

# **The Health Benefits of Financial Inclusion: A Literature Review**

**Report for NHS Greater Glasgow and Clyde**

**Louise Dobbie and Morag Gillespie  
Scottish Poverty Information Unit**

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The Scottish Poverty Information Unit believes that poverty is caused by the unequal distribution of opportunities and resources rather than the lack of resources in society. SPIU aims to assist those committed to eradicating poverty in Scotland through robust policy analysis, quality research and widespread dissemination of poverty information. SPIU seeks to work in partnership with others towards the goal of reducing poverty and extending social justice in 21st Century Scotland.

Contact:

Morag Gillespie

Scottish Poverty Information Unit

School of Law and Social Sciences

Glasgow Caledonian University

Cowcaddens Road

GLASGOW G4 0BA

[Morag.Gillespie@gcal.ac.uk](mailto:Morag.Gillespie@gcal.ac.uk) (Tel: 0141 331 3766)

NHS Greater Glasgow and Clyde is committed to tackling the effects of structural inequalities. Its Equality Scheme ensures accountability for leadership and ownership for legislative requirements around this. Work across NHSGGC on employability and financial inclusion ensures that services intervene to ameliorate the effects of socio-economic inequality. The NHSGGC Financial Inclusion Group oversees this work and has a remit to develop the evidence base on financial inclusion, including the most effective interventions; establish connectivity between services; influence policy and strategy; develop performance indicators; create opportunities to share tools and developments that support financial inclusion and develop appropriate pathways between acute and community services.

Reference is made in this report to documents produced within NHS Greater Glasgow and Clyde. Further information about these and copies are available from:

Noreen Shields, Planning & Development Manager

Corporate Inequalities Team

GGCNHSB, Dalian House

350 St Vincent St

Glasgow, G2 8YU

Tel: 0141 201 4975 Fax: 0141 201 4601

Email: [noreen.shields@ggc.scot.nhs.uk](mailto:noreen.shields@ggc.scot.nhs.uk)

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## Report Conventions

**Advice Services:** This term is used to incorporate services that deliver welfare benefits or welfare rights advice (generally restricted to advice about welfare benefits and income maximisation work); debt or money advice (includes advice on a range of money related issues, including debt and income maximisation work) and general advice (including CAB services that provide advice in addition on issues such as employment, housing, taxation and utilities).

**Financial Exclusion** is concerned with “the lack of access to and use of a range of financial services”.<sup>1</sup> Exclusion can arise from a complex set of overlapping barriers and for a range of reasons including access, terms and conditions, marketing and price and self-exclusion. People who are financially excluded tend to be poor, live in relatively deprived areas and have certain characteristics such as being unemployed, sick, a disabled person, lone parent or single pensioner.<sup>2</sup> As well as the greater likelihood of being poor, financial exclusion can mean people have lack a bank account or insurance, use high interest credit and pay more for utilities.

**Financial Inclusion:** This study uses the definition in the Scottish Executive Financial Inclusion Action Plan, 2005:

*“access for individuals to appropriate financial products and services. This includes people having the skills, knowledge and understanding to make best use of those products and services. Financial exclusion is often a symptom of poverty as well as a cause.”<sup>3</sup>*

### Abbreviations

CAB	Citizens Advice Bureau
CHCP	Community Health and Care Partnerships
CPN	Community Psychiatric Nurse
DRS	Development and Regeneration Services
GAMH	Glasgow Association for Mental Health
GAIN	Glasgow Advice and Information Network
GCC	Glasgow City Council
HADS	Hospital Anxiety and Depression Scale
NHP	Nottingham Health Profile
NHSGGC	NHS Greater Glasgow and Clyde
RCT	Randomised Control Trial
REA	Rapid Evidence Assessment
SF 12/36	Short Form 12/36

# Section1: Background and Methods Used

## Introduction

This report was commissioned by NHS Greater Glasgow and Clyde (NHSGGC) and produced by the Scottish Poverty Information Unit. The aim of this review is to provide a summary of evidence on the health benefits of financial inclusion and to assess the need for more research.

