Can welfare rights advice targeted at older people reduce social exclusion?

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Abstract

It is known that in general people of pensionable age have gained in income compared to other age-groups in the British population over the last 20 or so years, and that a substantial minority still experience relative poverty. In this paper we report a small qualitative study into the effectiveness of a welfare rights service made available through primary care for men and women aged 60 or more years. Additional financial and non financial resources obtained by accessing previously unclaimed state welfare benefits were found to improve significantly the quality of life. Fourteen out of the 25 participants received some type of financial award as a result of the service offered, and the median income gain was £57 (€84, $101) per week. The impact of additional resources was considerable and included: increased affordability of necessities and occasional expenses; increased capacity to cope with emergencies; and, reduced stress related to financial worries. Knowledge of and access to welfare rights services also appeared to have a positive effect. It is argued that increased material resources are a necessary prerequisite for accessing social relations, services and civic activities and can reduce social exclusion among older people.

Key words: welfare rights; social exclusion, poverty, quality of life
Introduction

The material well being of Britain’s pensioners has improved over the last 30 years relative to those of working age, but, as among working adults, older people have experienced increased rates of inequality (Bardasi, Jenkins and Rigg 2002; Gillear and Higgs 2005). Pensioners in the bottom income quintile are reliant upon the state for 90 per cent of their income, yet a substantial minority continues not to receive state entitlements (Victor 2005). There are 23 different types of state benefit available to older people in the United Kingdom (UK), many of which are interlinked in a complicated network of entitlements (National Audit Office 2002). It is difficult to do more than estimate the proportion of older people that do not claim the benefits to which they are entitled. Recent estimates suggest that the proportion of older people not claiming the means tested Pension Credit\(^1\), designed to lift the poorest pensioners out of poverty, ranges between 34-42 per cent, and that the unclaimed amount is £1,630-£2,370 million (Department for Work and Pensions 2006). High profile organisations like the Citizens’ Advice Bureau (CAB), the local Age Concern organisations and Help the Aged regularly run benefit take-up campaigns targeted at older people. Over the last decade, it has been recognised that providing such services for older people in a health-care setting, usually a primary care centre, can be highly effective and beneficial (Paris and Player 1993). This is largely because of the regular contact that many older people have with primary care and the general view that primary care is less stigmatising than the venues more commonly associated with state benefits (Coppel, Packham and Varnham 1999, Abbott 2002, Hoskins and Smith 2002, Hoskins et al. 2005). There has recently been a more coordinated policy response to tackling social and health inequalities through the uptake of benefit entitlement among vulnerable groups recognised by the Department of Health.
(Acheson 1998), the Treasury (Wanless 2004) and the Social Exclusion Unit’s ‘Sure Start to Later Life’ initiative (Social Exclusion Unit 2005).

Despite numerous high profile campaigns, the problems of non-uptake of state welfare entitlements persists for a substantial proportion of older people (Department for Work and Pensions 2006). A recent study highlighted the limited knowledge that older people had about the welfare system, but also the very low expectations that many of the poorest had about their living standards (Scharf et al. 2006) and numerous studies have attested to the barriers facing older people claiming benefits (Corden 1999, Costigan et al. 1999, Mayhew 2002).

Low income, poor health and age have been identified individually as causal factors for ‘social exclusion’, itself a contested concept (Silver 1994, Atkinson 1998, Hills, Le Grand and Piachaud 2002, Social Exclusion Unit 2005). One general definition of social exclusion is,

… being shut out, fully or partially, from any of the social, economic, political or cultural systems which determine the social integration of a person in society. Social exclusion may, therefore, be seen as the denial (or non-realisation) of the civil, political and social rights of citizenship. (Walker and Walker 1997: 8)

Arguments have centred around whether social exclusion is a useful addition to discourses on inequality (Byrne 2005). Burchardt, Le Grand and Piachaud (2002) emphasised that social exclusion is a broad term which encompasses diverse standpoints about its underlying causes. These can be summarised as arising from: individual behaviour and moral values; institutions and systems – from the welfare state to late capitalism and globalisation; and discrimination and lack of enforced rights. These distinct views about the causes of social exclusion are related to
differing views about individual agency, one being that social exclusion arises from a lack of agency on the part of the excluded (blaming the individual) and another that exclusion is the outcome of the economic, political and civil institutions that make up the system. Scharf, Phillipson and Smith (2005: 77) have usefully applied the concept of social exclusion to older people; they argued that ‘social exclusion can potentially represent a flexible and multi-dimensional tool for examining the degree to which older people in different environmental settings simultaneously experience various forms of disadvantage.’ They operationalised their definition of social exclusion as applied to older people as exclusion from: material resources; social relations; civic activities; basic services; and neighbourhood.

Among older people, ill-health is a particularly important factor to consider in debates about social exclusion as it may seriously compound existing problems. Social inequalities in self reported ill-health increase in early old age (Chandola et al. 2007). Some 60 per cent of people aged over 65 have a long-standing illness (General Household Survey 2001) and this percentage is higher among lower socio-economic groups (Prescott-Clarke et al. 1997). Research on birth cohorts currently in mid-life indicates that those with caring responsibilities will be more likely to face a low income in later life (Evandrou and Glaser 2004); women are particularly at risk since most do not have a full state pension or adequate occupational pension (Ginn 2003a, Ginn 2003b, Price and Ginn 2006). The difficulties of many of those in the poorest health compounded by low income, not least because of the considerable costs associated with ill-health and disability (Argyle 2001, Smith et al. 2004).

