Equity in Healthcare

"More than just an appointment"

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Foreword

Prof Trevor Duffy - Head of Healthcare Leadership, Royal College of Physicians of Ireland

Access to care is about so much more than getting an appointment. In March 2023, the Royal College of Physicians of Ireland (RCPI) held a Masterclass on Health Equity. This masterclass was part of an attempt to understand the bigger story behind people not attending appointments or engaging with the health system. It was important to us in designing the Masterclass that we brought together the right mix of people to explore the prevailing and complex issue of healthcare equity.

In practice, none of us has all the answers. But by working with our colleagues, community and government agencies, and key workers, we can have a profound impact in addressing the societal and systemic issues of access to care for individuals and for populations. A multifaceted approach to community healthcare in Ireland is vital in addressing healthcare equity and there is important work underway, some of which is captured in this report.

RCPI is committed to tackling this huge and growing challenge of healthcare equity. We have highlighted issues such as homelessness, the direct provision system, and the impact of COVID-19 school restrictions on vulnerable children. We have urged government to address health to prioritise funding and healthcare initiatives to address health inequalities. Earlier this year, RCPI has formally adopted health equity as one of its high-level advocacy priorities for 2023-2025.

I hope this paper will be useful for anyone working in healthcare to understand the stories behind the statistics of health inequalities. I think it can help us all to be more inclusive in our interactions with patients, and it empowers us with information and compelling data to advocate for high-quality inclusive healthcare and better health outcomes for all.

Some stark figures

- **12,411 people, including 3,669 children** were in emergency (homeless) accommodation in Ireland in May 2023.[1]

- **In July 2023, there were 21,696** people in International Protection Accommodation Services (IPAS)/direct provision centres, of which **4,629** are children.[2]

- In 2022, **12,009** people received treatment for problem drug use. This is the highest annual number recorded by the National Drug Treatment Reporting System (NDTRS) to date.[3]

- By June 2023, Ireland granted **84,613** Temporary Protection Permits to people from Ukraine.[4]

- Forced displacement due to climate change, conflict and economic instability is increasing worldwide. The UN Refugee Agency (UNHCR) estimates there were **108.4 million** forcibly displaced people worldwide at end of 2022.[5]

- Ireland's Traveller population of 30,000-35,000 experience poor health outcomes relative to average population, and lower life expectancy. **Traveller women live 11.5 years less than women in the general population; Traveller men live 15 years less**.[6]

- The Roma population in Ireland is approximately **5,000.** They have been historically excluded and stigmatized in Europe.

What does inclusive healthcare look like?

Rose's story

(Story from Prof Cliona Ni Cheallaigh - Clinical Lead for Inclusion Health Service at St James Hospital. Identifying details have been changed.)

"Rose was referred to me by one of my nursing colleagues in a day service for people who use drugs. The nurse was concerned about the fact that she had a very deep ulcer and he felt that the bone was visible and had been trying to get her to come to hospital for over a week. He could tell she was afraid to come in but was able to reassure her that he knew our team and that we were kind. Rose came to see me in clinic, and she was really frightened and very ashamed. I had a student nurse and a student doctor in the room, and she asked if they could leave. She kept repeating "I can't believe I've brought this on myself. I'm so ashamed". She was ashamed of the smell coming from her foot ulcer, and it obviously tapped into a huge wealth of insecurity, stigma, and shame that she had experienced throughout her lifetime. Rose is a Traveller. She was taken into state foster care at six weeks. Her mum had an alcohol dependence problem and died when she was only six, and she's had a very challenging life since then. She's had heart failure, she has type two diabetes, and now has what was evident to be osteomyelitis. This was a lady who clearly needed to be seen. She had a very severe, not uncommon medical problem, but because of her life experiences she felt that it was her fault, and she was ashamed and fearful that instead of being met with kindness and care that she was likely to meet with being shamed and people looking down on her. This fear was so strong that she felt it was safer to walk around in incredible pain and risk having her foot amputated rather than coming into hospital."
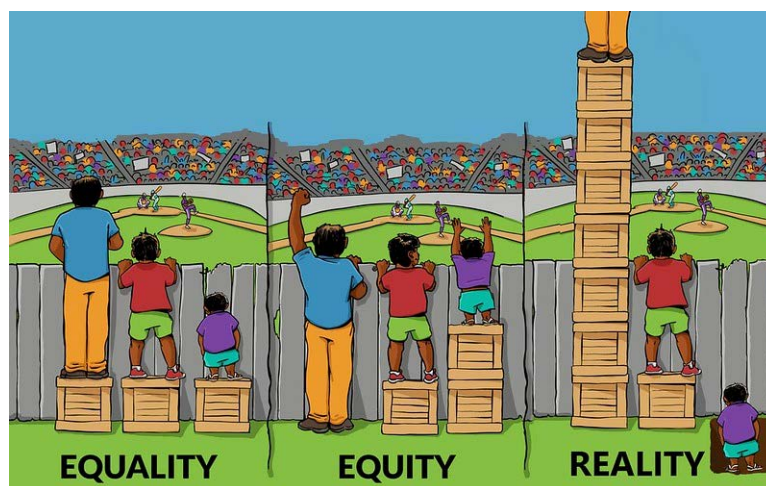
Equality, equity, reality