The links between poverty and ill-health are well established and people living with long term ill-health or disability are more likely to be living in poverty, a key factor in poorer health outcomes that have far-reaching effects on individuals and their families. However it has been argued that less is known about the pathways that link ill-health to poverty or how they may be broken. In particular, limited attention has been given to social participation, access to non-labour income, and other knock-on effects.<sup>4</sup>

The specific association between poor mental health and poverty is also recognised and there is a strong association between debt and poor mental health,<sup>5</sup> with consequences for the relationship between mental health and financial inclusion. Cullen et al have highlighted that the anxiety and stress that accompany debt are known to impair health and affect relationships with family and friends.<sup>6</sup> One quantitative research study highlighted that:

*“The fact that a quarter of people with mental disorder were in debt has direct implications for effective clinical assessments and care planning, as well as for awareness in debt counselling agencies, utility companies and financial organizations.”<sup>7</sup>*

Current evidence shows that the health inequality gap is widening - income inequality has risen in each of the last three years and is now at its highest level since our comparable time series began in 1961.<sup>8</sup> The recent economic downturn is likely to worsen the situation for the most deprived communities and excluded groups including women, black and minority ethnic people, disabled people, homeless people, refugees and asylum seekers. The situation of children in families vulnerable to unemployment and other disadvantage is also likely to be affected. There is now greater acknowledgement of the potential for measures that tackle financial exclusion to reduce health inequality and tackle the social determinants of ill-health. A key recommendation in the Equally Well framework stated:

*“Universal public services should build on examples of effective financial inclusion activity, to engage people at risk of poverty with the financial advice and services they need. Removing the stress caused by debt will improve people’s health and wellbeing.”<sup>9</sup>*

Welfare benefits in the UK are complex and potential beneficiaries may face a range of barriers to accessing entitlements to benefits, including, for example, age, health, transport, access, literacy or cognitive difficulties.<sup>10</sup> Improving the take up of benefits entitlements, or income maximisation, has been a key area of investment by the NHS as one means of helping to address low income and poverty and contributing to

reducing health inequalities. This includes support for provision of services from within healthcare settings, particularly primary care.<sup>11</sup>

The development of the broader approach involved in financial inclusion is relatively recent and it embraces a range of services or activities including money advice and income maximisation work, awareness raising and service provision around, for example, savings or low cost credit, and financial capability or money management support and guidance. While advice is integral to financial inclusion, more holistic approaches are now recognised as essential.

However, in relation to health improvement, advice has been important to debate so far and is the most researched area of financial inclusion. It remains the most common financial inclusion activity located in health services and the number of projects and services delivered in health settings has grown. Most often evaluations and research on such projects and services have recorded activities and, for example, the types and amounts of benefits gained. However, most have not measured the health benefits for clients or the benefits to health services, including some research within the NHSGGC area.<sup>12, 13, 14</sup>

## **NHS Greater Glasgow and Clyde objectives on financial inclusion**

The NHS has contact with people as part of their rehabilitation and self-care pathway and, therefore, an opportunity to support people in accessing wider social needs, such as welfare benefits entitlements. Research has identified that:

*“Roughly two thirds of the population consult their general practitioners at least once a year. General practitioners and community nurses are exceptionally well placed to detect those who are suffering genuine financial hardship but they are not well equipped to give advice about the complex system of state social security benefits.”<sup>15</sup>*

NHSGGC is committed to tackling the effects of structural inequalities. Its Equality Scheme ensures accountability for leadership and ownership for legislative requirements around this. Work across NHSGGC on employability and financial inclusion ensures that services intervene to ameliorate the effects of socio-economic inequality. The NHSGGC Financial Inclusion Group oversees this work and has a remit to develop the evidence base on financial inclusion, including the most effective interventions; establish connectivity between services; influence policy and strategy; develop performance indicators; create opportunities to share tools and developments that support financial inclusion and develop appropriate pathways between acute and community services.

To develop an inequalities sensitive health service NHSGGC wishes to skill health practitioners to understand the social issues and structural inequalities facing their patients, support patients with these and have the capacity to refer them to appropriate services. NHSGGC has involvement in partnerships that have access to a range of resources and staff who have knowledge of financial inclusion and can work together to join up the pathway for health and social care clients to improve their health outcomes.

Various parts of NHSGGC have piloted approaches to financial inclusion. In order to take a preventative, upstream approach to tackling these issues, the lessons from current practice need to be mainstreamed in a sustainable way. NHSGCC Financial Inclusion Group is coordinating a proactive approach and has developed an action plan, which it reviews regularly. A recent mapping exercise of current financial inclusion provision across NHSGGC found different levels of service provision and no consistent referral pathways but concluded that “*there is a wealth of activity developing on financial inclusion in health settings which could be replicated or used to develop more consistent models*”.<sup>16</sup> The Financial Inclusion Group is developing service standards that will facilitate monitoring in the longer term across NHSGGC.