The study reported here offers us the opportunity to examine the impact of additional material resources on the lives of older people and to explore the relationship between material resources and the other dimensions of social exclusion
The overall aim of the study was to evaluate the impact of increased material resources on people aged over 60 using a randomised controlled trial (Mackintosh et al. 2006). This paper uses the findings of a parallel qualitative study, the purpose of which was to examine the views of a sub-sample of respondents about the impact of welfare rights advice (Moffatt et al. 2006a). The data we report here enable us to address the following questions: (i) what impact does receiving extra resources have for older people on low incomes and/or in poor health?; (ii) how effective is a welfare rights service in increasing the incomes of low-income older people? We argue that access to adequate material resources is a necessary prerequisite for accessing social relations, services and civic activities.

Methods

This qualitative study took place concurrently with a randomised controlled trial (RCT) pilot study to assess the impact of welfare rights advice provided through a general medical practice (viz. a National Health Service (NHS) primary health-care centre). The qualitative study focuses on patient’s experiences arising from their involvement with both the intervention and control arms of the study which started in June 2002. The RCT recruited 126 participants from four general practices in Newcastle upon Tyne, north east England, over a period of five months. Participants were interviewed on entry to the RCT using a face-to-face structured questionnaire examining physical and mental health, financial circumstances, psychological functioning and social well-being. Participants were randomly allocated to intervention and control arms. The intervention group were given a welfare rights consultation within two weeks of the baseline interview and re-interviewed with the structured questionnaire at six, 12 and 24 months; the control group received their
welfare rights consultation six months after the baseline interview and were followed up at six and 12 months. The delay of six months between groups receiving welfare rights advice was chosen as a compromise between what was regarded as ethically acceptable and allowing a sufficient time delay between intervention and control arms of the study for the condition to be different (Moffatt et al. 2006a). Some 117 (93%) participants completed all stages of the data collection. At baseline, all participants were asked whether they would be willing to take part in a more in-depth interview, 96 (76%) agreed to do so.

A welfare rights officer from Newcastle upon Tyne City Council Welfare Rights Service with considerable experience providing advice in primary care, particularly with the over 60 age group, worked closely with the research team throughout. The welfare rights officer took part in general practice briefings, alongside members of the research team and undertook the intervention which comprised a standard welfare rights assessment for each participant, with the necessary follow up work for claims, appeals and tribunals, and onward referrals to other services.²

Sampling

The sampling frame was formed by the 96 informants who gave their consent to be contacted during their baseline interview for the RCT. The study sample comprised respondents purposively selected on the basis of gender, age, general practice and participation in both intervention and control group. Additionally, participants were selected to include the range of possible outcomes resulting from the welfare rights consultation. This included those eligible for: financial resources only; non-financial resources only; both financial and non financial; and, those not eligible for any additional resources.
Data collection

Interviews took place between April and December 2003 in participants’ homes after their welfare rights assessment; follow-up interviews were undertaken in January and February 2005. The interview schedule had a semi-structured format and covered: changes in circumstances as a result of welfare rights advice; perceived impact of material and/or financial benefits; perceived impact on mental and/or physical health; perceived impact on health related behaviours; perceived social benefits; and, views about the link between material resources and health. All participants agreed to the interview being tape-recorded; interviews ranged in length from 35 to 120 minutes, most lasting between 60-75 minutes. Immediately afterwards, observational field notes were taken. Interviews were transcribed in full. Twenty five initial interviews were carried out in 2003; ten participants were interviewed with partners who made active contributions. Twenty two follow-up interviews were undertaken in 2005 between twelve and eighteen months later (three individuals were too ill to take part).

Analysis

Data analysis followed the framework approach (Ritchie and Lewis 2003). Each of the transcripts was read and re-read, and a conceptual framework devised which was discussed at length with the researcher collecting the structured interview data for the RCT. Coding was undertaken by one person (SM). Thematic categories were applied to each interview using the coding procedure in the NVIVO software package. Data were indexed and charted systematically and resulting typologies discussed with other members of the research team, ‘a pragmatic version of double coding’ (Barbour 2003). This method of organising the data allows participants’ circumstances, experiences and views to be compared within and across groups in a framework derived from their own accounts. The analysis and interpretation were fully grounded
in the data. Two kinds of internal validation were used, constant comparison (Silverman 2000) and deviant case analysis (Clayman and Maynard 1995), since both methods are important for internal validation (Barbour 2001, Barbour 2003).

Results

Table 1 summarises key characteristics of the sample. The fourteen participants in the intervention group had a longer interval between their welfare benefits consultation and interview (average 10.4 months) than the eleven in the control group (average 4.6 months). This was because the control group received their benefit assessment six months after the intervention group, leaving less time to collect the data within the study period. Therefore, at first interview, those in the intervention group had longer to experience any circumstantial changes resulting from their welfare assessment, although data from the follow-up interviews allowed participants from both intervention and control groups to relate any impact over a longer term period, between eighteen and twenty-four months from receipt of benefit. Although no couples or individuals had incomes below 60% of the median income, the UK Government’s usual definition of low income (Barnes 2005), most participants were in the second or third lowest income quintiles. The circumstances of those in the sample ranged from single pensioners with no occupational pension living in rented accommodation and entirely reliant on state benefits to home-owning couples with occupational pensions and considerable savings. Most participants found it difficult to manage on their current level of resources; most were in poor health with one or more chronic health conditions or were caring for a chronically ill relative.