It may appear that Rose has equal access to healthcare (free care via a medical card), but from her story it's clear how shame and stigma can prevent people from accessing healthcare. We need to look at equity of *outcomes*, rather than equal access.

Poverty affects health and shortens life expectancy by approximately five years.[7] Social exclusion, experienced by people who are homeless, use drugs, have been in prison, are Travellers, Roma and/or have been forced to migrate, also shortens life expectancy and can cause multimorbidity and frailty in people in their forties and fifties.[8] Social exclusion occurs when someone experiences multiple disadvantages as well as poverty, including lack of access to education, housing, meaningful occupation, and participation in society. This can happen because of poor literacy, discrimination, and internal and external stigma. People who are socially excluded have much higher health needs as well as much poorer access to healthcare than the general population.

Clinicians need to be aware of how they may unwittingly disadvantage those who are already disadvantaged. For example, sending a written appointment letter as the only way for someone to access care, to someone who is homeless or illiterate, shuts people out of care. Awareness of the concept of *structural violence* (a form of violence wherein social structures or social institutions harm people by preventing them from meeting their basic needs) is also important- including calling this out when it is apparent. Rose's life has been more difficult because of societal structures. Clinicians see this all the time.

Being poor makes you sick

- Poverty doubles your likelihood of dying. In 2018 in Ireland, the standardised mortality rate[i] for those in the least advantaged socio-economic group was twice as high as in the most advantaged group.[7]
- The perinatal mortality rate for unemployed mothers in Ireland (2000-2019) was between 1.6 and 2.2 times the rate of mothers in the higher professional group.[7]
- The average age of death for a single homeless man in Dublin was 44 years and for a single homeless woman was 36 years. [9]
- Those in less advantaged socio-economic groups accounted for higher proportions of deaths from COVID-19 relative to their shares in the population aged 65 and older.[7]
- People living in deprived areas in Ireland were more likely to report that they had suffered from a wide range of conditions compared to those in wealthier areas.[10]

It's not all about health behaviours

Medical training can give the impression that if you correct health behaviours such as cigarette smoking, exercise, and healthy diet, then poverty doesn't have any other effect. But about two thirds of the way in which poverty harms health are not understood scientifically.[11] There is a cycle of adversity throughout the life cycle, beginning in utero, and compounded in early childhood and throughout the person's life. Someone can easily become trapped in this cycle.

Levels of trauma are unequally distributed throughout society

What happens in your childhood has a very profound effect on how you see yourself, how you see the world, and how you expect the world to treat you. In socially excluded populations, such as people who have experienced homelessness, there is a higher prevalence of childhood trauma. In one Irish study of a homeless population, approximately 75% of people experienced four or more adverse childhood experiences, (including abuse and neglect). [12] This compares with 3-5% in the general population.[13] Other studies show

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[i] Standardised mortality ratio (SMR) describes whether a specific population (e.g. patients in a certain hospital) are more, less or equally as likely to die than a standard/ reference population

that more than 70% of people receiving treatment for drug or alcohol abuse reported a history of trauma.[14]

Allostatic load and inflammation

Physical environment, nutrition, and health behaviours impact on health. The cumulative physical effect of long-term chronic stress (allostatic load) is less well appreciated. It's not a coincidence that Rose, who has experienced so much stress, stigma and neglect suffers with heart disease, heart failure and diabetes. It's thought that these kinds of experiences cause chronic inflammation at a low level in the body affecting immune responses.[11] Research on COVID-19 vaccine antibody responses indicates the lower your social status the less you respond to covid vaccination.[15]

Addiction

Many people tend to look at addiction as an individual choice rather than understanding what drives addiction. It's important to understand that people often use drugs and alcohol to manage incredibly difficult emotions and experiences.

