

GP experience of the impact of austerity on patients and general practices in very deprived areas

Concerns have been raised in several quarters about the consequences of the Government's welfare reforms and other austerity measures, which have been implemented since October 2010. These concerns include the negative impact that cuts in benefits are having on some of society's most vulnerable individuals and families.

GPs and primary healthcare professionals are at the frontline in responding to the needs of these people. "GPs at the Deep End" work in 100 general practices serving the most socio-economically deprived populations in Scotland. This report draws on the recent experiences of Deep End practices, as they were asked to reflect on the effects of austerity measures on patients and on patient care. Responses included general comments and individual case studies.

The report makes for grim reading. It describes the direct and indirect consequences of austerity policies on patient health and on the systems that are in place to support health and wellbeing. The case studies are a graphic illustration of the strain these systems are already under; and more importantly, the strain that the most vulnerable – the elderly living in fuel poverty or the homeless mother and her child – are experiencing right now.

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Report compiled on behalf of the Deep End Steering Group by David Blane and Graham Watt, with thanks to the general practitioners in the Deep End who contributed to the survey

INTRODUCTION

This report comprises the responses of general practitioners working in the 100 most deprived general practices in Scotland to the question "How have the current austerity measures affected your patients and your practice in the last week (beginning 20 February 2012)?"

The responding practitioners work in general practices and a homeless health centre in Glasgow, Edinburgh, Dundee and Ayrshire, including the 1st, 10th, 12th, 58th, 59th, 66th, 75th, 79th and 89th most deprived general practices in Scotland (out of the total of 1030 practices).

The draft report was circulated to all Deep End practices, seeking further comment and confirmation that the cases described are typical.

BACKGROUND

Austerity measures were introduced following the UK Government's spending review announced by the Chancellor in October 2010. This included £81bn of cuts in public spending over four years.

In April 2011, claims for benefits on the basis of incapacity for work were transferred to claims for employment and support allowance (ESA). Entitlement was re-assessed using the new stricter criteria of the Work Capability Assessment (WCA).

The Welfare Reform Act – representing the biggest change to the welfare system for over 60 years – received Royal Assent on 8th March 2012. The Act introduces a new Universal Credit which will replace most existing benefits and limits the total amount of benefit a person can claim.

As well as these broader plans for welfare reform that will come into effect in 2013, there are changes to working tax credits to be implemented from April 2012. A report on the UK Parliament website provides an estimate of the number of households that are expected to no longer be entitled to tax credits as a result of these changes, including over 25,000 households in the central belt of Scotland.[†]

MAIN FINDINGS FROM DEEP END PRACTICE RESPONSES

Most of the issues raised relate to the direct and indirect sequelae of austerity policies – benefit cuts; service cutbacks; and an increasing number of patients being taken off Employment Support Allowance (ESA) or Disability Living Allowance (DLA). These can be divided into issues affecting patients; practices; secondary care/support services; and social work/housing:

[†] To qualify for working tax credit from April, couples with children will have to work 24 hours a week between them, not 16 as before, and one of them will have to work at least 16 hours a week.

Patient health

A central concern of Deep End practices is the number of patients with **deteriorating mental health**.

At one end of the spectrum, there are those who are in work, and previously well:

- under increasing stress at own jobs due to cutbacks
- taking on extra work/jobs, with resultant impact on family and relationships
- experiencing stress of job insecurity

At the other end of the spectrum, there are those with chronic mental health issues and established physical problems who are “**deemed fit for work**” and have their benefits cut:

- struggling to make ends meet
- increasing contact with GPs and psychiatry
- increasing antidepressant/antipsychotic use
- self-medicating with drugs and alcohol

Aside from the direct detrimental effects of drugs, alcohol, and worsening mental health on **physical health**, it can also be affected indirectly as many patients are reluctant to take time off work due to job insecurity. Additionally, GPs report less time to deal with physical problems, as these are no longer a priority for the patient.

I observe this again and again that I cannot address medical issues as I have to deal with the patient's agenda first, which is getting money to feed and heat.

This **financial hardship** is manifesting in several ways, but perhaps most striking is the growing number of individuals and families experiencing **fuel poverty** – the combination of increased costs and falling benefits resulting in a choice between heating and eating. Practices reported cases of an elderly patient going to a friend's house in order to wash; families relying on relatives to pay for food and cigarettes (unable to stop smoking due to stress); and a mother resorting to prostitution to feed herself and her family.

In my surgery I am hearing from patients who for 2–3 days a week cannot afford to heat their houses (many use metered cards which are more expensive than direct debit payments).

Changes to the benefit system were cited by most respondents as impacting on patients' health and practice workload. Practices described an “**endless cycle**” of **appeals**, during which time the patients' benefits are reduced. One GP calls this “completely unnecessary [and] completely avoidable”; another felt that the WCA (Work Capability Assessments) were ill-matched to the clinical reality.

*For obvious reasons the patients in X [deprived area of Glasgow] call Corunna House [where the Work Capability Assessments are done] “**Lourdes**” because all the sick come out cured!*

Practice impacts

- **Changing workload.** Most patients appeal the WCA decisions and ask for letters in support of appeals. This is encouraged by benefit support workers and solicitors. As noted, however, it impacts on practice time that would otherwise have been spent on health concerns.