Table 2 summarises the outcome of the welfare rights consultation for study participants and indicates that a wide range of financial and non financial benefits
were obtained. Attendance Allowance\textsuperscript{3} was claimed more than any other single benefit, reflecting the poor health and increased care needs of many in the sample. By the end of the follow-up period, fifteen participants received some financial award, the median income gain was £57 (€84, $101) (range £10 (€15,$10) - £100 (€148,£178)) representing a 4\%-55\% increase in weekly income. Eighteen participants were in receipt of benefit, either as a result of the intervention or because of claims made prior to the study. By the follow-up interview all but one participant (Case 24) had been receiving their additional resources for between 17 and 31 months. Welfare rights advice was viewed positively by all participants irrespective of outcome. However, for those who received additional financial resources, the impact was considerable and centred on four linked categories summarised on Table 4, around which the results are organised.

\textit{Necessities}

All recipients used their additional money to pay for necessities, without which their ability to participate in daily activities such as getting around, buying decent food, engaging in social activities, paying bills and obtaining extra help would have been restricted. As Table 4 demonstrates, transport was a key item on which additional resources were spent, and participants’ narratives indicated how crucial accessing transport was to participation. As a group, the participants were generally in poor health, many with mobility problems, which impaired their ability to get around for essential activities. Just over half the respondents had no car. The type of transport used as a result of the additional resources included both private (car) and public. However, mobility difficulties often precluded taking public transport in the form of buses or trains. For those without cars, being able to afford taxis for shopping, visiting friends and engaging in activities was life-transforming. Mr MacDonald, a
keen bowler, described the devastation he felt at being unable to drive and how he was now able to continue with his leisure activities:

I’d had a car for 45 years and it was like cutting my right arm off and now if I want to go out and I don’t want to go by bus I just get into a cab and that’s the difference it makes. I am not worried about it if I want to go anywhere.

Among the participants who did drive, a constant theme was their reliance on the cars for almost every activity they engaged in outside their homes. Thoughts of giving up their cars filled many with a sense of dread. However, some participants were unable to take full advantage of their cars for anything other than essential activities due to the high cost of petrol on their limited incomes. Following the additional income, participants spoke about spending money on petrol, thus enabling them to enjoy trips to the countryside, or to visit friends and relatives living at a distance. Participants often acknowledged the positive impact this had on their well-being, particularly in cases of serious illness. Mrs O’Hara gave an account of the difficulties she faced caring for her seriously ill husband on a low income with no resources available for the outdoor activities they had always enjoyed together. Following additional income, she described how they were now able to engage in pleasurable activities, especially those which had a ‘spur of the moment’ element to them:

We have been quite depressed last month … now we can afford petrol to go up the coast in the car. A tank full of petrol if we feel like it … we cheered ourselves up … whereas it would have been another miserable day, it did us good.

Overall, increased mobility resulted from better access to transport, whether taxis or private cars, and enabled participants to engage more fully in a wide range of activities, without which they would have been more isolated, lonely and depressed. As well has positively enhancing mobility, additional resources enabled participants
to maintain social activities and social networks, often difficult in the face of chronic health problems. Without such activities participants faced increasing social isolation. Mrs Parks eloquently described how, following the death of her husband, she had stopped taking part in the mainstay of her social life due to lack of money:

I was living on the bare pension … it doesn’t leave you much for entertainment, and I couldn’t go very far, because that’s why I stopped going to the [name] Association … but when they started to go away for weekends and different places for reunions and whatnot, well I couldn’t go because I couldn’t afford to go. You see, now I could, it makes that difference. It’s not a lot but just that little bit difference between not being able to afford anything and above normal, to having a little bit of enjoyment and a little bit of entertainment. It’s marvellous the difference it makes.

On receiving additional money as a result of their benefit entitlement, participants mentioned a range of activities that they were able to engage in more frequently, re-start or begin afresh. These included visiting relatives more often, maintaining activities such as choir, bowling, social clubs and walking in the countryside. Overall, participants talked about a renewed ability to enjoy their leisure time. None of the activities mentioned required large amounts of resources. Despite this, the limited incomes that people were living on and the other demands placed on that income (food, heating, utility bills, home maintenance etc) meant that leisure activities were a lower priority. The very activities that would facilitate enjoyment, social participation and positive physical and mental well-being were beyond the reach of many, so that prior to receiving entitlements, most participants were leading a very marginal, isolated existence. The narratives clearly illustrated how the flow of material assets is crucial for a healthy flow of social assets or capital, as issue to which we return later.
Buying healthier and better quality food was mentioned by a number of participants, especially but not exclusively by those on the lowest incomes. Many participants mentioned how they would like to eat a healthier diet, by which they usually meant lean meat, fresh fish and fresh fruit and vegetables. Some were advised to change their diets for health reasons. However, all participants mentioned the higher cost of healthier food and many could afford only what they regarded as less healthy, but cheaper items. For Mrs Lewis, the additional income was used thus:

It has made a big difference [Attendance Allowance] because it means that I haven’t had to skimp so much on buying the groceries. And being as I’ve now got to buy fruit and things like that which I never used to buy before … because I’ve got it from the doctors that I’ve got to lose weight, and its helped me to be able to get me the extra bits that we need. Where it would have been more difficult without that.

By the time the follow-up interview were undertaken, participants had been receiving additional resources for a considerable time. Many people mentioned that they were eating a healthier diet, particularly in relation to better quality foods and no longer buying the cheapest of everything. Interestingly, several people mentioned that they were now able to afford to stock up on certain food items so that in the event of ill-health or severe weather they would not be forced to visit the shops on a daily basis if they did not wish to or were unable to.

