European Commission

Thematic session 3: Addressing the health needs of vulnerable and isolated groups- Concept Paper

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Contents

1 Introduction

The VulnerABLE project is a two-year pilot initiative of the European Commission (DG SANTE), run by ICF, in partnership with EuroHealthNet, the UCL Institute of Health Equity, the European Public Health Alliance, Social Platform and GfK. The project aims to increase understanding of how best to improve the health of people living in vulnerable and isolated situations, identify and recommend evidence-based policy strategies, and raise awareness of the findings and support capacity-building within Member States.

The project involved a range of research activities, including a cross-national survey with 1,938 respondents belonging to potentially vulnerable groups[1] across 12 Member States; a literature, policy and data review of existing evidence on health needs and challenges of these groups; an inventory of good practices in addressing health challenges; expert focus groups and interviews with key stakeholders.

This paper has been prepared for the Dissemination Conference of the VulnerABLE project in November 2017. It brings together the key project findings on the topic of 'Addressing the health needs of persons belonging to potentially vulnerable groups', as well as posing questions for the event.

2 Defining vulnerability and the project target groups

Health inequalities can be understood as 'differences in health status between individuals or groups, as measured by, for example, life expectancy, mortality or disease' that arise from 'avoidable difference in social, economic and environmental variables' (European Commission, 2009). Those people who experience the worst health status may also experience vulnerability. Vulnerability is a social phenomenon affected by multiple processes of exclusion that can lead to or result from health problems.

The concept of vulnerability is not static. Individuals can be more or less at risk of being in a vulnerable situation, depending on the interaction of personal (inborn or acquired) and societal and environmental factors. Those factors provide or deprive individuals from certain types of resources. Social determinants of vulnerability are also influenced by the political, historical, cultural and environmental context (Rogers, 1997).

The VulnerABLE Project focused on nine target groups who are known to experience poor health and/or face particular barriers in accessing healthcare. This included the following:

- Families who are in a vulnerable situation (e.g. lone parents with young children)
- Having physical, mental or learning disabilities, or poor mental health
- The in-work poor
- Older people who are in a vulnerable situation
- People in unstable housing situations (e.g. the homeless)
- Prisoners (or ex-prisoners in a vulnerable situation)
- Persons living in rural/isolated areas in a vulnerable situation
- The long-term unemployed/inactive (not in education, training or employment)
- Survivors of domestic and intimate partner violence.

[1] The groups included in the project were: families who are in a vulnerable situation (e.g. lone parents with young children); having physical, mental of learning disabilities or poor mental health; the in-work poor; older people who are in a vulnerable situation; people with unstable housing situations (e.g. homelessness); prisoners (or ex-prisoners in vulnerable situation); persons living in rural/isolated areas in a vulnerable situation; long-term unemployed/inactive (not in education, training or employment); survivors of domestic violence.

In practice, these groups can overlap, and not all members of all groups may experience vulnerability (e.g. we are interested in older people, but not all older people experience vulnerability). There may also be other groups of people that experience vulnerability (e.g. Roma people, asylum seekers); however, this project did not focus on these groups.

2.1 The health needs and challenges of vulnerable groups

People who belong to potentially vulnerable groups tend to experience significant health challenges and often present a range of complex health needs. Below we discuss key issues in defining each vulnerable group and the rational for inclusion in the project, alongside an overview of the health needs of each group.

Families who are in a vulnerable situation (e.g. lone parents with young children) are difficult to define as they are an internally diverse group. For example, not all young children are vulnerable, but some may experience vulnerability as a result of specific characteristics (e.g. being born with a disability) or particular circumstances (such as poverty). Parents may also experience vulnerability impacting on their own health as well as their child's. The inclusion of this group in the project recognises the importance 'the family' plays in shaping the environment in which children grow and develop, which can have a significant impact on child health, teenager years and in subsequent adult life.

This group is likely to experience significant deprivation, disadvantage and poverty leading to poor health and contributing to barriers in accessing healthcare (e.g. treatment costs). Evidence suggests significant and positive correlations between poverty and childhood mortality rates (Sengoegle et al., 2013), as well as respiratory, circulatory and oncological diseases, mental health problems and risky health behaviours in later life (UCL IHE, 2015). Lone-parent mothers are also more likely to report higher rates of poor health compared to mothers in two parent families (Rousou et al. 2013).

