INTRODUCTION
Inclusion health groups are defined as:

‘... people who are socially excluded, typically experience multiple overlapping risk factors for poor health (such as poverty, violence and complex trauma), experience stigma and discrimination, and are not consistently accounted for in electronic records (such as healthcare databases). These experiences frequently lead to barriers in access to healthcare and extremely poor health outcomes.’

Some are uncomfortable that this is such a broad definition, however this whole field only exists because structures and services are not set up to ensure everyone achieves equitable care. This is entirely socially engineered; for example, we have an asylum system that purposely stops people working and having access to many social goods and services. Society is constantly changing so this field has to remain flexible to account for that; in essence, the social determinants drive how we need to respond as a health service.

This catch-all way of thinking also enables us to consider intersectionality and the commonalities of responses that might be useful to effectively meet peoples’ needs. It is not intended to detract from the individual identities and distinct experiences of marginalised groups. It led to our current research about missingness in health care.

‘Dig where you stand’ is a quote from the book *Soil and Soul: People versus Corporate Power* by the wonderful thinker, Alastair McIntosh. Reading it gave me the confidence to embrace the uniqueness of living and working in Scotland in the 21st century, to be confident in my sense of self and how that relates to my own identities, and the sociopolitical forces that have shaped me. I was given permission to consider the place that I live and the work that I do as important; wonderful effort and change is not just happening somewhere else, it can happen here.

MISSINGNESS IN GENERAL PRACTICE
The research team’s current research defines missingness as the ‘repeated tendency not to take up offers of care that has a negative impact on the person and their life chances.’

This is an effort to understand and bring together what can be done to address missingness across patient groups and learn from many fields. There is excellent work being done in a range of settings; we want to ensure its relevance for all healthcare settings.

There is a large international literature about the causes of missed appointments and a moderate one about interventions to address them. However, they are usually considered at the service level and rarely is there a distinction made between a person who misses one appointment and one who misses many. Our theory is that this conflates why the evidence of effectiveness is mixed for interventions such as text-message reminders.

Our previous epidemiological study hypothesised that patterns of high missed appointments were a proxy for poor health and social vulnerability. We sought to explore that using GP, hospital, and education-linked data. We defined high serial missed appointments as patients who missed an average of ≥2 GP appointments over a 3-year period.

Overall, 19% were high missers of GP appointments, were more likely to have an adverse childhood experience recorded, have reduced school attendance, higher levels of school exclusion, and lower educational attainment historically. A GP appointment delay of 2–3 days was associated with highest risk of missingness. More socioeconomically deprived patients registered in more affluent setting practices had the highest risk of missing appointments, and practice factors had a stronger influence than patient factors.

How we deliver care to patients matters. Patients with more long-term health conditions had an increased risk of missing appointments. However, we were shocked when we looked at mortality outcomes; patients who were high missers were at much greater risk of all-cause mortality; for example, for patients with mental health diagnoses they had an eight times higher risk of premature death compared to patients with similar diagnoses who missed no appointments.

When we examined patient’s journeys in health care, high missers of GP appointments were both higher users of
inpatient and outpatient care, and more likely to miss hospital appointments and take ‘irregular discharges’ from care. Mental health service missingness was very high. Contrary to what we hypothesised; emergency department use was the same across all groups.9

CONCLUSION
Missingness in health care is a strong risk marker for a poor outcome so needs urgent attention from the healthcare community. In the current study, we are conducting a realist evidence synthesis, realist interviews, and a series of intervention development workshops to find out what causes missingness and interventions to address it.3

The experience of GPs at the Deep End Scotland has been that politicians and policymakers do listen to what we say, and act – collective voices do make a difference.

Consider this yourself – where do you stand – in your research context, in your teaching context, in your clinical practice, in your policy context? Where should you dig?

What should you be unearthing, getting involved in, getting in, and about (to use a bit of Glaswegian) to sort out?

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Provenance
Commissioned; not externally peer reviewed.

This article is an excerpt from the Helen Lester Lecture, delivered at the Society for Academic Primary Care 51st Annual Scientific Meeting in Brighton, July 2023.

Competing interests
The author has declared no competing interests.

Acknowledgements
I want to acknowledge the survivorship of the people considered to be in Inclusion Health groups and who I meet in my clinical, teaching and research practice. They continue to be an inspiration to me and should be to us all, through their resilience and strength in the face of adversity.

DOI: https://doi.org/10.3399/bjgp23X734985

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