Activities such as housework, shopping and gardening were becoming increasingly difficult for many people because of health problems and, particularly by the follow-up interview, a number of participants were paying for extra help with these tasks. Such ‘low level’ assistance has been identified as crucial to maintaining older people’s ability to remain living independently in their own homes (Clark, Dyer and Horwood 1998). Many services hitherto provided by the ‘home help’ in the UK, are reserved for older people in ‘significant’ need. Those, like the participants in this
study, who required help with some daily tasks, but were ‘managing’ were without any formal assistance from social services. Mrs MacLeod described the arrangement that she entered into with her neighbour as a result of receiving her benefit entitlement:

Well it makes me independent, doesn’t it? You see my next door neighbour … she’s a young lady and she’s smashing … she comes in every week and I pay her … it’s a business deal, it’s on a proper footing, it’s not just neighbourly … Not only that, you feel independent … you can do things for yourself. And that’s a great boost when you get a bit older … it gives you a bit of a boost to your self-confidence I think, you know which helps, it keeps the depression off a bit to know you can do things for yourself.

**Occasional expenses**

Table 4 shows that a wide range of ‘occasional’ expenses were purchased as a result of the additional income obtained. Some of this expenditure was for ‘one off’ replacements of items such as washing machines, fridges or televisions items. Living on a fixed income, with little in the way of savings, meant that replacing most items was a cause of anxiety. Most mentioned that they would rather go without than slide into debt to pay for a replacement item. Mrs O’Hara explained the difficulties which she and her husband encountered:

…it’s when you want to put another coat of paint on or when you need to replace your bedsheets. They don’t last forever, and they’re not cheap. When you’ve got used to just your old age pension and there isn’t a lot of extra spare cash, it’s all those things you have to think about.

Weekend trips and short holidays were mentioned by a number of participants. On the face of it, these might appear like ‘luxuries’ and perhaps a rather frivolous use of state benefits. However careful consideration of the day to day realities of life on low incomes would suggest that this is a highly beneficial use of additional funds as it has
such a positive impact on well-being. The trips were usually modest affairs, lasting 2-4 days; one participant went on a four day break to Scotland, her first holiday in 30 years. Those who did manage to go on short trips looked forward to them immensely, this was partly because it offered a break from the general routine, but such trips obviously raised the spirits of many.

A number of participants, particularly by the time of their follow-up interview, were enjoying being more fully engaged with family, friends and wider society through their increased capacity to reciprocate in a number of ways. This was evident in participants’ accounts of buying gifts for family and friends and reciprocating for help received with a gift or by paying their way. The social significance of reciprocation for many older people should not be underestimated. Many respondents described feeling marginalised within their families, among their friends and by society at large as a result of their low incomes, their ill-health or both. Being able to fulfil normal social roles such as reciprocating was highly regarded by participants:

Mrs Juniper: I used to feel terrible getting lovely presents from them [family, particularly grandchildren] and I couldn’t afford very much [for them], but now I can and I love it.

Mrs Merrifield: I have two good friends who are very helpful so I buy them some boxes of chocolate or something like that you know, just to show my appreciation.

*Capacity to cope with future crises*

Uncertainties over the future were regularly mentioned. Participants talked about the potential problems brought about the onset of illness or the worsening of existing conditions. Money worries were a constant source of anxiety. Concerns about ill-health and money were particularly acute for those with little in the way of savings or assets. Prior to receiving additional income, many participants were in their words, ‘just getting by’ with no prospect of putting any money aside for the future.
Following the receipt of additional resources, a number of participants, like Mr Service, talked about how they could now save up for items they required, or increase their savings:

That’s [extra benefit] a nice handy little nest egg that would cover almost any emergency, well not almost any, but the minor emergencies.

A number of participants, both home owners and those living in rented accommodation, were concerned about the suitability of their accommodation in the future and the possible crises that further health problems might precipitate. Concerns were voiced about managing stairs, gardens, cleaning and household maintenance and the onset of or exacerbation of health-related conditions that made managing in their homes increasingly difficult. Some participants discussed the need in the future for more suitable accommodation, and were aware that such housing existed. Home owners generally felt more suitable accommodation was completely out of their reach due to differentials between the value of their homes and more expensive purpose-built accommodation; those in rented accommodation (all local authority) believed that more appropriate accommodation would be available only for those less able than themselves. Housing issues other than those specifically related to finance were beyond the remit of the welfare rights advice service, but the concerns of participants raise issues about the suitability of existing accommodation for some older people and the lack of available alternatives for those on low incomes.

Peace of mind

Participant narratives highlighted the daily stresses and strains of living on fixed low incomes. Financial worries were a constant source of anxiety for people in the study either because they could not afford necessities and one off payments or would not
have sufficient to fall back on in the event of a crisis. The study was full of examples where people did without in order not to go into debt: foregoing a healthy diet; not having the house heated to a comfortable level; not buying new shoes or clothes when required; not going out with family or friends. The list of privations was long. We are not suggesting that the additional resources transformed participants’ lives to the extent that they had no more worries. However, participants’ accounts would suggest that the constant nagging worries about money that are a daily reality for people on low incomes were considerably reduced. As Table 4 indicated, most participants described greater ‘peace of mind’ a phrase that was repeated often throughout interviews. Having more (not necessarily adequate) money generated a tangible sense of well-being and was still remarked upon at follow-up interviews, suggesting that the effects were relatively long-lasting.