People who **have a physical, mental or learning disability, or poor mental health** form a group that encompasses both disability as an umbrella term which includes impairments, activity limitation and participation restrictions (WHO, 2016a); and, mental health as 'a state of mental wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community' (WHO, 2016b). This group has been included in the project because they are more likely to experience major physical health problems such as obesity, circulatory and respiratory diseases, compared to the general population (Disability Rights Commission, 2007). They also tend to have a shorter life expectancy and increase risk of premature death than the general population (Hollins et al., 1998), as well as being at increased risk of poverty, unemployment, poor housing and barriers in accessing services, compared to those without physical and learning disabilities or mental health issues (Nocon, 2006).

The in-work poor are a people who are in employment but whose income is below a given poverty line. The in-work poor are likely to be groups of people in part-time employment and those in temporary employment (i.e. zero-hour contracts). This group has been included in the project because of its association with poverty and the implications this may have on health. For example, whilst employment greatly reduces the risk of poverty, it does not eliminate it. Low paid work and high living costs can mean that employed individuals still live in poverty and health problems increase as disadvantage worsens (European Commission, 2013). The evidence suggests that low paid jobs are often associated with stress (due to high psychological demands), respiratory and circulatory diseases, as well as higher rates of risky health behaviours (Karlasson et al., 2010; Marmott et al., 1991).

Older people who are in vulnerable situations may be affected by particular factors that make them more susceptible to the risk of vulnerability in later life (e.g. socioeconomic, education, environmental and health factors), compared to the overall elderly population, as well as the general population. This group has been included in the project because health tends to deteriorate with age or have multiple long-term health conditions (that are not addressed in middle age), and as a result, older people are likely to become more dependent on, and greater consumers of, healthcare services compared to the rest of the population (Zaidi, 2014).

In addition to frailty and biological ageing, other factors affecting the health of older people also include the living built environment (including transport, availability of local facilities and service such as supermarkets, safe public places, housing) and sometimes one challenge (such as loss of visions) can impact on mobility that, in turn, influences vulnerability and isolation. Socioeconomic factors, as well as education and wealth, can have a direct and indirect impact on the health of older people. For example, access to greater material resources in the early stages of old age can facilitate individuals participating in cultural and leisure activities, contributing to autonomy and feelings of control. For those older people who lack access to these things, they are at greater risk of vulnerability which is likely to exacerbate health problems experienced in old age and lead to worse morbidity and earlier more mortality to less vulnerable older people (Pinquart and Sorensen, 2000).

People in unstable housing situations (e.g. the homeless) covers a broad spectrum of living conditions, including roofless (i.e. sleeping rough); houseless (i.e. living in housing specifically for the homeless); insecure (i.e. living in insecure accommodation); and, inadequate living conditions (i.e. accommodation that is unfit for purpose).

The health needs of people living in unstable housing situations is characterised by multiple physical and mental health needs. This includes communicable diseases (e.g. tuberculosis), respiratory and circulatory diseases, injury as a result of violence, poor oral health, feet problems, skin diseases and infections, drug and alcohol addiction, and severe mental health problems (Griffiths, 2002). This group also experience significant barriers in accessing mainstream services (e.g. lack of permanent address).

Prisoners (or ex-prisoners in vulnerable situations) are a relatively easily defined group, yet there is a distinct lack of data on the state of the EU's prison population. This group have been included in the project because prisoners are at greater risk to a wide range of health issues compared to the general population, including infectious diseases, physical trauma, substance abusive behaviours, chronic diseases and poor mental health (Barry, 2010). A newly emerging group within prisons are foreign nationals, which is resulting in problems around language barriers and cultural differences.

Persons living in rural/isolated areas in vulnerable situations are difficult to define as a group due to the differences rural environments can have on different rural populations. For example, people living in cities in Bulgaria were most likely to have higher quality of life compared to those people living in rural areas. In contrast, people living in rural areas in Denmark were more likely to have a higher quality of life compared to those living in cities (Eurostat, 2015b).

Challenges around the organisation and provision of primary care or general practitioner availability and the provision of emergency or out of hours services in rural areas is also problematic, sometimes resulting in overstretched GP coverage for patients in the emergency itself and/or creating gaps for patients in their surgeries.