## Research Methods Used

The broad aim of the study was to summarise the health benefits of financial inclusion and to assess the need for more research and it involved the following:

- A review of evidence of the health and quality of life impacts of financial inclusion initiatives, with particular reference to collating evidence of NHS-based interventions & the health benefits of these
- Exploring models of practice and learning to improve practice and identify evidence of the tools and barriers that exist
- Reviewing research methods used in existing studies
- Development of recommendations about future policy, practice and research

The research team undertook a Rapid Evidence Assessment (REA). REAs provide a balanced assessment of what is already known about a policy or practice issue. Systematic review methods are used to search and critically appraise existing research. They aim to be rigorous and explicit in method and so systematic. In comparison, REAs make concessions to the breadth or depth of the process by limiting particular aspects of the systematic review process. The method is appropriate for this review because the policy area is relatively new and there are few existing studies. Full details of the search strategy and analyses conducted are provided in Appendix 1. The REA included peer-reviewed journals and local monitoring and evaluation reports. It also involved review of other important sources such as government, in-house and commissioned reports, independent (non-journal published) research (e.g. studies commissioned by the Joseph Rowntree Foundation), and analyses or commentaries from stakeholders (e.g. ‘poverty lobby’ organisations, consumer groups). It focused on English language sources and data, and on reports published in the last 10 years, with an emphasis on UK studies. Evidence of the health impacts of financial inclusion was recorded where identified.

The data searches covered the time period from 1999 to 2009. This reflects the pace of change in the area of financial inclusion policy, which makes many older sources redundant. The review searched for material using the most important bibliographic social science databases and search engines, as well as following references and citations in the texts consulted.

## Section 2: The Health Impacts of Financial Inclusion

This section reviews the information available on the impact of financial inclusion work on the health of individuals. It reflects the fact that most research relates to advice provision that addresses either welfare benefits or more general advice needs, including money advice. However, where it has been found, information is identified that relates to wider financial inclusion initiatives and their relevance for health services and improving health. The report also seeks to broaden discussion of the impacts of advice to embrace not only the physical and mental health outcomes of interventions for participants but also the wider effects on quality of life and wellbeing.

The links between poverty and poor physical and mental health are clear and improvements to health, wellbeing and quality of life are amongst key reasons for developing advice services linked to primary care.<sup>12</sup> However, the causal pathways are complex and the way in which an increase in individual income can improve individual health is not clear. Referring in 2002 to a small number of studies that considered the health benefits of advice, Abbot argued that welfare benefits advice located in primary care can be expected to have limited impact as a health intervention. Rather, it offers more potential for relief from psychological stress for service users and may also make a small contribution to the physical health of individuals and to the social capital of communities.<sup>17</sup>

### Existing literature and evidence reviews

Since 2002, there has been a small number of reviews of the health impacts of advice. One review which included 55 studies was conducted by Adams et al in 2006. It focused on the health, social and financial impacts of welfare rights advice in healthcare settings.<sup>18</sup> They identified that, in quantitative studies, the instruments used to measure health impacts included non-specific measures of general health such as the Short Form 36 (SF-36, a general health scale), the Hospital Anxiety and Depression Scale (HADS, a questionnaire commonly used to screen for anxiety or depression), the Measure Yourself Medical Outcome Profile scale (MYMOP, a patient generated wellbeing scale), the Nottingham Health Profile (NHP, a quality of life scale), and the Edinburgh Post-natal Depression Scale. Key points concerning quantitative studies relating to health and social outcome highlighted by the authors included:

- Amongst seven studies that had a comparison or control group - 11 of 72 separate comparisons reported were “statistically significant at the 5% level including comparisons relating to SF36 vitality, SF36 mental health, SF36 bodily pain, SF36 role functioning emotional (and) NHP emotional reactions”.
- Of six studies reporting non-financial results using recognised measurements scales and before and after study design, 6 of 59 separate statistical comparisons reported across 3 studies were found to be significant – SF36 vitality, SF36 role functioning emotional, SF36 mental health, SF36 general health, NHP pain and NHP emotional reactions.

Their assessment was that overall: sample sizes were small; follow up was limited to 12 months at most; and few statistically significant differences were found and these tended to relate to measures of psychological or social, rather than physical health.