Perhaps the most powerful account about the difference made by accessing the full benefit entitlement came from a woman who had been struggling to get by on the basic state pension for many years. She had no idea about the benefits to which she was entitled and was even asked to return an Attendance Allowance benefit following the death of her husband, whom she had nursed at home, despite the fact that she had never claimed Attendance Allowance. There are still many older people, particularly women, living on the basic state pension unaware that there are benefits which they could claim (Toynbee 2004). This is how Mrs Parks described the impact of having her full benefit entitlement:

You are not waiting in terror or in horror for the next this to come through the door because it might mean you are going to be strapped again. I had enough of that when I was younger.

*Views on the relationship between money and health*
Given the well-established relationship between socio-economic position, resources and ill-health (Marmot and Nazroo 2001; Chandola et al. 2007) it was a matter of some importance to examine discourses around the relationship between money and health. Two main issues could be identified from the narratives. The first of these concerned the more specific question about the relationship between additional money and the recipients’ health. What did participants think the impact of additional resources would be on their own health? The second issue to emerge concerned more abstract notions of the relationship between money and health. Regarding the first question, there was an unequivocal response that extra money or resources would have no effect whatsoever on individual health conditions. Poor health was attributed to specific health conditions and a combination of family history or fate, which were immune to the effects of money. Mrs Carruther’s view on this was typical:

I think it doesn’t matter how much money you’ve got, if your health is going to deteriorate then it will deteriorate.

Most participants had at least one chronic condition and felt that because of these conditions, plus their age, additional money would have no effect. No-one expected any improvements to their own health conditions as a result of receiving additional resources. However, a number of participants linked the impact of the intervention with improved ways of coping with their conditions because of what the extra resources enabled them to do as this exchange between Mrs Juniper and the interviewer demonstrated:

Mrs Juniper: I’ve got so much wrong with me my dear I don’t think anything affects it. I suppose the fact that I have a more positive outlook on life now I’ve got a little bit more money. And I suppose that can affect your health. But there isn’t anything that money can buy that would make me any better … I certainly don’t get the depressions that I used to get.
Interviewer: And why would you say that is?

Mrs Juniper: Well, I don’t know. It’s just, generally not having to worry about money anymore. It’s so nice to be able to feel you can splash out a little bit.

Interviewer: Yes. So if someone was to ask you what effect having this extra’s had for you, thinking in terms of health in it’s very broad sense, physical health as well as mental health, what would you say?

Mrs Juniper: Well, it just, it’s difficult to explain really. I’ve still got all these things wrong with me, but they don’t seem to bother me as much now as they did, I don’t know, you know I feel a lot happier about my life since I got that extra money. It has made a difference, a real difference.

This narrative indicates that being better able to afford daily necessities, access transport, keep up with friends and family and maintain leisure activities did not directly impact on health conditions. What these additional resources did enable was an increased capacity to cope with ill-health; participants were more fully engaged in the more enjoyable and fulfilling aspects of life and had fewer immediate financial worries.

Despite the fact that no-one expected their own health conditions to improve, most people believed that there was a relationship between resources and health. This was usually couched in terms of affording the basic requirements to eat well, pay bills and live in a comfortably heated home. Many respondents had encountered difficulties meeting these basic needs themselves and were therefore speaking from experience. Others, like Mrs Wright, were aware of the privations experienced by older people other then herself and empathised with those who lacked adequate financial means in their retirement:

If you’ve got somebody who is just on the basic pension, because there is an awful lot who haven’t had pensions from work or anything that didn’t save, didn’t know about having to … they may not have enough to cope, and it’s pretty obvious when you hear about them dying of
hypothermia … there was something on the radio yesterday that this is the worst area in the
country for old people dying of hypothermia and we’re the worst off people in the country, so
many people on the dole, on benefits … it makes you wonder if people haven’t got the money
and they’re going to miss out on either food or heat.

Overall, study participants were clear that having additional resources would not
improve their health conditions as such, but accounts indicated that coping with
particular health conditions and day to day living was made easier.

**Discussion**

A key question concerned the impact of receiving additional resources for older
people on low incomes and/or in poor health. Analysis of this relatively small sample
indicates that there were a number of ways in which financial benefits impacted on
recipients’ lives: meeting essential day-to-day expenses, increasing capacity for one-
off expenditures, increasing savings and coping with emergencies. We argue that this
had a positive impact on personal well being and the overall effect was to increase
independence and participation in society, in other words, it reduced social exclusion.
Another way that this can be construed is that adequate resources are part of the
citizenship rights of older people (Higgs 1997, Craig 2004) although discourses
involving citizenship rights have in recent years been somewhat superseded by
discourses around social exclusion (Hills and Stewart 2007). However this is
conceptualised, the study was replete with examples of an often modest increase in
the flow of material assets precipitating an increase in the flow of social assets or
capital. Reference to ‘flows’ of material and social assets here is deliberate. Assets
conducive to longevity, health and well-being – not only material and social, but also
biological, psychological, cultural and spatial (Scambler 2002) – are neither best
studied through cross-sectional investigation nor, indeed, readily quantifiable. First, they can come and go: assets can increase over a short period, as in this study, or decrease just as rapidly. Second, they continuously interact, as this study again exemplifies. Third, they can compensate for each other as far as health outcomes are concerned: a loss of material assets might be made good by a gain in social assets and vice-versa. Finally, studies oriented to the lifecourse suggest that particular assets may be particularly salient for certain conditions at particular periods of the lifecourse, in this case, the need for additional resources in later life to offset the requirements of a disability or health condition, when living on a fixed and relatively low income.