> *"What I've really come to appreciate is that when a person presents with an addiction, how suddenly they can change in our eyes from a good and deserving patient to a "bad" person who if they just got their act together…wouldn't be wasting our time. I think that reflects a lack of emphasis in our education of understanding addiction and what drives it. And systemically, the rules and regulations in hospitals such as being banned for using drugs – while I understand why that happens – reflect significant barriers to health equity."*

> Prof Cliona Ni Cheallaigh - Clinical Lead for Inclusion Health Service at St James' Hospital.

"I'll believe in you until you believe in yourself"

Paul Merrigan has worked in the homeless and addiction sector for 10 -15 years. He is now Case Manager for the Inclusion Health Programme in St James Hospital – the first of its kind of the country to have a case manager working in this way. He is studying towards a Master's in Inclusion Health. This is part of his story.

"I was in state care from the age of 3. My mother had a heroin addiction and I had to be detoxed from heroin when I was born. So, I ended up in state care for most of my childhood. I just never had the feeling of love and being wanted, and I always felt abandoned and rejected. And so, I can understand what Rose went through…I've seen in hospital settings where people don't get the respect that they deserve where people just don't feel like they're worthy… Lot of patients still see hospital as an institution and there can be a generational lack of trust in institutions that have failed people.

I eventually turned my life around with a lot of help and support and it was with good professionals I had in my life whether that was in the community or doctors, nurses, health professionals. I remember being told 'Paul, I'll believe in you until you can believe in yourself'. That has always stayed with me, the compassion, noticing that you're just the same as everyone else - you just need an extra helping hand. Our patients, they're the same as me. They've maybe been dealt a raw deal in life, and they've been through a lot of abuse, neglect, trauma, addiction and retraumatization. And I suppose what I try to give them is what I was given. Support, reassurance that they're not alone saying- 'We're going to support you. And we're going to give you the care that you deserve and need the same way as anyone else in society'.

You know, when we're talking about giving care to a patient, the slightest little act of kindness or care you can give is huge and it will stay with them for a lifetime."

Social adversity in Paediatrics – Stories behind the statistics

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"Children are the world most valuable resources and its best hope for the future" John F Kennedy for UNICEF July 25, 1963

Many parents and caregivers coming into Irish Paediatric services have lived a lifetime of adversity with multiple adverse childhood experiences and trauma, which not only result in their own poor physical and mental health, but it robs them of the resilience and the skills to navigate a complex system of health supports. Clinicians need to try to understand what it means for a family or a caregiver who has been directly and significantly impacted by this adversity. Statistics are important, but clinicians also need to understand the people and the stories behind the statistics.

Stories shared by Dr Aoibhinn Walsh – Consultant Paediatrician with Special Interest in Inclusion health.

Treating the child *and* the mother

"A four-year-old child came to our A&E with a relatively minor injury. She had bloods done which showed she was anaemic. Our haematology consultant rang me because she noted that the child's address was a hotel. She felt it was probably a nutritional issue and that the child would be best fit in our social inclusion clinic. We saw her within a couple of weeks. They had been in the country about two months. Her mother, a single parent, was with her. We took an hour in the consult with an interpreter to really try and tease out a lot more about her history and her mother's background. Not only did she have a severe nutritionally-based iron deficiency anaemia, she also had severe vitamin D deficiency. She had multiple, severe dental caries and was referred to have 10 teeth extracted, which of course was contributing to her malnutrition. She also had faltering growth and chronic ringworm infection of her scalp and her groin.

That was the child's health, but we very gently asked some questions of the mother. We asked her about the birth history of the child, and it turns out the mother was a repeated victim of sexual and gender-based violence both pre-conception, during the pregnancy, and postnatally.

The sexual and gender-based violence was the reason this woman came with her child to Ireland. Neither she nor the child had ever been screened for blood borne viruses and the mother had not had any sexual health testing.

We tested the child for blood-borne viruses and called Cliona who saw her mother in clinic the next week to perform the mom's blood borne virus and STI screening testing. I also signposted her towards Ruhama and the rape crisis centre. This shows that Inclusion Health in Paediatrics is not just about treating the child. You can't treat the child without looking at the caregiver. In this instance I couldn't treat the mother, but I could signpost and refer her towards the treatments and supports she needed".

