

### SOCIAL EXCLUSION AND HEALTH INEQUALITIES

Over 40 years ago, Julian Tudor Hart formulated the inverse care law, stating that 'the availability of good medical or social care tends to vary inversely to the need for it in the population served'.<sup>1</sup> This still applies today, and the gap in life expectancy is widening between different social groups.<sup>2</sup>

Social exclusion is 'the inability of an individual, group, or community to participate effectively in economic, social, political, and cultural life, alienation, and distance from the mainstream society'.<sup>3</sup> This broad definition refers to people who are suffering multiple and enduring disadvantage and who do not have the opportunities that many of us enjoy.

There are many social groups that are facing substantial health inequalities, and this issue highlights some of them. As outlined by Watton,<sup>4</sup> the average life expectancy for single homeless men is still 47 years, a whole 30 years below the national average, whereas for people with intellectual disability, the gap is 16 years.<sup>5</sup>

While social exclusion is often regarded as a predominantly urban issue, since the highest concentrations of some of those groups are usually found in cities,<sup>6</sup> there are specific aspects of exclusion affecting rural populations. The editorial by Osborne,<sup>7</sup> for example, highlights the staggering statistics on suicide among isolated farmers, which is twice the general population, as well as a high incidence of depression.

The underlying reasons for these striking inequalities arise from a complex interaction of factors including housing, income, education, social isolation, and disability.<sup>2</sup> This requires an integrated approach between different bodies and agencies at both national and local level.

### POPULATION APPROACH

The Health and Social Care Act 2012 now formalises our role in considering the population's health within our clinical commissioning groups (CCGs). Further, CCGs have the statutory duty to 'reduce inequalities between persons with respect to their ability to access services [ ... and] outcomes'. This includes vulnerable groups such as homeless people, Gypsies and Travellers, and sex workers, as they are reporting some of the worst health

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outcomes in the country. For example, between 24–68% of sex workers are reporting symptoms of depression,<sup>8</sup> and 38% of Gypsies and Travellers have at least one life-limiting long-term condition.<sup>9</sup>

Thanks to the 2012 Act, the role of primary care has now become even more pivotal, as in addition to acting as gatekeeper to the system and being the main point of contact with the patient, it will also determine local commissioning priorities.

To help CCGs to meet these obligations, the Royal College of General Practitioners has developed a toolkit for GP commissioning consortia looking at how to improve access to health services and outcomes for these populations.<sup>10</sup> This guidance has been produced as part of the Department of Health's Inclusion Health programme, and it aims to provide professionals and commissioners with practical support and examples to commission health services in ways that improve health outcomes for the most vulnerable groups.

Staff in fact too often lack the skills, resources and professional support to deal appropriately with socially excluded patients, who frequently present with multiple and complex needs requiring truly multidisciplinary approaches. On this regard, voluntary sector organisations act as conduits, building bridges between services and disengaged users who are unable or do not want to use them. They can help commissioners to make services more accessible and develop communities and individuals by building skills and capacity.

In addition, these organisations often also provide services of their own, including outreach, community advocacy and representation, and cultural awareness training for public sector staff, among others. It is particularly in this role that voluntary sector organisations have strong links with local communities, and their knowledge from providing those services is unrivalled.

CCGs are also part of health and wellbeing boards (HWBs) together with colleagues from local authorities (LAs) and NHS England, to jointly commission the right services for their population. On this purpose, it is important for them to draw on a robust underlying joint strategic needs assessment (JSNA), which is an accurate and encompassing representation of the profile and the needs of the local area, including socially excluded groups. In turn, the JSNA should inform the set of priorities collectively agreed by the HWB and set out in the joint health and wellbeing strategy (JHWS). The strategy should address the needs of the whole population, and should extend beyond a narrow health and social care services perspective by also looking at the potential for integration.

These documents were previously owned by primary care trusts, and with the public health reforms, they will now be produced by LAs together with the CCG, under arrangements made by the HWB. While current practice is heterogeneous, to meet the new health inequalities duties described in the 2012 Act, and to make sure that the JSNA is truly a comprehensive reflection of the needs of the whole local population, commissioners have to ensure that the groups suffering most acute inequalities are included.

The evidence available suggests that for different reasons, patients from some of the most vulnerable groups are currently being failed by the system. This is not only morally unacceptable, but it also has enormous human and economic costs.

While the problems faced by the NHS and other health organisations are often cross-cutting, there is a lack of collaborative structures and mechanisms to share good practice, in order to avoid individual organisations having to 'reinvent to wheel'. The commissioning guidance presented in this article, as well as the other contributions in this issue have highlighted

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#### ADDRESS FOR CORRESPONDENCE

**Paramjit S Gill**

Primary Care Clinical Sciences, University of Birmingham, Edgbaston, Birmingham B15 2TT.

**E-mail:** p.s.gill@bham.ac.uk

that there is a wealth of information and initiatives already available, which often, with little time and effort, can make a big difference for patients.

#### WHAT CAN GENERAL PRACTICE DO?

In addition to physical barriers, such as opening hours and locations, there are many invisible ones, including literacy, patient perceptions, staff attitudes, and poor communication. While some of these issues are easy to resolve, others are more complex. The Deep End project, for example, has highlighted that, in addition to managing complex health issues, practitioners working with excluded groups spend a growing amount of time coordinating services from other agencies and dealing with non-health matters, such as benefit claims and fitness for work assessments.<sup>11</sup> This is a reflection of the fact that, to tackle the more structural problems, there is a need to invest in additional resources to 'improve the health of the poorest fastest': so-called proportionate universalism.<sup>2</sup>

The principal role of general practice is to deliver high quality primary care to people irrespective of their circumstances. This includes ensuring multidisciplinary working, providing appropriate access to services, and designing services to suit the particular population being served, all of which are essential aspects of general practice. The College has outlined its vision for this in *The 2022 GP: a Vision for General Practice in the Future NHS*.<sup>12</sup>

Successful examples range from specific services, such as the White House Surgery in Sheffield,<sup>4</sup> to simple awareness raising messages such as 'Faster Care' for diagnosing people with learning disabilities<sup>5</sup> and being responsive to the hidden or unspoken needs of vulnerable groups such as isolated farmers.<sup>7</sup>

By using the wide range of interventions currently available and by focusing on people's health, social care, and other needs in a holistic way, commissioners can make a real difference, enabling these groups to live longer and more fulfilling lives.

While the problems faced by socially excluded patients can often seem

insurmountable, the solutions are sometimes very simple and effective. As GPs, we need to listen to our patients' suffering. This requires us to reflect on our own values, and what illness means within the patient's own chaotic life story.<sup>13</sup> We need to emphasise the caring, compassionate professionalism for *all* our patients that goes with our technical skills.

**Paramjit S Gill,**

GP & Reader in Primary Care Research, University of Birmingham, Birmingham.

**Adrian Hegenbarth,**

Research Fellow, Clinical Innovation and Research Centre, Royal College of General Practitioners, London.

#### Provenance

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#### Competing interests

Paramjit S Gill is Royal College of General Practitioners Clinical Champion for Social Inclusion and member of the RCGP Health Inequalities Standing Group. Both Paramjit S Gill and Adrian Hegenbarth were funded by the Department of Health to develop the toolkit for GP commissioning.

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