It is necessary to exercise some caution with the conclusions which can be drawn from a qualitative study with a relatively small sample (Mays and Pope 2000). We must adequately address the question, with what degree of certainty could we transfer these findings to other settings or contexts and be assured of reaching the same conclusions? Methodologically, we have followed the accepted practice in fieldwork, analysis and interpretation (Seale 1999, Mays and Pope 2000, Barbour 2001, Barbour 2003). At the 24 month follow-up, we had the opportunity to obtain further qualitative data from a further 21 participants in the RCT who had received additional financial resources which confirmed the findings reported here (Moffatt et al. 2006b). Ritchie and Lewis (2003: 269) comment that, ‘It is at the level of categories, concepts and explanations that generalisation can take place.’ We are suggesting that the data here indicate that additional resources for those on low incomes are likely to reduce social exclusion and that the albeit limited literature on poverty and social exclusion among older people backs up this claim.
The findings of the recent Poverty and Social Exclusion Survey (PSE Survey) offer an interesting point of comparison with those from the modest qualitative investigation reported here (Pantazis, Gordon and Levitas 2006). Not only do the PSE Survey data confirm the existence of a substantial minority of older people in relative poverty - 18% reported that their incomes were insufficient to avoid absolute poverty, 21% said their incomes were below the overall poverty threshold level, and 27% actually had incomes below the overall poverty threshold level (Patsios 2006) - but they specifically address flows of social assets or capital.

According to the PSE Survey poverty is a major cause of pensioner exclusion, although not of course the only one. Patsios (2006: 452) summarizes:

Many pensioners - particularly poorer, older and single ones – are excluded from social relations because they cannot afford to participate in common social activities, are socially isolated, they lack potential social support, do not engage in civic affairs, or are socially confined …

And:

Poverty is clearly a major cause of pensioner exclusion – it is associated with restricted utility service use, increased debts, inability to access elderly services (home helps, meals-on-wheels, etc), inability to participate in common social activities and increased confinement …

Poverty, deprivation and social exclusion are inextricably linked. Reminding us of the derivation of the concept of relative poverty, Patsios (2006: 543) suggests that poverty should be viewed as ‘both material deprivation and the exclusion from social opportunities that makes it possible for many older people to take part in the activities that are deemed customary and ‘necessary’ in their community’. In a review of the impact of policies aimed at reducing poverty and social exclusion among older
people Phillipson and Scharf (2004) point to the success in recent UK government policy in reducing the proportion of older people on absolute low incomes and reducing the proportion of pensioners experiencing relative poverty. However, they conclude that,

The impact of policies on social exclusion has been uneven … it has been less successful in challenging inequalities which are carried through into old age and which reflect the experiences of particular birth cohorts and groups within these cohorts. (Phillipson and Scharf 2004: 8)

Pertinent to this discussion too is Gordon et al’s (2000) distinction between ‘individual exclusion’ and ‘collective exclusion’. The former refers to services being unaffordable, and the latter to services being either unavailable or unsuitable. The PSE Survey results indicated when individual (affordability) and collective (availability) exclusion are combined for each major type of public and, especially, private service, in general, poorer pensioners are much more likely to be excluded than non-poor pensioners. The study reported here demonstrated how increasing resources could reduce social exclusion among a small group of older people, which could arguably apply to many older people in similar circumstances.

Of further relevance to our discussion is recent work which has systematically assembled the current best evidence on health needs and the minimal costs in meeting them for older people in England (Morris et al. 2007). A minimum income for healthy living was derived from a mass of evidence on diet and nutrition, physical activity, housing, medical care entailing costs, psychosocial relations and social inclusion. The calculated minimum income for healthy living was 50 per cent higher than the state pension and appreciably higher than the official minimum income safety net (after means testing). Morris and colleagues’ (2007) calculations were based on
the population over 65 without significant defined disability, and did not include the 40 per cent of people aged over 65 with disabilities who, as our study clearly demonstrates, are likely to require additional essential income support and services. Morris et al’s study provides the first objective benchmark of the income required to enable older people to attain the basic requirements of healthy living. We now know the minimum amount required for healthy living, yet the level at which benefits are currently set is wholly inadequate to meet these needs. The narratives presented in this paper starkly illustrate the consequences of inadequate income in later life and lend support to the arguments for greater additional resources to meet the costs associated with poor health and disability particularly for those on low incomes. Work from the Institute for Fiscal Studies indicates that the proportion of those aged 65 and over living in poverty in the UK is set to remain at its current level, around one-in-five between 2007-08 and 2017-18 (Brewer et al. 2007). Moreover, Morris et al’s (2007) work indicates that the use of the government’s definition of relative poverty in official statistics underestimates the actual numbers of older people living in poverty and unable to engage in activities likely to sustain physical and mental well-being.

We mentioned in the introduction that the much debated and disputed interface between agency and structure is a feature of the social exclusion debate. Hitherto the focus of most commentaries has been on the apparent lack of agency with respect to claiming benefits, particularly among older people (Kerr 1982, Craig 1991). The findings presented here demonstrate something of the character of the linkage between agency and structure. It was abundantly clear that what might be cast as a failure of agency on the part of older people - to recognize and claim their entitlements for support - is better understood as a structured phenomenon. Further
analysis of interview data reported in detail elsewhere, showed that the structure of health and welfare programmes over the life course had influenced older people’s propensity to claim, and it took a policy-oriented and quasi-experimental intervention to facilitate the exercise of agency (Moffatt and Higgs 2007).

