The 2015 RCGP publication *Health Inequalities* reflected on evidence from the 2010 Marmot Review, which concluded that, in England, people living in the poorest neighbourhoods will, on average, die 7 years earlier than people living in the richest. Furthermore, the average difference in disability-free life is 17 years; thus, people in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability.

**SPECIFIC NEEDS OF WOMEN INVOLVED IN SBP**

Health inequalities are not simply a difference in health outcomes, but also a difference in health outcomes combined with barriers to accessing the healthcare system. In addition to physical barriers such as opening hours, location, and transport, there are other barriers contributing to this exclusion, including patient perceptions of services and expectations of what will be offered if they seek help, staff attitudes to patients, and communication difficulties.

Women involved in street-based prostitution (SBP) are an underserved group and their health is a source of international concern. These women are a high-risk population, and street-based workers are at greater risk than their parlour-based counterparts due to an increased prevalence of intravenous drug use and poorer engagement with healthcare. Women have specific health needs relating to their lifestyle and occupation, as they are more likely to use drugs, have a less stable home environment, and experience occupational violence. Women involved in SBP often have chaotic lifestyles and complex socioeconomic backgrounds, factors that may have initially led them into prostitution. The standardised mortality ratio for those involved in prostitution in the US is three times greater than that of the general population. Women commonly experience social exclusion and stigma related to their occupation, and belonging to a marginalised group subject to socioeconomic disadvantages is in itself detrimental to health.

“Women commonly experience social exclusion and stigma related to their occupation, and belonging to a marginalised group subject to socioeconomic disadvantages is in itself detrimental to health.”

**CONTINUITY OF CARE, COMMISSIONING, AND THE THIRD SECTOR**

The 2015 RCGP publication made two recommendations that are particularly relevant to improving the care of women involved in SBP:

- Focus on incentivising ways of working that promote continuity of care in areas where patients would benefit most from a continuous therapeutic relationship with their GP — particularly areas where a high number of patients are living with multiple morbidities.

- ‘Fund outreach programmes to help often excluded groups such as those with mental health problems, learning disabilities and the homeless to access general practice.’

Few women in our study reflected positively on relationships with general practice, or described an ongoing therapeutic relationship with one supportive GP. Primary care was failing these women. The concealed nature of the industry makes commissioning specific services for this patient group challenging, and women may not wish to access a service that would mean disclosure of the nature of their work; however, being able to access a specific service might improve access to care, enabling women to avoid disclosure to all but a specialist team of practitioners. Much of the work that GPs can do to make a difference in reducing health inequalities needs to be taken forward in collaboration with, or signposting to, other professionals. This should include the third sector (or so-called ‘voluntary services’), which plays a key role in supporting people in groups from underserved populations, but which all too often are commissioned on a short-term basis, and thus work in a state of uncertainty.

In the report by the Primary Care
“... recommendations around better use of technology to promote access and increasing the length of primary care consultations would potentially offer currently underserved groups (such as women involved in SBP) the opportunity to access improved and more acceptable care.”

Workforce Commission,12 the message was clear:

‘... primary care needs to change. It will still be based around the GP practice holding responsibility for the care of its registered patients, but practices will have a stronger population focus and an expanded workforce. Many existing healthcare professionals will develop new roles, and patients will be seen more often by new types of healthcare professional such as physician associates. Clinical staff will have better administrative support and, when needed, healthcare professionals will be able to spend more time with their patients to discuss and plan their care.’

Much was made in this report of strengthening the role of pharmacists, increasing recruitment to practice nurse and physician associate posts, and highlighting patient demographics with particular needs. However, there was little focus on the role the third sector plays in supporting patients. Proposed new workforce models have not included third-sector services, and without these some patients will not be served appropriately by primary care.

However, the recommendations around better use of technology to promote access and increasing the length of primary care consultations would potentially offer currently underserved groups (such as women involved in SBP) the opportunity to access improved and more acceptable care. Taking into account the important role third-sector organisations and integrating them within the broader workforce models have not included third-sector services, and without these some patients will not be served appropriately by primary care.

Can primary care rise to the challenge of offering acceptable, patient-centred care to currently underserved groups, such as women involved in SBP? Will clinical commissioning groups forward-plan sufficiently to ensure integration of responsive health, social, and third-sector services?

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