- **Access affected.** Pressure on appointments and appointment length as a result of the above, including increasing volume of unscheduled appointments in some cases.
- **Staff morale.** Several practices report sadness and frustration among staff members at their inability to alleviate the suffering they see, and increased stress due to extra workload. Again, this has potentially significant detrimental impacts on patient care.

Secondary care and support services

- **Patient transport** for outpatient appointments has been affected by cutbacks, such that there have been reports of many patients complaining about long waits, with some elderly, frail patients arriving home after midnight. Will this result in higher DNA rates?
- **Delay of discharge letters** from secondary care, which can result in potentially serious prescription errors, is often due to typists being off, or unfilled posts.
- Increasing **funding and access barriers** to residential detox.
- **Addiction workers struggling** to do any structured addiction work because they are too busy trying to help patients in crisis.
- Patients are attending Community Addiction Teams for money due to benefits being cut; but addiction and social services have **run out of funds for crisis loans**.
- Other examples that Deep End practices gave included rehab services, occupational therapy, and heart failure nurses being **harder to access**.
- One respondent felt like GP practices were a “dumping ground”, as other services are **affected by cutbacks**.

Social work and housing

- Several descriptions of a service that is **overworked and understaffed** and that is, ultimately, failing some of the most vulnerable members of society.
- Reports of **vulnerable adults and children being unallocated** despite serious concerns for their safety and/or wellbeing.
- Difficulty getting social work colleagues to attend practice meetings.
- Increased **difficulty getting patients into respite care**.
- Increasing **reliance on voluntary sector**.
- Addiction services and social services have been categorically told to turn to charities for basic items such as beds and cookers when children are being returned from care to their parents.

We have a working single mother who became homeless due to community violence, she has been in a cold damp flat sleeping on a mattress on the floor with her 11 month old child for nearly six months, housing has been unable to find her a suitable flat.

ANNEX – CASE STUDIES[†]

- Patient refugee, fleeing violence from another city, staying in a temporary voluntary sector night shelter (winter initiative) every night last week, presented looking for mental health support and medication. Previously on antidepressants, no money, all worldly goods with him in a small bag, winter initiative closing at end of week and no idea where to go now. Signposted to State homeless centre but as no local connection unlikely to be housed for more than 28 days, given basic food and toiletries from health centre stock, very distressed/sobbing.
- T, mid 40s, has been coming to see me for the last few months. She has chronic depression with multiple previous suicide attempts. She suffers from angina and has had an MI in the past. She lives in a flat with her boyfriend. T has recently been deemed fit for work, but is appealing this decision. Money is extremely tight, and she and her boyfriend are currently surviving on his benefits alone. T has suffered from physical, sexual and emotional abuse all her life and her current relationship is no exception. T wants to visit her daughter (whose young child has recently been removed from her care), but can't afford the coach fare – her partner (not the daughter's father) won't pay, as he will not allow T to leave him, even to see her own family. T is waiting for her daughter to pay for the coach ticket. The daughter in turn is waiting for her own benefits to come through. Another daughter is homeless.
- Mother, early 40s, who was sexually abused in her childhood. She has seen me regularly since mid-2010 when she presented with alcohol dependency, talking for the first time in her life about her abuse, contemplating change. She was referred by myself to addiction services team. She received a detox in late-2010 and had a very minor relapse over xmas. She is currently trying to consolidate her life and I am working slowly towards confidence issues and possibly return to work. She was found to be capable of work, a judgement I disagree with at present and I worry that her mental health will deteriorate. Her benefits got stopped. She was diagnosed with Type 2 Diabetes in November and instead of working with her setting goals for her diabetes I wrote a letter for an appeal and referred her to the benefits worker as these were her priorities.
- Single woman in her 30s asked to do work of several staff at self scanning in supermarket where she works due to cutbacks. Can't cope, stressed, makes looking after three teenage school kids with behavioral problems harder. Attends emergency surgery crying +++. Feels unable to address own problems, doesn't know who to turn to so comes to GP. Long, unscheduled consultation.
- Male Eastern European patient with insulin dependent diabetes and likely retinopathy and degree of renal impairment. No access to public funds and getting food from shelters and other charitable donations. Sleeping rough but recent access to bed in a flat though he has to find another £100 in next week to pay rent or will have to sleep rough again. Requesting letter to support him attending locations distributing food explaining his medical problems. In theory not entitled to secondary care services but requires secondary diabetic services.

[†] Please note that patient details such as age, nationality and location have been changed in order to ensure anonymity.