Social adversity with disabilities – advocacy and signposting

"A nearly eight-year-old girl came to our clinic. She was born outside of Ireland with a traumatic birth in a very rural part of the country with no medical infrastructure. She would have had obvious additional needs from birth. She was stigmatized within her own country. Her own father was physically violent towards her, so the mother brought her to Ireland leaving her two other children behind with relatives because she was so afraid for the child's safety. They were in IPAS emergency accommodation in a hotel.

When I saw her in clinic, it appeared the child had a moderate to severe intellectual disability and likely autism spectrum disorder. Unfortunately, her behavior had really deteriorated with all the upheaval. This was a child who loved to roam and be outside for sensory regulation - now confined to a hotel room with no space or outside area. She had stopped sleeping. She spent hours a day screaming which was causing distress to the other hotel residents. This in turn made the mother retreat even further into herself. The child had never had a medical assessment, no multidisciplinary team interventions and she'd never been to school.

We were able to look at the child's nutrition, do some preliminary investigations to try and establish the diagnosis but more importantly we signposted the mum to services. We advocated for her with local disability teams to prioritize psychological assessment for appropriate schooling. We obtained medications to try and improve sleep and while there's still a long way to go, they're in a much better place. We also advocated for them with IPAS for more appropriate accommodation to meet this child's really significant physical and developmental needs."

Understanding missed appointments

"We see cases of faltering growth all the time and I've yet to find a child with an underlying organic cause for their faltering growth. These are children coming in with often severe nutritional deficiencies. They may not have any kitchen on-site where they live, or they may only have intermittent access to a kitchen, or the kitchen facilities can be really inadequate. When you're trying to address growth, you're also thinking of that picky eater toddler phase. I love to encourage messy play, to encourage children to be allowed to be sensory around food. But food costs money and I'm telling parents to let their children throw food around to mess with it and not necessarily eat it. If it's not your house, if you're in a hotel and with carpeted floors and it's perceived that you are ruining the furnishings, that doesn't sit well with the accommodation providers.

One child comes to mind. She was an Irish born child and a member of the Roma community. Her mother was amazing- she had no primary level education, but she was really invested in her child's wellbeing and seeking to educate herself. The child had iron deficiency anaemia, Vitamin D deficiency, dental caries, and faltering growth. We treated her nutritional deficiencies. We linked to the community dietitian who was really supportive of the family.

She was doing well but didn't attend her final appointment before discharge. We reached out to the mom to find out why. She'd split from the father of her child because of domestic violence, and she'd been threatened that her physical safety was at risk if she came to the inner city again. This was impacting this child's care, so we arranged for follow up in another one of our sites.

If we hadn't reached out to the mother, she would never have come back to clinic. It shows that any health policies that are developed need to be about so much more than the provision and funding of medical care."

Mismatch between service delivery and need

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*"The availability of good medical care tends to vary inversely with the
need for it in the population served." Julian Tudor Harte, 1971 - The
Inverse Care Law*

