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## Contribution of health to social inclusion

topics:

- health and social inclusion/exclusion
- caring for individuals vs. caring for groups
- pathologising of social deviancy
- the system of “National Health Service” in Great Britain

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### The importance of health for public wellbeing

The relationship between the health of the people and the wellbeing of society has now been acknowledged for some time. As the development of science and technology gave mankind some significant opportunities to influence its own health, beginning in the 19<sup>th</sup> century health became even more overtly a social and political issue. The 19<sup>th</sup> century British Conservative Prime Minister, Benjamin Disraeli, remarked “the health of the people is really the foundation upon which all their happiness and their powers as a state depend”. The significance of the poor physical health of recruits to the British Army at the very beginning of the 20<sup>th</sup> century in stimulating national insurance for sickness has been frequently noted, and ill health was one of the five giants Sir William Beverages’ welfare state was intended to slay.

Today, around the world the importance of health as a means of tackling social exclusion is widely recognised, either explicitly or implicitly. From World Health Organisation projects to eradicate infectious diseases, to the acknowledgement, even in the United States of America of the need to provide State subsidised health care to the elderly and the poor, to the explicit targets for the reduction of inequalities in health in the National Health Service in Britain the point is accepted. We know that chronic disease and disability go hand in hand with poverty, unemployment poor social and living conditions, and compound them to produce further social exclusion and isolation to individuals. My own organisation, an National Health Service (NHS) Trust specialising in mental health, operates a number of services whose aim is to enable those who have experienced mental illness to return to employment and wider social networks. It is well know that they have great therapeutic benefit and that their absence increases the risk of relapse.

## Health and social inclusion

The contribution of health to social inclusion would then appear to be clear – the promotion of one supports the other, and they combine together to produce a virtuous circle. This indeed was one of the proverbial assumptions underlying the foundation of the National Health Service – availability of good health care to all, free at the point of use would, over time, reduce demand as the health of the population improved. We now know the reverse to be true. Indeed the relationship between health and social inclusion is historically rather more ambiguous. A major contributor to the availability of healthcare for the poor in the 19<sup>th</sup> Century was the development of Infirmaries linked to poor law workhouses. These sprang up as adjuncts to a system whose purpose was a form of social exclusion in the most literal sense – the identification, separation and repression of the pauper. Illness and infirmity however proved subversive of the principles by which the poor law was founded; within seven years of its enactment Parliament decreed that the smallpox vaccination, though administered by poor law medical officers did not pauperise the recipient. By 1867 the Metropolitan Poor Act which in London led to an explosion in the provision of general, specialist, isolation and mental hospitals broke this principle for good. Nevertheless the stigma associated with care derived originally from the poor law remained lodged in the popular memory and many of those institutions were unable to shake it off even after decades of the National Health Service. My own grandmother was adamant that she would not be treated in a former poor law infirmary even in the 1990s.

Today the ambivalence is expressed rather differently. There is certainly an important strand in current thinking on the future development of health care which emphasises the importance of addressing inequalities and tackling social exclusion. The poor are more likely to be ill, and the ill, especially those with chronic diseases, are more likely to have difficulty in obtaining the benefits of social integration, particularly work, which is in turn a major contributor to recovery and rehabilitation. Another increasingly important strand however is responding to the needs of individuals when providing health care, as opposed to blanket treatment of social groups or cohorts. This is accentuated by the emphasis on providing care for the individuals in a way which suits the increasingly diverse circumstances of their lives. Its most obvious manifestation spells the end of that traditionally British collective activity, the queue, by the declared intention to abolish waiting lists.

### The "two tier" system: collective and individual care

Both of these strands have been present to some degree for many years in British health care, although the importance of responding to the individual has become more pronounced lately. The previous Government's reforms of the NHS saw the introduction of general practitioner fundholding as a means of allowing the individual General Practitioners (GP) to meet the needs of their individual patients more flexibly by giving them the ability to pay for treatments either within the practice or in hospitals of their choice including those in the private sector. This arrangement was seen by some as being socially inequitable, allowing the patients of GP fundholders to get a better service than those of non-fundholders – the so called "two tier" system. The emphasis of policy under the present Government is on creating a universal system which is nevertheless capable of meeting the needs of individuals. It is indeed the case that at times over the past 20 years the two strands have worked well together. For example the sustained policy emphasis on

the replacement of large long stay institutions for the mentally ill and for people with learning disabilities by community based services has both responded much more explicitly to the needs of individual patients and fostered a much greater sense of social inclusion with access to real employment opportunities, social integration and the whole range of opportunities associated with ordinary life. The only sinister dimension to this change has been the growing public hostility, fuelled by some sections of the media, to the acceptance of mental illness within society. It is nevertheless true, I believe, that stigma was greater, albeit less apparent when the mentally ill were consigned to remote institutions.