- Eastern European pregnant lady with no money or food. Living in squalor with approximately eight other adults. No money available or access to any public funds. Begging for money.
- Female, mid 50s, with lifelong mental health problems and a history of self-harming and has never worked. She probably has learning difficulties (although has not been diagnosed as such) and limited literacy skills. She has been presenting more frequently in the surgery with increased anxiety and episodes of self-harm. She is having to live on £168 per fortnight because her benefits have been cut. She is relying on handouts from her family (who are all local residents and also struggling financially) but is going without heating over 3 days a week until her money is sent through. She is already linked into the community health team but this will not address the underlying trigger to her increased presentation with mental health problems which are a consequence of her poverty.
- Male, early 50s, out of work because of osteoarthritis but also has a history of depression that has been relatively stable until now. Until a few years ago he worked continuously in the labouring trade and was not often out of work. Since the economic downturn he has essentially become long term unemployed. He was receiving disability allowance but this was then cut and he has now entered the appeal process. His family are helping him with his mortgage because he is unable to make his payments otherwise he and his wife will become homeless. Like many patients who have little savings because they have worked in low paid jobs and find themselves later in life unemployed there is a great deal of anxiety and uncertainty about their future. This patient's mental health problems have escalated and he is being seen by mental health services. At this juncture he could not psychologically cope with re-training.
- Mother and young daughter with complex issues. Mother was stable on high dose methadone but because of personal circumstances (threats on her life following a violent assault) she moved out of the area and re-located. Whilst she was temporary re-located she remained my patient because of her methadone prescribing. The youngster has been brought up in a family where virtually all adults have addiction issues and I have concerns about this child's mental health. There has been a prolonged period of instability where the combination of benefit cuts and social circumstances have resulted in homelessness where the whereabouts of this child was unknown whilst she was staying in various locations either with her mother or other adults. There was already social work involvement but it took several contacts/letters from the addiction workers and myself to finally have a child protection plan for this child (there has also been involvement from Child and Adolescent Mental Health Services but this has been short-term). At one point this parent had no money to buy this child any clothes where they were both almost 'rough sleepers'. I am highlighting this case particularly because some of the most vulnerable children in our society are becoming even more vulnerable because of austerity measures. Not only are they being denied their basic rights to protection, participation and provision there is a stress for staff at the frontline who are unable to alleviate their suffering. In the long term the adverse outcomes for these children carries a greater economic burden for society. No child can possibly muster enough resilience to cope with these experiences.
- Mum and dad working different night and day shifts to allow for child care for their three- year-old. No family help. Can't sell flat – trying for two years –

and would like another child if they could move. Leads to stress and depression.

- The Tuesday started with half an hour on the phone to give the police the relevant medical information for two of our patients who had been found dead in their homes the previous day. Separate incidents – both in their thirties and both with drug paraphernalia around – one with a tourniquet still on his arm the other recently self discharged from hospital with cirrhosis. I think we get inured at times to these deaths of young people – but two on the same day... This week I have felt particularly hard hit and sad... for them... for their families and friends... and for all our young folk – where are our priorities?
- Single parent, late 30s, developed acute onset sciatica having been fit and well and working previously. She was walking with a stick and required a variety of analgesic agents to control unpleasant sensory symptoms. MRI showed clear nerve root impingement, but due to a high BMI she required to lose weight before she could be considered for general anaesthetic. She was referred to the local weight management service but has not yet managed her weight goal because of extremely stressful social circumstances. Early on in her sickness, a few weeks after her MED3 (fitness for work certificate) started, she was assessed and found fit for work, and had her money stopped. In my opinion this was a medically inappropriate decision. I did not realise it at the time but this was not a quirky isolated example of an aberrant process. A deluge of similar situations followed and I quickly realised I could not challenge each one as workload made that impossible. I slowly became aware of the Appeals process and people coming for MED3s. The last few months have been among the most depressing, disturbing times in my many years as a GP.

The following five cases represent snapshots from one practice:

- (1) Divorced man, late 40s, recently unemployed and struggling with depression – deemed fit for work. If his story had been listened to it would be clear that he is currently unfit for work. His response? “I couldn’t give a toss/really low”. Family very worried – daughter has moved to live with him as she does not want to leave him on his own. Concerning situation exacerbated by attitude of local Benefits Agency. His own safety is borderline – he is clearly unfit to hold down a job.
- (2) Epileptic man, mid-20s, deemed fit for work. His epilepsy is not controlled, he is attending the epilepsy clinic at the hospital on a regular and frequent basis as his medication is steadily increased trying to reduce his seizures and he is deemed fit! Not safe and unfit.
- (3) Woman, late-50s, has struggled with depression since the (premature) death of her husband five years ago. She rarely leaves the house alone/is variable with personal care/ fortunately has siblings and children who keep in regular contact with her but she is clearly unfit for work.
- (4) Man, late-50s – diabetic neuropathy – deemed fit for work – has not worked for years – diagnosis nine years ago. Stress of appeal is a completely unnecessary burden.
- (5) Woman, late-40s, works for the local council – seeking help as a result of her stress. The major problem is the stress of changes at work/general level of anxiety regarding job security and how those still in work will cope with the pressure.

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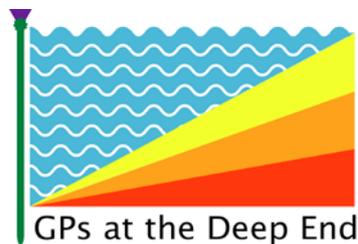
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<http://www.gla.ac.uk/departments/generalpracticeprimarycare/deepend/>