and unrealistic expectations.

Keypoints

- Unemployment is associated with poor health.
- Seven per cent of the population are disabled/sick compared with 5% unemployed.
- Back pain and depression constitute over 50% of the long-term sick.
- Individual coping style may influence both health and employment outcomes.
- PCGs have a potential role in co-ordinating preventive treatment and rehabilitation services for the working age population.
- GPs have a crucial role in sickness certification to promote health and independence while protecting the sick and disabled.

- Better communication between primary care, occupational health, social security, and employment services: joint local initiatives and training programmes.
- Identification of mediators and the optimum point of intervention in the development of chronic dependency.
- Development of rehabilitation initiatives, particularly for back pain and depression.
- Training in certification for GP registrars and medical students.

Box 1. Research and development needs.

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