The most recent statement of policy, The NHS Plan published in July 2000 is emphatic about both strands. Amongst the ten NHS core principles its states are:

“The NHS will shape its services around the needs and preferences of individual patients, their families and their carers – the NHS of the 21<sup>st</sup> century must be responsive to the needs of different groups and individuals within society, and challenge discrimination on the grounds of age, gender, ethnicity, religion, disability and sexuality. The NHS will treat patients as individuals with respect for their dignity. Patients and citizens will have a greater say in the NHS and the provision of service will be centred on patients needs.”

Also: “The NHS will help keep people healthy and work to reduce health inequalities – the NHS will focus efforts on preventing, as well as treating ill health. Recognising that good health also depends upon social, environmental and economic factors such as deprivation, housing, education and nutrition, the NHS will work with other public services to intervene not just after but before ill health occurs. It will work with others to reduce health inequalities”.

Are these two strands however at some more fundamental level irreconcilable? Can health care geared to the needs of the portfolio worker, laptop in hand, not rooted in any one community, citizen of the world living an irregular and unregulated 24 hour lifestyle still address the needs of an excluded underclass, locked into the poorer parts of town, denied access to, all or failed by the education system, unskilled in the modern job market? The absolute health of the poorest and the richest has improved over the past few decades, but the gap between them has not reduced it has grown, and it continues to get wider. Can health services realistically expect to meet the needs of these two groups together?

### **How to find the balance?**

This is in many respects a particular version of the perpetual dilemma that characterises the bargains between individuals and society at large. The tension manifests itself in all sorts of ways in the daily experience of an NHS mental health Trust. For example we are in the process of developing new units for mentally disordered offenders which will improve their treatment, offer a much more effective and civilised alternative to prison, reduce re-offending and increase public safety overall. Despite the well-evidenced benefits of such plans there nevertheless provoke strong opposition from some of the local communities where they will be built. At a more obviously more clinical level there exists a constant dilemma for doctors and nurses admitting people who are very ill and disturbed to a ward which they will share to some degree with others in the same state. There are obvious advantages and disadvantages in that circumstance both for the individuals involved and those responsible for their care. The dilemma inherent in this,

incidentally, is not overcome by the provision of individual single bedrooms, but increasingly our practice is geared wherever possible, to looking after people in their own homes – assuming of course that they have them.

It is not of course a dilemma that is unique to the field of mental health – a wider debate has developed across the whole field of disability. The social model of disability places the onus on society to allow individuals a real life by adapting its patterns – access to buildings, constraints around employment etc. to their needs as opposed to well intentioned, but nevertheless isolating exclusion by providing artificial alternatives to real life.

In all of these cases practice resorts to striking a balance rather than a straight choice between the triumph of one principle at the expense of the other. The nature of the balance is constantly refined – we have moved on from the closure of long stay institutions to attempts to tackle the first onset of mental illness in a sympathetic, individualistic way which will avoid the exclusion of the individual both from their schooling or employment, or even family, precisely because we are able to adapt more flexibly to their particular needs and not process them through some gigantic and alienating mental health system. It would be foolish to pretend this is yet the norm, but it is the ideal, and it represents our latest approach to the reconciliation of the two. I believe that the development of a vocal and active user movement in mental health services has been instrumental in this development, and has compelled the system, sometimes regrettably against its own better judgement to listen and to go to meet people on their own ground. It is a road down which we still have much further to go, but it is a way in which mental health services may have stolen the march on health care as a whole.

## Conclusion

My overall conclusion therefore is that it remains possible for health services to address, indeed to be major agents in tackling social exclusion, whilst embracing the consumerist temper of the times and responding to the needs of individuals. However we should never forget that this involves striking a balance, not in some magical reconciliation of two principles which remain potentially at odds with one another. There are two dangers in particular of which we should be wary. The first is the pathologising of exclusion to the point where all social deviancy or wrongdoing is seen as the consequence of illness – “you must be sick”. The loss of the ability to distinguish between wrongdoing and disadvantage can only be to the detriment of the disadvantaged. I am loath to see a reversal of the civilising effect of health care on the Victorian Poor Law. Linked to this is the second danger, in my view the most serious of all. It is the risk that all of those offering health services let society at large off the hook of its responsibility for tackling social exclusion by over exaggerating the ability of health care to take the responsibility for itself. A similar risk exists for many public servants – teachers, policeman, social workers; that they paradoxically find themselves the victims in the curious *ménage à trois* between social inclusion, consumerism and public service.

It is therefore vital that health care remains modest about its contribution to social inclusion and that political society as a whole shoulders its responsibilities for this vital dimension of the relationship between individuals and society.