Of the other studies identified, the authors saw little merit in seven which used in-house questionnaires with “little evidence of validation”. These “found consistently high levels of clients agreeing with statements concerning the positive impact of the advice on their health, quality of life and living situations”.<sup>18</sup>

In the 14 studies reporting qualitative data, most data were gathered through interviews with individuals including those receiving advice, advice givers and primary care staff. The most common use of qualitative data was to assess perceptions of the impact of advice and these showed:

- Advice based in healthcare settings, particularly primary care, was valued and it legitimised advice, improving access and reducing stigma
- Advice and benefits helped elderly clients maintain independence
- Advice decreased worry and anxiety and improved mental health and quality of life irrespective of whether individuals had an income increase as a result of advice
- Advice and increased benefits increased physical health and reduced use of health services.
- Advice was seen as ‘expert’ and professional
- Negative comments concerned GPs’ lack of awareness of the service, concerns about losing benefits and benefits increases being offset by deterioration of health due to long term illnesses

Adams et al described the evaluations found as having limited scientific rigour and linked this to scarce resources and skills. They concluded that there was a “theoretical potential” for advice to improve health, but they recommend more robust methodologies including longer follow-up, since the health and social effects of increased financial resources may take years to become apparent. They also advocated the use of randomised control trials. This issue is discussed further below (page 17).

Other reviews were identified which considered the health impacts of advice. In 2002, Greasley and Small<sup>19</sup> considered the same evaluations of the benefits of welfare advice on the health and well-being of participants as were included in the more recent review by Adams et al. Wiggan and Talbot’s 2006 review of the impact of welfare rights advice included some consideration of the health impacts of advice. Their assessment was based more on a social model than Adams et al. While they discussed some of the same studies, they concluded that the literature indicated “significant improvements in mental health of clients following successful welfare rights intervention and improvement in physical health, although these may be more limited”.<sup>20</sup>

A review of social support services for people affected by cancer, focusing on financial advice and support, highlights problems, bureaucracy and delays but identified less research that discusses the impacts of advice.<sup>21</sup> However the study highlights recent positive developments in the MacMillan Cancer Care Advice project. Most recently, Green reviewed money advice giving methods in 2009 and considered their relative costs and effectiveness for different client groups. Research gaps she identified included: the impact of individual money advice approaches, understanding of the impact of debt advice on different population subgroups and debt advice outcomes in Scotland, but she did not discuss health impacts of advice.<sup>22</sup>

## **Individual Studies - research and evaluations**

This review has identified 16 key studies or journal articles which have reported health and social outcomes of financial inclusion interventions and these are summarised in Table 1. We have focused on studies published since the review conducted by Adams et al. However, a small number have been included here because they contain information relevant for the present review, which is concerned with financial inclusion activity, rather than a singular focus on the provision of advice in healthcare settings. These studies are annotated in the Table.

All of the studies identified discuss health impacts of advice provision. Two studies evaluated other approaches in addition, such as awareness raising sessions, money management guidance, or development activities.<sup>10,23</sup> The studies generally focused on the provision of welfare benefits advice, including income maximisation work. However, Citizens Advice Bureaux (CAB) and many other advice services advise clients on a range of social, legal and welfare rights issues (including, for example, housing, employment, taxation and debt) and several studies highlight the wide range of issues addressed and the fact that individual clients may raise more than one problem.

The interventions involved: delivery of advice located in primary care services (seven studies); one project, discussed in two separate articles was located in a social services department;<sup>24,25</sup> two were located within the advice providers premises; and one longitudinal study considered the health impacts of advice in both the mainstream CAB service and outreach in primary care.<sup>26</sup> The remainder involved a mix of delivery methods including telephone advice, home visits following screening or referral by primary care and other staff. Half the studies had no specified target groups or aimed to reach a range of different service user groups, some others targeted people aged 60 or more and individual studies were concerned with people with chronic conditions, stroke patients and people with mental health problems.

The providers of advice were most commonly a mix of services, CAB services or local authority welfare rights, while one study involved a voluntary sector mental health service. The providers in two studies were unclear. Excluding the project monitoring data gathered by advice providers, half of the studies used qualitative methods and the remainder were evenly split between mixed method and quantitative studies. Within these, the qualitative and quantitative elements of two studies were reported in separate articles and considered separately here.

In the studies with a quantitative element, the Short Form 36 (SF36) was used in five cases to measure health impact. However, more than one measure was used in some studies and the Hospital Anxiety and Depression Scale (HADS) was used in two studies, while a further six instruments were each identified once.

Sample sizes varied considerably, including attrition rates in those studies that had follow-on interviews. Only two studies used randomized control trials (RCTs), one of which was abandoned because of sample attrition.<sup>27</sup> Sample sizes also varied considerably in the qualitative studies. Most involved interviews with individuals accessing services, although in four studies other groups included were staff from the advice services, primary care or other service providers.

The main message from across the studies is that both qualitative and quantitative methods identify benefits from advice in terms of improved mental health, reduced stress or anxiety and better quality of life, but there is less evidence of improvements to physical health. Relatively short follow-on study periods and other methodological issues are suggested to have contributed to modest results in some studies.