Data from Scotland **(Figure 1)** illustrates how the above is true today.[16] In the most deprived
communities, there are more than **twice as many patients living with multiple mental and
physical health conditions** (120% more patients with combined mental-physical
multimorbidity) compared with the most affluent communities. GPs in the most deprived
communities are working 20% more than GPs in affluent communities (consultations/1000
registered). At the same time funding is similar across the most deprived and most affluent
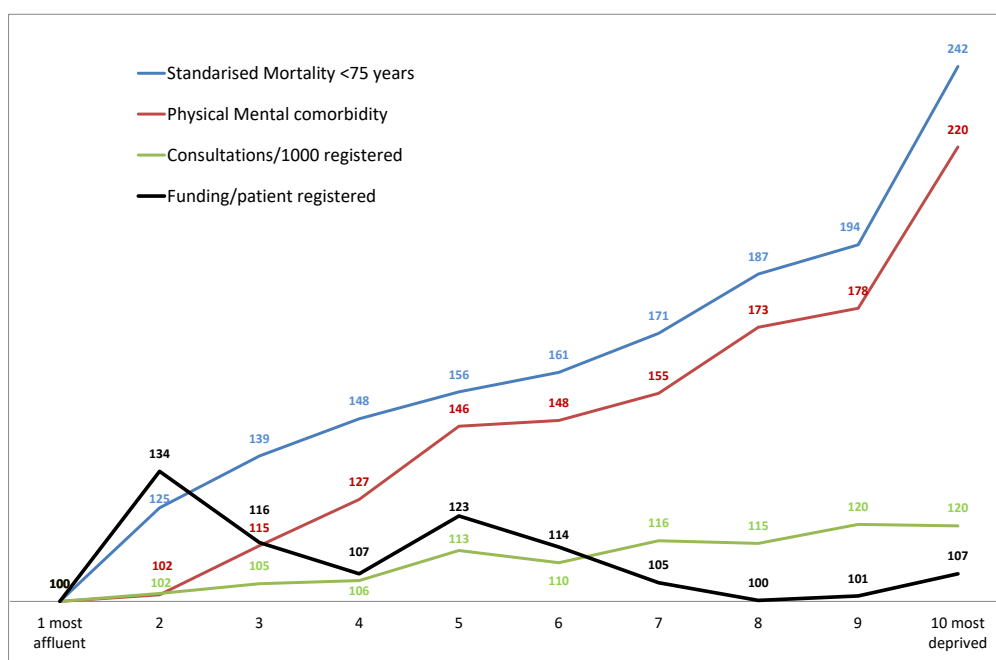communities (the black line).

*Figure 1: McLean G, Guthrie B, Mercer SW, Watt GC. General practice funding underpins the
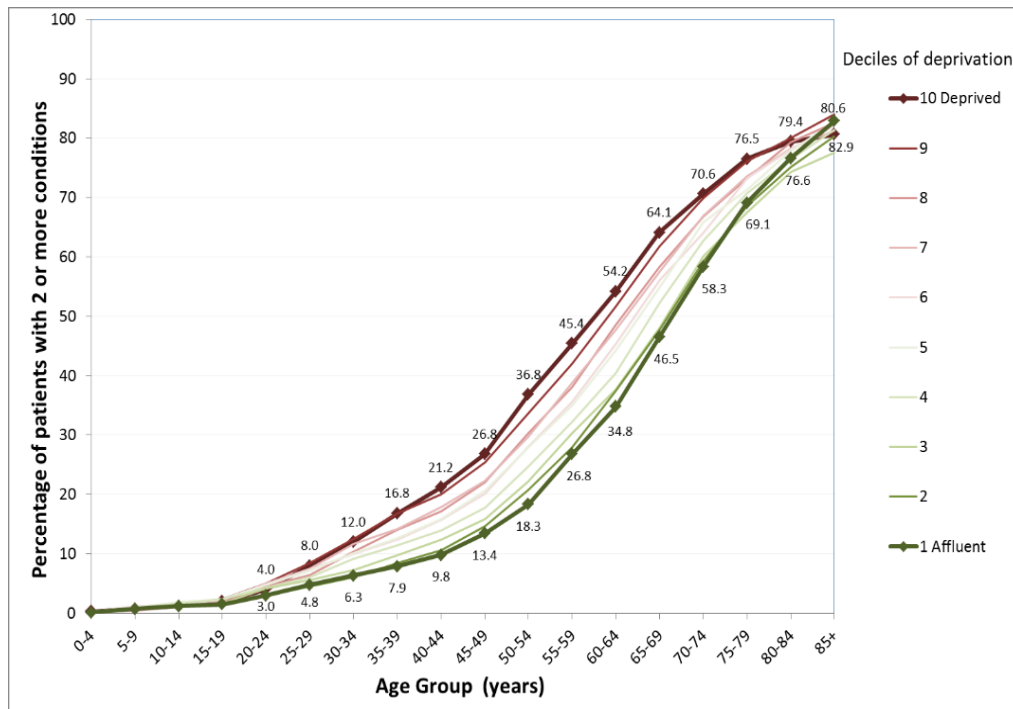persistence of the inverse care law: cross-sectional study in Scotland? BJGP 2015; 65(641): 799-805.*

Figure 2: Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Barnett, Karen et al. The Lancet 2012. Volume 380, Issue 9836, 37 - 43

Another study **(Figure 2)** shows that people in the most deprived communities develop multiple long-term conditions (multimorbidity) **10 -15 years earlier than those in the most affluent communities**.[17] This means a 55- to 60-year-old in a most disadvantaged area would have the same health needs as somebody getting closer to their 70s in a more affluent area.