Evidence suggests that vulnerable people living in rural areas may experience particular barriers in accessing quality healthcare services, which can be affected by a wide range of factors including poor travel infrastructure, difficulties in recruiting and retaining

healthcare professionals in rural areas, and a lack of specialist health services (e.g. mental health, maternal care, pharmacies) (WHO, 2010).

The long-term unemployed/inactive (not in education, training or employment) group is made up of people of working age who have been out of work and actively seeking employment for at least a year. The concept of an economically inactive population encompasses people with varying degrees of attachment to the labour market. For the purpose of this project, the focus is on inactive people of working age.

Employment is one of the most important sources of income for households in the EU. This group has been included in the project because households with low levels of employment are more likely to experience poverty and social exclusion (Eurostat, 2015a). Poor households are also more likely to suffer from material deprivation linked to low income, as general ill-health and health problems increase as disadvantage worsens (European Commission, 2013).

The evidence points to a wide range of health needs among this group, including premature aging linked to increased stress and risk of mortality (Ala-Mursula et al., 2013); poor mental health (including depression and anxiety) (Dubois and Anderson, 2013); increased risk of negative health behaviours (Bosque-Prous et al., 2015); and poor self-reported health (Friedl et al., 2007).

Survivors of domestic and intimate partner violence are often difficult to identify as reliable and comparable data on the prevalence of domestic violence in the EU and its Member States is lacking. In part, this is due to difficulties in collecting data due to the issue being unreported by survivors and unidentified by mainstream services (FRA, 2014). This group has been included in the project because domestic and intimate partner violence is a widespread phenomenon in all Member States. Primarily affecting women and children, it is a significant public health issue estimated to affect one in three women the world over (WHO, 2013).

Evidence indicates that this group present a range of complex health needs including sexual and reproductive health problems, musculoskeletal injuries and poor mental health (FRA 2014).

2.1.1 Approaches to universal and specialised interventions

Universal approaches to healthcare aim to support the whole population through making healthcare accessible to all. This includes equity in access to healthcare services and equity in the quality of healthcare services. It should also ensure that the cost of using such services does not place consumers at risk of financial harm.[2] However, despite Member States' approaches to the provision of universal healthcare, there are structural barriers which negatively affect access to healthcare for some groups of people, which can lead to or perpetuate vulnerability (European Commission, 2014).

An effective way of addressing the health needs and challenges of vulnerable people is through targeted interventions, particularly ones targeting groups who experience barriers to accessing services. These interventions typically seek to identify and address the needs of specific groups of people (e.g. older people) or address specific issues (e.g. poor public transport infrastructure preventing physical access to healthcare services) through interventions such as mobile health services.

Specialised healthcare services have also been effective in supporting access to healthcare in Member States where universal healthcare is not available or less effective in addressing the issue.

[2] http://www.who.int/health_financing/universal_coverage_definition/en/

3 Specialised initiatives to address the health needs of persons belonging to potentially vulnerable groups

During the course of the project the study team identified a number of specialised initiatives to address the health needs of persons belonging to potentially vulnerable groups. These included:

- Mobile services
- Monitoring initiatives
- User co-production
- Capacity building
- Community care

This section provides an overview of frequently used approaches to address health needs of the target groups within EU Member States.

3.1 Mobile services

Mobile services can offer enhanced access to healthcare services which may be beneficial in overcoming a range of barriers to healthcare, such as long travel distances or treating hard-to-reach-groups (i.e. rough sleepers). For example, one form of improving access to healthcare is to bypass standard referral routes that require the patient to present at primary healthcare services and bring healthcare services directly to the affected individual.

Find & Treat is an active Tuberculosis (TB) Screening service based in London, UK. It is a mobile health unit that travels to different areas of London to screen homeless people for TB. The service has been running since 2007 and is commissioned through the National Health Service. It now screens around 10,000 high risk individuals a year. Service data taken between January 2008 and June 2013 showed that Find & Treat conducted 45,385 X-rays leading to 385 referrals, resulting in a total of 84 diagnoses of pulmonary Tuberculosis. Of these cases, 84% went on to fully complete treatment within 12 months (UCL, 2014).

