Healthcare as if people mattered:

April 2

2008

towards truly equitable health services

This document is a summary of a PoHG Workshop held at the UK Public Health Conference, Liverpool Echo Arena April 2nd 2008. It provides an over view of the aims of the workshop and key points from the discussion groups.
Healthcare as if people mattered: towards truly equitable health services

Politics of Health Group Workshop 2nd April 2008

UKPHA conference Liverpool Echo Arena

**Chair:** Alex Scott-Samuel

(Liverpool)

**Presenter:** Sarah Corlett (London)

**Presenter:** Pauline Craig (Glasgow)

**Presenter:** Sam Semoff (Liverpool)

**Participants:** 35 - 40

**Rapporters:** Barbara Brady; Debbie Fox; Aldo Mussi; Sam Semoff.
Summary

While there is no shortage of rhetorical commitment to tackling health inequalities within the UK health sector, policies tend to be characterised by a focus on action to change individual behaviour or to intervene pharmacologically. In other words, policies tend to have mid- or downstream perspectives and are based on (usually unstated) values which are not orientated towards health equity (such as consumerism, commercialism and localism).

The aim of the workshop was to initiate debate on 'the social relations of health care' and to work towards health services which truly reflect the values of both staff and users. In the context of health inequality, we believe that fairness and social justice should permeate the processes, content and outcomes of the services provided.

The issues discussed included:

1. the political content of the education and training of health professionals providing different services
2. new ways of interacting with service users which incorporate an awareness of, and sensitivity to the ways in which their health may be shaped by their social circumstances
3. the potential for new types of service which are sensitive to inequalities issues
4. new approaches to health service provision which prioritise inequality-related needs of users

Following a brief introduction by the chair the presenters made three 10 - 15 minute presentations covering key aspects of the issues summarised above. Participants were allocated to facilitated small groups, each of which discussed members’ views on the workshop themes and their knowledge and experiences relevant to them. Each group began by agreeing ground rules, in order to ensure equal opportunities for full participation by members in discussions. Each group were asked to agree three action points, which were fed back to the final workshop plenary session.

Presenters and links to their presentations

Pauline Craig  ‘Healthcare as if equity mattered – issues for debate’
Sarah Corlett  ‘Health as if people mattered - happiness and spiritual life’
Sam Semoff  ‘Equitable health services - importance of recognizing specific needs’
Key points from the Workshop

Rapporteur: Aldo Mussi

On Professional training
- More explicit recognition during training that all health & training is political and values led
- Services may assume they’re ‘colour-blind’ but practitioners operate their own politics (and at either extreme)
- Must look beyond own professional role, especially at the contribution of eg self care/ self help and Expert Patients.

Better interaction with users
- Better cultural competence
- The ‘Good Patients List’ is very revealing: we are still too service-led, and do not recognise people unless they are our ‘patient/user’
- Be mindful of power differences

Potential for better services
- More time for interaction/ conversation with the public
- Seeing beyond the ‘individual’ – a public health perspective
- Recognising the role of values/ power/ broader determinants in shaping peoples health
- Involving people in shaping services and interventions
- Stronger partnerships with other professions and agencies (including the less-high profile such as CAB)

Rapporteur: Barbara Brady
- Role of Joint Strategic Needs Assessment but this needs to be differentiated at community level to ensure actions/ plans are sensitive/ appropriate
- Debate on the role of the NHS in the Public Health agenda. It has a role but must be seen in the wider context
- Heated debate about putting the NHS back in its box!

Rapporteur: Sam Semoff

Communities
- Most of the discussion focused on the importance of involving communities in the development and delivery of services. It began with the first contributor noting the absence from the conference of people from communities most affected by health inequalities. This was partly attributed to the high cost of the conference fees.
- Other contributors noted that the idea of involving communities has been talked about for many years with “consultation” now a requirement in many instances. However the consultations were often little more than “tick the box” exercises
and indicative of the fact that service providers did not really value the input of communities.

- This failure to value communities was linked in part to the lack of epidemiology and in particular social epidemiology in undergraduate teaching with one contributor noting that in five years training to be a GP, she had only three days of epidemiology. This was challenged by a speaker during the feedback, leading to the consensus that there was much variation in undergraduate teaching when it came to the importance of communities.

**Fuel Poverty (Sams own thoughts he would like to share with us)**

- This issue of fuel poverty was raised and in particular, the fact the legislation setting up the privatization of the utilities was done in such a way as to enable them to charge people on prepayment meters as much as 15% more than people paying by direct debit. It was pointed out that if impact assessments were carried out effectively, this would be highlighted. It was also noted that this is a clear example of the political link to health.

- During the feedback Alex pointed out that the UK is virtually the only Western country where fuel poverty is an issue. Countries such as Canada recognize the importance of the need for people to have adequate fuel to keep warm and this is reflected in the laws governing the utility providers.

- I did a bit of checking on the internet and there is a lot being done around fuel poverty, the rising costs of utilities and the difficulties it causes. However I did not see anything where the groups raising the issue of fuel poverty were specifically looking at the inequality in tariffs depending on how one is able to pay. Perhaps that is because it is so political.

- Some years ago when water was being privatized, the companies wanted to install prepayment meters as we now have with gas and electric. Thus if people were unable to feed the meters, their water supply was cut off. Public health people played a key role in the moves to prevent this happening, arguing the importance of people having adequate supplies of clean water should take preference above all other considerations.

- There are in effect two issues. One is the wider issue of fuel poverty and its implications for health. The other is the specific issue of the inequality of the tariff system. UKPHA should be working with groups and individuals concerned with both these issues.

**Rapporteur: Debbie Fox**

Given the amount of time for discussion, the group decided to focus on the political content of the education and training of health professionals providing different services.

- Taking a ‘Vignette’ approach to service development as discussed by Pauline Craig, was considered a useful and powerful way of influencing policy. This has great
potential to ensuring the different aspects (determinants of health) of a persons life are considered in delivering affective individual care, and also provides a way of getting practitioners/ learners to think across real life issues from an ‘equity focused’ standpoint.

- It is important to look at gaps in service provision – those things that people don’t use either because they do not know about them or the gap reflects an unmet need.
- The NHS is currently too introspective. It needs to open out to lay knowledge not just as expert patients but as co designers, planners and evaluators of systems and structures for health care services.
- Organisational culture, regardless of the content of educational curricula, may reinforce, prevent or restrict the degree to which health care professionals are able to take risks and develop skills in alternative ways of working to reduce health inequalities. Thus forcing them to work in silos.
- Practitioners may feel overwhelmed by the political aspects of their work and consider them unmanageable. Training and education should include mechanisms to develop confidence and competence in dealing with service user diversity and complexity.
- The length of professional experience was not considered to necessarily be an advantage in capability to address the determinants of health at an individual level, as people come in to health care professions with varying degrees of politicalisation. This may on occasion cause tension between their personal and professional values.
- The political science of health should be included in cross-disciplinary curricula and continuing professional development to increase understanding of the political determinants of health, and the role of values in society generally and the NHS specifically.

This was seen as the start of a discussion that needs to continue.

Thank you to all involved for making this a lively interactive discussion.