Addressing the mismatch through planning and targeting

To address this mismatch through planning and targeting, we need:

- Funding based on the health needs of the population. Having data on these needs is crucial.
- Understanding of workforce and workforce planning.
- Population resource planning.
- Decision making and resource allocation made across all Government departments – recognising health is influenced by multiple issues, the wider social determinants of health.
- Being poor leads to poor health, we have known this for decades. Instead of being surprised by it, we can anticipate and plan services around it.
- Appreciate that it is much more cost-effective in our system to address those who have the highest health needs.

Ireland had a much lower COVID-19 infection and mortality rate among homeless populations compared to other major cities. Just 2% of homeless people got COVID-19 (compared to 10% in Boston).[18]

A health systems approach to health inequalities

The issue of health inequalities needs to be framed in such a way that makes the individual clinician feel they can do something about it. Avoiding stigmatizing and shaming language is also important in this framing.

> *"..staff are more likely to engage if inequalities are framed around healthcare and the specific services for which they are responsible, such as inequalities in chronic disease management or non-elective admissions alongside concrete actions, rather than high-level more abstract health outcome inequalities, such as differences in life expectancy."[19]*
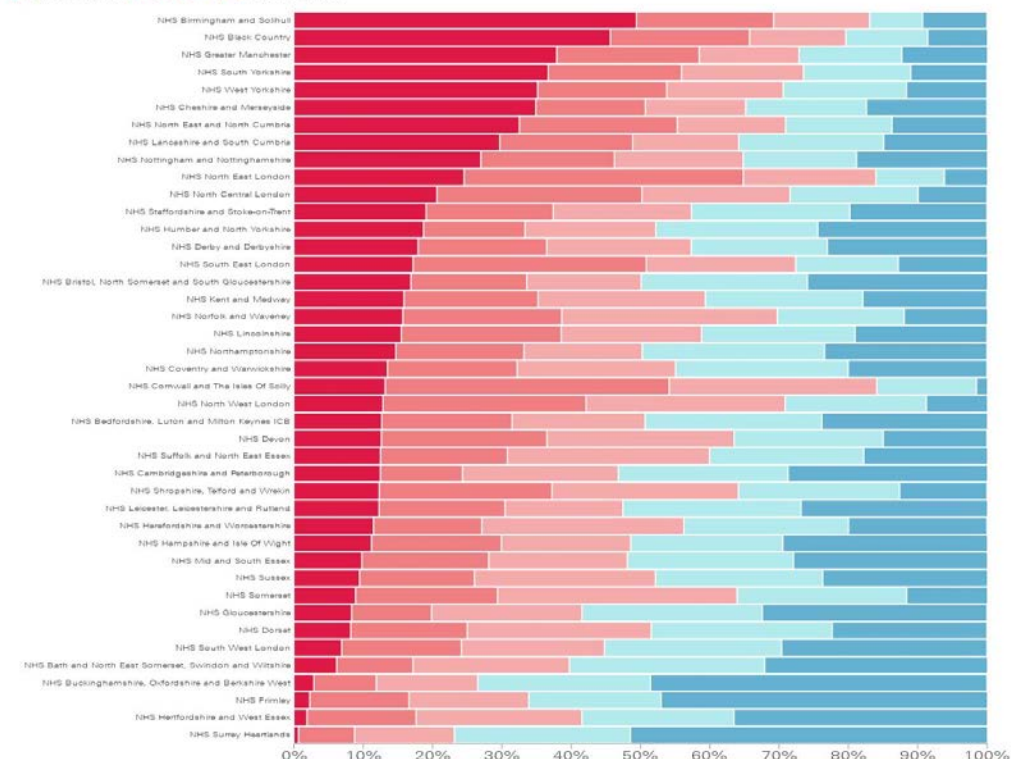

Figure 3: https://www.health.org.uk/publications/long-reads/integrated-care-systems-what-do-they-lok-like

What is needed is a *"fundamental redistribution of resources, funding, workforce, services, and power"* and long-term organisational change to consider health equity in all decisions. [19]

People in low-income groups *"are particularly dependent on the public health system – and are most affected by failure to invest in it".*[20] Investment alone, however, is not sufficient unless it is specifically designed to eliminate inequalities. **Figure 3** showing integrated care areas in England illustrates this.[21] In the Birmingham and Solihull integrated care areas - over 50% of people are in the most disadvantaged groups. Whereas in Surrey it's less than 2%. If the same resources are given to both areas, you can't expect to get the same outcomes. To deliver effective integrated care, we need to address such differences in service planning.