While Abbott et al identified that the benefits of increased income were modest but valuable,<sup>28</sup> other studies stressed that increased income could help manage health better, improve lifestyle and help relationships, for example with children.<sup>10, 26</sup> One qualitative study identified that stroke patients' rehabilitation and speed of recovery was improved.<sup>29</sup> Conversely, Moffatt and Scambler found that the poor health of the people they interviewed was attributed to factors that were considered "immune to the effects of money", except to the extent that more money affords greater capacity to manage health conditions.<sup>30</sup>

The links between income increases and positive health changes are very complex.<sup>17</sup> This raises questions about how important the nature of the health condition is in relation to the point of intervention in the patient pathway. For example, health may be affected more by income increases in acute health conditions or at the initial stages of diagnosis or falling ill (such as stroke or cancer) compared with more chronic health conditions for which income over the long-term or income inequality may be more important.<sup>31</sup>

A further consideration is that advice and income maximisation may help to slow or prevent further deterioration in health. The links between poor mental health and other physical health conditions and the evidence of the positive impacts of advice on mental health from these studies, provide positive arguments for advice. However, the impact on physical health may need much longer term studies than have been possible thus far. In the short-term though, "helping to ease the problems of those who are both deprived and very unwell, even an imprecise intervention can be of value".<sup>32</sup>

Campbell et al suggested that advice or other external factors may have played some part in health stability, as opposed to the increase in financial income per se.<sup>24</sup> In one study "many participants spoke at length about having the chance to talk, and having someone take an interest, suggesting that the welfare consultation itself had a therapeutic effect".<sup>33</sup> The importance of access to 'talking therapies' was

recognised in the design of the Health Plus Project in Bradford. In addition to providing advice, this project employed 2 full time equivalent counsellors to provide brief intervention therapy to patients suffering from mild to moderate mental health issues. However to better meet needs and demand for the service, the design was revised to include a larger multidisciplinary therapeutic team of 9 full-time posts with a team leader.<sup>34</sup> In a similar vein, research in Scotland found that, for people seeking advice about debt, the impact of advice in reducing the stress and anxiety surrounding indebtedness can be important. This need not necessarily involve an increase in income, so much as helping people to make their financial situation manageable through a range of strategies from negotiating repayments through to bankruptcy.<sup>35</sup>

## **Broader Financial Inclusion Interventions**

The body of work identified has an almost exclusive focus on welfare rights advice and there are few studies referring to financial inclusion initiatives other than welfare benefits advice. For example within NHSGGC, the Health Improvement Team within Acute Planning developed a successful bid, following consultation, to fund a pilot project that would meet the money advice and financial inclusion needs of people affected by stroke. The pilot service was designed to meet the immediate financial needs of people affected by stroke within the acute setting and facilitate a transition to specialised community based financial inclusion services when and if required. The evaluation report highlighted that “feedback from all stakeholders noted a positive impact on patient rehabilitation and speed of recovery. In particular, NHS staff noted the direct impact financial worries could have on individuals affected by stroke and the crucial role they can play in helping people access support”.<sup>29</sup> Unfortunately, further research is needed to support this finding and ascertain other element of the work which were not reported on, including the financial capability work.

Liddell conducted a review which considered recent evidence on tackling fuel poverty and the impacts on human health. One of the studies included was an evaluation of the Scottish Central Heating Programme which found limited impacts on health. Importantly, the evaluation found that the programme was not well targeted at low income groups since “as many as 50% of homes targeted by CHP were not fuel poor even though they passed all eligibility criteria”. Nonetheless, Liddell concluded on the basis of other existing evidence that such initiatives do have the potential to reduce the effects of poverty and contribute to reducing health inequalities:

*“The health impacts of tackling fuel poverty appear noteworthy, especially when taking into account that they derive from a source as seemingly tangential to human health as home heating and cavity wall insulation. Improved mental wellbeing amongst the elderly, when taken in conjunction with impacts on adolescents, children and infants that have the potential for a life-long legacy, provide an evidence base that supports the rationale for fuel poverty strategies of the past, present, and future.”<sup>36</sup>*

The wider literature on fuel poverty has not been reviewed here. However, people living in poverty face higher fuel costs than average, particularly if they are using

prepayment or card meters and if they are repaying arrears.<sup>35</sup> The options to help reduce fuel costs are, therefore, related and potentially important areas of activity to reduce financial exclusion, reduce costs and improve health.<sup>23</sup>