We turn finally to the question of the effectiveness of a primary health care based welfare rights service in increasing the incomes of older people. The study reported in this paper was drawn from a pilot RCT of 126, 58 per cent of whom received a welfare benefit award (31 financial, 16 non-financial and 21 both), the median weekly financial award was £55 (€81, $98) per household (Mackintosh et al. 2006). Our findings carry important lessons for policy, particularly the effectiveness of welfare rights services in increasing the incomes of older people and in the relationship between resources and social exclusion among older people. There is considerable evidence from a range of organisations that benefit take-up campaigns specifically targeted at older people can be highly effective, especially when organisations collaborate with other agencies working for the benefit of older people. A survey carried out by Citizens Advice Bureau (CAB) in 2003 found that 102 Bureau had carried out take-up campaigns aimed at older people; of the 68 Bureau that gave details about financial gains, there was an estimated £13 million gained in previously unclaimed benefits (Citizens Advice Bureau 2003). Some of the most detailed evaluations of effectiveness of take-up initiatives have taken place in health-care settings, usually in conjunction with CAB or Local Authority Welfare Rights Services (Adams et al. 2006). Earlier, we alluded to the reasons why older people may find health settings more acceptable, but there are also extremely practical reasons why health settings can be advantageous both to older people and to service providers. Many older people, including the housebound, are in regular contact and
well known to health care practitioners, as a result of preventative services (e.g. winter flu injections) or because of ill-health, disability or their caring role. Primary health care is therefore a worthwhile setting in which to make contact with older people, particularly those who are likely to be entitled to health related benefits. We are not arguing that health settings are the only appropriate places in which welfare rights services should be targeted at older people. Instead, we are suggesting that many of the characteristics which lead to successfully increasing older people’s incomes apply to health settings, but could be adopted in other settings. These characteristics comprise: actively seeking opportunities to connect with older people and alerting them to their entitlements, proactively offering advice during retirement and particularly during times of poor health, the onset of disability or when in a caring role; and, active assistance with the process of claiming. This is a considerable shift from the model of national information campaigns encouraging people to seek and claim benefits which results in a consistent and substantial level of non-claiming. The ‘Link-Age Plus’ pilot programme, part of the Sure Start to Later Life initiative is the UK Government’s most recent policy aimed at reducing social exclusion among older people. A key part of this involves providing a ‘single accessible gateway’ to services for older people. It is as yet too early to say whether this strategy will have the same degree of success as targeted welfare rights initiatives in tackling the problems of non-uptake of state benefits, especially since there are as yet no concrete government proposals to reduce the complexity of the benefits system (House of Commons Committee of Public Accounts 2007).

**Conclusions**

What the small-scale qualitative study reported in this paper does is explore in some detail, the impact of receiving extra resources among low income older people and
highlight the effectiveness of proactive welfare rights services in increasing incomes. The study sheds some light on the patterning of social exclusion among older people documented in quantitative studies like the PSE Survey and offers a degree of clarification around the explanatory potential of concepts like material assets, social assets and social exclusion in relation to quality of life. It shows how, on a day-to-day basis, an overly weak flow of material assets can be intimately related to a reduced flow of social assets. Moreover it suggests that this relationship is frequently causal. This is not to assert that it is invariably causal; that the causality is never reversed; or that the strength of the flows of quite other assets - biological, psychological, cultural and spatial – cannot also be causally decisive (Scambler, 2002). There is a powerful case for further qualitative, including ethnographic, research to clarify just how asset flows known to be efficacious for quality of life and longevity might impact on social exclusion.
Acknowledgements

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Notes

1 Pension Credit (formerly Minimum Income Guarantee) is a means-tested benefit with two components: Guarantee Pension Credit available to those aged over 60; Savings Pension Credit available to those aged over 65

2 Permission to carry out the study was obtained from Newcastle and North Tyneside Joint Local Research Ethics Committee and from Newcastle Primary Care Trust. The project was registered in accordance with the Data Protection Act.

3 Attendance Allowance – non means-tested UK state benefit paid to claimants over 65 who require frequent attention throughout the day and/or night in connection with their bodily function, or continual supervision throughout the day and/or night to avoid substantial danger to themselves and/or others
Table 1: Summary of demographic and socio-economic data

<table>
<thead>
<tr>
<th>Group</th>
<th></th>
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<tbody>
<tr>
<td>Intervention</td>
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<tr>
<td>Control</td>
<td>11</td>
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<thead>
<tr>
<th>Sex</th>
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<td>Male</td>
<td>11</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
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<table>
<thead>
<tr>
<th>Mean age (range)</th>
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<tr>
<td>Widowed</td>
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<table>
<thead>
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<th>Mean interval between benefit assessment and interview (months)</th>
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<tr>
<td>Intervention</td>
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<tr>
<td>Control</td>
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<tr>
<td>GP3</td>
<td>6</td>
</tr>
<tr>
<td>GP4</td>
<td>6</td>
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</tbody>
</table>

<table>
<thead>
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<th>Housing tenure</th>
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<tr>
<td>Owner occupied</td>
<td>16</td>
</tr>
<tr>
<td>Rented</td>
<td>8</td>
</tr>
<tr>
<td>Rent free</td>
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<table>
<thead>
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<th>Council tax band</th>
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<tbody>
<tr>
<td>Band A</td>
<td>17</td>
</tr>
<tr>
<td>Band B</td>
<td>2</td>
</tr>
<tr>
<td>Band C</td>
<td>4</td>
</tr>
<tr>
<td>Band D</td>
<td>2</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Car ownership</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No car households</td>
<td>13</td>
</tr>
<tr>
<td>Car owning households</td>
<td>12</td>
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</table>