Information here provided by Dr Susan Smith - Professor of General Practice, TCD, GP, Inchicore & Coordinator of Deep End Ireland

The role of employment and job seeking as a determinant of health

This topic, raised during the Q&A in the RCPI Masterclass on Health Equity, generated much discussion. Below is a contribution to this topic from the Faculty of Occupational Medicine

There is strong evidence that work is generally good for physical and mental health and well-being.[22] [23] It delivers real benefits not just for individuals and businesses but also for communities, the economy and wider society. Unemployment, precarious work and worklessness are associated with poorer physical and mental health and well-being. [24] [25] Employers and workplaces are key enablers for providing access to work for those with a disability and other health conditions.[26]As a consequence, being in employment and having access to a job is a key determinant of health.

Employment facilitates access to economic resources that are essential for material well-being and full participation in society. It is central to individual identity, social roles, and social status. Within society, employment and socio-economic status are the main drivers of social gradients in physical and mental health and mortality.

Of course, work must be good work as it is recognised that various physical and psychosocial aspects of work can also be detrimental to health. These aspects of employment along with appropriate health and safety measures need to be given the priority they deserve to prevent negative outcomes.

When physicians are treating patients, it's important to determine work status, be aware of the occupational history and consider the type of work being currently undertaken. This will assist in factoring in a return to work to the clinical care pathway for the patient at the outset. In addition, the physician should be advocating at the patient level that work is generally good for health and more broadly support the creation of job and employment opportunities particularly in socially deprived communities and for those with disability and chronic illness.

The specialty of occupational medicine is uniquely placed to provide support to doctors and their patients. It plays an important role in supporting employers to maintain and promote employee health and wellbeing through assessments of fitness for work, advice about reasonable adjustments, work ability or return to work plans, and signposting to treatment for specific conditions.[27]

What can clinicians do?

How can I be more inclusive in my practice?

- Someone who has experienced a lot of trauma- will "light up" (fight or flight response) much faster than another person. Our systems react by immediately excluding them and punishing them. We must protect staff and each other, but could we learn to not respond straight away, how to de-escalate? Instead of seeing it as a behaviour to be punished ("they can't behave like that"), could we see it as an organic response? Then just take a bit more time, a different approach (apply principles of trauma informed care- see below).

- Understand unconscious bias. We may have unconscious thinking about '*Who deserves what*".

- Onus is on us to be inclusive. If patient doesn't come to clinic, we should think about what we can do to make sure they access care. Include community healthcare professionals hostel works, key workers etc. Look at why they didn't come- are there other care responsibilities etc.?

- Need to stress that service is free, especially preventive services like immunisations and screening.

- We need to make it clear that if someone stops engaging with care or doesn't show up for an appointment, they are still allowed to come back and the fact they left doesn't mean they're not worthy or not entitled to care.

- Try to ensure that you or your team are seen as safe people - be clear it's not a punitive process if they discharge themselves/stop engaging with care.

- It's important that a consultant shows leadership for the rest of the team. We need to understand the *"why"* and continue to serve this patient with that understanding.

- Think with our hearts and emotions, tune in to patients' emotions. Awareness and patient empathy are crucial components of care.

- Extra time and care. It's not a given that people who are socially excluded and may have had bad past experiences with authority figures, will trust in the care relationship. It may need more time to build trust.

- Framing the problem- we can all do something small. Think about the specific services for which you are responsible.

"What happened to you"? Some key principles for delivering trauma informed care

- **Time**. It's not only about the medical diagnosis or treatment. It's about asking difficult questions, establishing a relationship of trust with parents/caregivers. This needs time!

- **Historical context.** Try to understand familial and intergenerational cycles of adversity, and the historical context for specific population groups. For example, Roma people who have been systematically discriminated against for generations.

- **Education**. This means not just schooling, but language, literacy, numeracy, and health literacy. There is an onus on us to understand what the limitations might be and tailor our questions to this. For example, literacy levels impact whether someone may be able to administer the correct medication dose and the understanding of basic health concepts that we may assume parents and caregivers are familiar with.