Whilst this approach may be useful in addressing the health needs of some vulnerable groups, delivery of mobile services, which breaks away from traditional and more stationary approaches to healthcare delivery are heavily dependent on the time and initiative of health commissioners and healthcare professionals to implement and deliver alternative methods of provision.

3.2 Monitoring initiatives

Monitoring initiatives are useful in measuring the quality and impact of health services and interventions, as well as assessing whether Member States or organisations are compliant with standards, regulations and the guidance implemented to improve and/or promote health. The collection of information in a systematic way plays a key role in the ability of health systems to ensure health improvements in an effective and efficient way (Smith et al., 2008).

For example, the POAT Salute[3] programme in Italy, aims to address deficits in knowledge and skills within four regional health systems through assessing the main health needs of local populations, linking demographical and epidemiological data to map weaknesses within the health system and respond accordingly (Equity Action, 2013). The approach can be used to serve all vulnerable target groups as it assess the needs of all people within the population. Monitoring initiatives have also been successfully implemented in the UK prison system as a way of improving the health of

[3] Plan for Re-organisation and Capacity Building

inmates. Regularly produced Health Needs Assessments take account of a range of information, including the demographics of the inmate population, provision of health services (including planned and unplanned secondary care usage), the prevalence and management of physical and mental health needs, and recommendations for improving healthcare (HMP Birmingham, 2015). Whilst monitoring initiatives offer a range of benefits, implementing monitoring initiatives can be challenging. The process of collecting and analysing population data and service outputs of health systems can be resource intensive in terms of both time and cost (Smith et al., 2008).

3.3 User co-production

User co-production is usually understood as engaging service users in the design and production of services they use, particularly in health and social care sectors. It has been found to improve the quality and efficiency of services as well as improve outcomes for users, challenging the traditional relationship between professionals and service users (The Health Foundation, 2010).

The approach has been used by the Irish Red Cross to raise prisoner's awareness of personal health and hygiene, first aid and wellbeing. Through its Community-based Health and First Aid in Action programme, the Irish Red Cross recruited around 800 inmates who volunteered to be trained as peer educators and organise hand-on health promotion activities among fellow inmates. Research suggests that between 2009 and 2012, the programme provided health and wellbeing information to approximately 2,000 inmates, with inmates reporting feeling more confident and empowered to improve their health (Irish Red Cross, 2016). Other projects, such as the Guardian Angel programme (Schutzengel) in Germany aims to prevent the development of physical and/or psychological problems in young children from vulnerable families, through improving parent health related behaviours, living conditions and social networks. Key to the project activities is the development and co-production of parent Cafes and meeting points, providing a space for parents to meet and harness peer support, alongside the provision of specialist healthcare advice (EuroHealthNet, 2004).

One of the main weaknesses of this approach is the lack of an agreed definition. It is therefore important to be careful in how the term is used and not to confuse co-production with initiatives that simply offer or encourage activities such as volunteering or service user consultation. Co-production is more than this and should offer the opportunity to transform public services, promote equal participation, and include users in the commissioning of public services (Nesta, 2009).

3.4 Capacity-building

Capacity-building is most commonly defined as the development of strengths within individual and organisational resources, in order to perform appropriate tasks or address new challenges. It is more than just training people to do conduct actions, but assisting people or organisations in gaining knowledge and experience to implement sustainable change and problem solving capabilities to perform effective actions (DETERMINE, 2010). Within the EU, there is considerable variance within Member States and regions of resources and experience in addressing health needs, as well differences in awareness and professional knowledge. Capacity-building is an approach that can overcome barriers to healthcare provision or resources, by developing capacity within existing services both within and outside the health sector that seek to address the wider determinants of health to improve services and deliver treatment for challenging health issues.

IRIS (Identification and Referral to Improve Safety) is a domestic violence and abuse (DVA) training support and referral programme in the UK. It is based within General Practice and aims to build capacity of professionals to best identify and support women who are experiencing domestic violence from a current partner, ex-partner or family

member. Information and signposting for male survivors and perpetrators is also given. IRIS involves a collaboration between primary care and third sector organisations specialising in violence against women and girls (VAWG). An advocate educator is linked to general practices and based in a local specialist service. The advocate educator works in partnership with a local clinical lead to co-deliver the training practices. Evaluation of the programme suggest it has led to improved referrals to specialist domestic services and recorded identification of women experiencing abuse (Feder et al., 2011).