<table>
<thead>
<tr>
<th>Two person household weekly income (N=13)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>£291</td>
</tr>
<tr>
<td>Range</td>
<td>£206-£622</td>
</tr>
<tr>
<td>Median</td>
<td>£270&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Single person household weekly income (N=12)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>£183</td>
</tr>
<tr>
<td>Range</td>
<td>£131-£241</td>
</tr>
<tr>
<td>Median</td>
<td>£171&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>a</sup>: Median weekly income for two person household (before housing costs) £293

<sup>b</sup>: Median weekly income for one person household (before housing costs) £179 (Department for Work and Pensions 2002)
Table 2: Summary of the outcome of welfare rights consultations with 25 participants

<table>
<thead>
<tr>
<th>Financial Benefits</th>
<th>Participants in receipt of benefit(a) (N)</th>
<th>Amount gained for household per week (Sept 2002-Sept 2003)(b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance Allowance Higher Rate £57.20</td>
<td>7</td>
<td>362.10</td>
</tr>
<tr>
<td>Lower Rate £38.30</td>
<td>3</td>
<td>114.90</td>
</tr>
<tr>
<td>Severe Disability Premium/Allowance</td>
<td>1</td>
<td>42.25</td>
</tr>
<tr>
<td>Carer’s Premium</td>
<td>1</td>
<td>20.25</td>
</tr>
<tr>
<td>Council Tax Benefit</td>
<td>5</td>
<td>41.51</td>
</tr>
<tr>
<td>Income Support/Minimum Income Guarantee/ Pension Credit</td>
<td>7</td>
<td>123.32</td>
</tr>
<tr>
<td>Housing Benefit</td>
<td>1</td>
<td>15.71</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>720.04</td>
</tr>
</tbody>
</table>

**Non-financial benefits**

- Blue Badge: 4
- Staywarm: 2
- Aids & adaptations: 3

\(a\): Some participants received more than one benefit

\(b\): Omitted from this table are one Disability Living Allowance (£30.30 per week) and one Severe Disability Premium award (£23.30 per week) for a participants’ son and two Attendance Allowance awards for a participants’ siblings (£76.60 per week) not resident in the household.
Table 3: Distribution of financial and non-financial benefit awards made to study participants by group allocation

<table>
<thead>
<tr>
<th>Type of Award</th>
<th>Study sample (N=25)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received no award</td>
<td>7*</td>
</tr>
<tr>
<td>Received some type of award(s)¹</td>
<td>18</td>
</tr>
<tr>
<td>Received only financial award(s)</td>
<td>7**</td>
</tr>
<tr>
<td>Received only non-financial award(s)</td>
<td>4</td>
</tr>
<tr>
<td>Received both financial and non-financial awards</td>
<td>7</td>
</tr>
</tbody>
</table>

*At first interview, it was found that four participants received an award prior to the study
** One participant received an award just prior to the follow-up interview, 24 months after the start of the study
Table 4: Impact of additional financial resources at first and follow-up interview* shown by proportion of income increase

<table>
<thead>
<tr>
<th>Case</th>
<th>Sex</th>
<th>Age</th>
<th>Status</th>
<th>% extra #</th>
<th>Non financial ##</th>
<th>Necessities</th>
<th>Occasional expenses</th>
<th>Capacity to cope with crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Transport</td>
<td>Social Activities</td>
<td>Food</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>72</td>
<td>W</td>
<td>55</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>17</td>
<td>F</td>
<td>84</td>
<td>W</td>
<td>52</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>14</td>
<td>F</td>
<td>82</td>
<td>W</td>
<td>51</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>74</td>
<td>M</td>
<td>33</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>15</td>
<td>F</td>
<td>62</td>
<td>M</td>
<td>31</td>
<td>✓</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>74</td>
<td>M</td>
<td>22</td>
<td>1,2</td>
<td>✓</td>
<td>X</td>
<td>✓</td>
</tr>
<tr>
<td>5**</td>
<td>M</td>
<td>75</td>
<td>M</td>
<td>21</td>
<td>1</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>1</td>
<td>M</td>
<td>75</td>
<td>M</td>
<td>19</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>7</td>
<td>M</td>
<td>75</td>
<td>M</td>
<td>18</td>
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<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>12**</td>
<td>M</td>
<td>79</td>
<td>M</td>
<td>18</td>
<td>1</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>22*</td>
<td>F</td>
<td>78</td>
<td>M</td>
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<tr>
<td>10</td>
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</tr>
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<td>9*</td>
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<td>W</td>
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<td>✓</td>
</tr>
<tr>
<td>11*</td>
<td>M</td>
<td>77</td>
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<td>4</td>
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<tr>
<td>24†</td>
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<td>20</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

* No follow-up interview due to ill-health
** Full financial award not received at time of first interview
# Extra financial resources as a proportion of baseline income
## Non financial awards: 1 = Blue badge, 2= Aids and adaptations, 3= Staywarm, 4= Community care alarm scheme
1 Received additional resources just prior to follow-up interview, 24 months after study started
2 ✓ denotes mentioned at first interview
3 X denotes mentioned at follow-up interview
References


Higgs, P. 1997. Citizenship theory and old age: from social rights to surveillance. In Jamieson, A.,


Toynbee, P. 2004. We cannot allow the poor to fall into the pensions abyss. Guardian, 24.


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