- **Signposting**. We need to investigate what supports are available for the problems we uncover and be able to point to freely available local and national or global resources.

- **Empowerment**. Treatment plans need to be feasible, sustainable, and practical for the families. We should have collaborative decision making in treatment plans. These need to be practical for the caregiver- e.g., making appointments at times that work for people.

- **Recognition** of cycles of adversity **and** our ability to influence change.

- **Ensure access to highest standard of care.** Poverty should never be the reason that people can't access the highest standard of care.

How can I be an advocate for health equity?

- Physicians have a privileged position in society and often local politician and decision makers will meet with doctors to hear their concerns. **Recognise the privileged position** you're in and use that position to advocate for patients, services, and policy and to dress inequities.
- **Make use of data**
  - To illustrate the inverse care law- that doctors, physios, nurses etc. in disadvantaged area have double the workload.
  - To show unacceptable **differences** in health outcomes. For example, Irish data on cancer deaths between 2009 and 2011 showed more than double the rate of cancer deaths in poor communities**.** There were 381 cancer deaths per 100,000 in Blakestown North-West compared with 128 per 100,000 in Castleknock South-East.[28]
- Important to **use stories** as well as data!
- Speak to the **effect it has on the health system**, emergency admissions etc.
- Look at **existing models**. GPs at the deep end, a group of general practitioners working in the most disadvantaged communities in Ireland**,** provides a good model. Similar groups exist all over the world, modelled on a project of the same name which began in Scotland.

How can policy makers and healthcare leaders respond?

- Funding and allocation that's based on need
- Universal access at the point of care particularly for primary care
- Infrastructure support
- Target services where they will really have the most benefit
- Data to support policy and planning
- Anticipate and plan for problems
- Consider a **National Health Inequalities Strategy**

Reading list and additional resources

Books

- Social Determinants of Health: The Solid Facts
- Poverty Safari – Darren McGarvey
- The Spirit Level and the Inner Level, Pickett and Wilkinson
- Chasing the Scream, Johann Hari
- In the Realm of Hungry Ghosts, Gabor Mate
- Mountains Beyond Mountains, Tracey Kidd
- Reading list from the King's Fund

HSELand – Examples of Training

- Intercultural Awareness eLearning Programme
- Introduction to Traveller Health: eLearning programme
- Ethnic Equality Monitoring: explains what ethnic equality monitoring is and why it's important in healthcare

RCPI training/events upcoming

https://courses.rcpi.ie/product?catalog=Gateway-to-Communication
https://courses.rcpi.ie/product?catalog=Be-Sound-Dont-Belittle

The HSE National Social Inclusion Office

The HSE National Social Inclusion Office supports equal access to Health Services for people from vulnerable groups. Its remit includes:

- To improve health outcomes across socially excluded / vulnerable groups
- Principles of response "Learning by doing"
- Ensuring sustainability
- Coordination, communication, and intergovernmental links
- Working with key NGOs, Government Agencies and other bodies - Safetynet, Peter Mc Verry Trust, Depaul, Anna Liffey, Simon Community, Crosscare, Merchants Quay
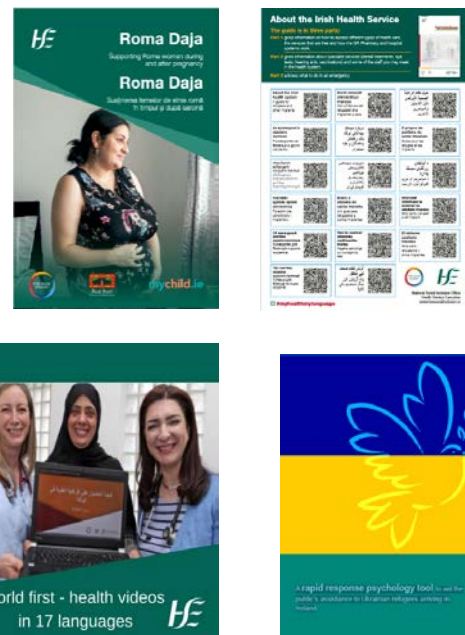

Figure 4: National Social Inclusion Office- Resources and Initiatives

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5 United Nations High Commissioner for Refugees – Figures at a glance. https://www.unhcr.org/us/about-unhcr/who-we-are/figures-glance

6 All-Ireland Traveller Health Study https://www.gov.ie/en/publication/b9c48a-all-ireland-traveller-health-study/

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