The approach of capacity-building is not without challenges. Building new skills and capabilities within services can be difficult and organisations have been found to experience a range of issues during implementation (Alexander et al., 2010). These include:

- Lack of or insufficient resources and time to fully implement the approach;
- Lack of recognition among a given workforce that professional or organisational development is relevant;
- Difficulty in accessing technical expertise to develop skills;
- Difficulty getting individuals and organisations to focus on weaknesses; and,
- Lack of options for funding support.

3.5 Community care

Community care involves the integration of healthcare within the community setting, moving away from costly hospitalised treatment to the delivery of care close to people's homes. It also involves developing health policies which seek to engage all sectors to actively work together to improve health.

The concept of dementia-friendly communities is a prime example of a community care initiative. Thought to originate from Japan, dementia-friendly communities involve community-focused policies to support people with dementia. Dementia-friendly communities aim to improve health and social care services for people with dementia within the community. In addition, they also aim to raise awareness of the issue of dementia, challenging the stigma associated with the condition, and train volunteers to better support people with dementia.

Across Europe, governments and NGOs have developed a range of initiatives which seek to create dementia-friendly communities. Research suggests that there are several key factors that should be considered when developing initiatives (Mental Health Foundation, 2016). These include:

- Specialist training, education and awareness-raising about dementia;
- Active inclusion of people living with dementia within the communities they live;
- Promoting and supporting partnerships, networks and collaborations between a organisations; and,
- Securing and sharing community resources.

Funding to support community care is often considered one of the main challenges associated with the implementation of such approaches as it may require pooled resources from healthcare, social care, local government, the third sector and private sector to be effective (Mental Health Foundation, 2016.

3.6 Conclusions

The target groups identified by the VulnerABLE project are likely to experience a range of complex health needs, typified by a high prevalence of disease and lower life expectancy compared to the general population. This paper highlights frequently used approaches identified during the project which demonstrate promising practices in addressing the health needs of vulnerable groups.

Whist universal approaches to healthcare aim to offer equitable access to all, there are some groups of people who continue to experience barriers in accessing healthcare, or fail to access healthcare by conventional means. Targeted or specialised interventions are an effective way of addressing the health needs of vulnerable groups, as they tend to be specifically tailored to the needs of particular groups or particular health needs (e.g. outreach services tackling communicable diseases among homeless populations). Monitoring the health of populations and the services is an effective way of understanding both the needs of the population and gaps in health service provision (e.g. health needs assessments of prisoner health).

To improve the effectiveness of health service delivery, engaging users in the co-production of services, including the commissioning, design and delivery of services, has been an effective way of empowering vulnerable groups to take more control of their own health (e.g. improving health education and behaviour for new parents). Capacity-building is also effective in developing new knowledge, skills and areas of health provision where there was a deficit in skills or failure to address a specific issue (e.g. identifying and supporting women experience domestic violence). More broadly, supporting the development of communities which offer greater integration of health and social care closer to people's homes whilst raising awareness of how to support the health needs of vulnerability across community populations.

4 Thematic session overview

Addressing the health needs of the target groups: What are the most effective ways to address the health needs of persons living in isolated and vulnerable situations?

- Setting the scene: main themes and project results – **Jo Robins, Trainer-vulnerABLE Project team**
- Presentation of two good practices:
- *Co-production-* ***Maria Gallagher, Public Health Wales***
- *Prison Health-* ***Samuel d'Almeida, France***
- Comments from **Daniel Lopez-Acuna, Expert Group on Social Determinants and Health Inequalities**
- Q&A session

5 Questions for the conference

The approaches for addressing health needs of vulnerable groups pose some key questions moving forward. These include:

- How can this information on vulnerable groups be used to raise their profile and address some of the challenges facing them?
- What are the key challenges/barriers to implementation of specialised initiatives to address the health needs of persons belonging to potentially vulnerable groups?
- How can we implement these new models of working into all our services, programmes and workforces, not just in health?
- Are there any other approaches that you are aware of/delivering that may be useful to address the health needs of persons belonging to vulnerable groups?

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