From health for all to leaving no-one behind: public health agencies, inclusion health, and health inequalities

Most national public health agencies now address communicable and non-communicable diseases and recognise the need for an actionable strategy on health inequalities. Public Health England, in England, UK, differentiates between approaches to inequality according to the need for universal or targeted action. The needs of inclusion health groups—those who are socially excluded—are thought to require a specific set of responses. This approach might have wider application internationally.

England has well established legal requirements to reduce health inequalities. The country's Secretary of State for Health has a legal duty to "have regard to the need to reduce inequalities between the people of England"[1] and the public health agency—Public Health England—is committed to improve the health and wellbeing of the population and reduce health inequalities. However, translating this commitment into effective action is hard. Health inequalities in England persist and by some measures are getting worse.[3] Some are associated with behaviours—eg, in 2016, 27·2% of adults in the most deprived decile smoked, compared with 7·9% of those in the least deprived decile[2]—but most health inequality is attributable to the wider determinants of health: the social, economic, and environmental factors that tend to shape mental and physical health.[3]

These determinants are ubiquitous and create a health gradient across the whole of society. This gradient is now widely understood to require a universal response according to the principle of proportionate universalism.[4] However, such universal action alone is unlikely to improve the lives of those with the worst health. For those with the worst health some form of targeted action is required. Two examples of such targeted action are legal instruments that tackle disadvantage and discrimination, and inclusion health approaches (table).

The Equality Act (2010) is an example of a legal instrument in England, and it covers nine protected characteristics.[5] Public health agencies can approach health inequalities by turning such legal instruments into actionable plans. This might include work to define and describe the relevant populations, an essential step to understand which characteristics are associated with which health outcomes and to intervene accordingly. Legal instruments on discrimination are an important safeguard but are unlikely to address the needs of society's most vulnerable people, such as those in inclusion health groups.

Social exclusion can be defined broadly as processes driven by unequal power relationships that interact across economic, political, social, and cultural dimensions.[6] These processes can manifest differently in different contexts, such that the population groups who are socially excluded is not always clear. In the UK, the concept of inclusion heath has typically encompassed homeless people; Gypsy, Roma, and traveller communities; vulnerable migrants; and sex workers,[7] but other groups can be included.

Social exclusion is associated with the poorest health outcomes, putting those affected beyond the extreme end of the gradient of health inequalities. These extremely poor outcomes have been described as a cliff edge.[8] For example, the prevalence of long-term conditions, such as asthma and chronic obstructive pulmonary disease, follows the traditional gradient through levels of deprivation in the housed populations of London and Birmingham; however, prevalence in homeless people is substantially higher than in housed individuals from the most deprived quintile.[8]

Common experiences cut across inclusion health groups. Most have been or are exposed to multiple, overlapping risk factors, such as adverse childhood

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	Universal action	Legal instruments	Inclusion health
Causes	Wider determinants of health	Disadvantage and discrimination	Social exclusion
Populations	Whole society	People with characteristics protected by the Equality Act	People who are homeless, vulnerable migrants, and others
Health outcomes	Gradient in health cutting across the whole society	Generally worse health compared with people without the protected characteristics	A high burden of mental and physical ill-health and substance dependency (cliff edge)
Public health action	Place-based approach	Defining and describing the relevant populations, and identifying appropriate interventions	Improving recording in electronic systems, improving service accessibility, and training health-care professionals

Table: **Approaches to health inequalities for public health agencies**

experiences, trauma, and poverty. Adding to this unfavourable start, many face multiple barriers in access to health services because of fear, language and communication issues, or past experiences of being turned away.[9] This results in overuse of some services, such as accident and emergency departments, and underuse of others, such as primary and preventative care, resulting in inefficiencies and extra costs. Many of these populations are also highly mobile, making it difficult to ensure access and continuity of care from services that are typically designed for fixed populations. These groups frequently face stigma, discrimination, and public misconception, and marginalisation can further be compounded by punitive social policies. Notably, inclusion health groups are not consistently recorded in electronic records, making them effectively invisible for policy and service planning purposes.[10]

These experiences can create a vicious cycle of health and social deterioration for those affected. Inclusion health groups commonly have very high levels of morbidity and mortality, often with multiple and complex needs including overlapping mental and physical ill-health, and substance dependency[9]— creating complex situations that health services are not always equipped to deal with and that traditional population-based approaches generally fail to address.

Public health agencies can have a fundamental role in understanding the health needs of inclusion health groups, identifying interventions to improve their health and providing leadership at local and national levels. Such activities must be done in close partnership with people with lived experience from inclusion health groups and be based on the best available evidence.

Unfortunately, very little evidence exists on structural interventions and public health approaches to inclusion health,[10] but consistent data collection will allow public health agencies to develop, implement, and evaluate structural interventions that improve the health of inclusion health groups. Ensuring that vital registration and health information systems consistently and ethically record membership of these vulnerable groups is crucial—something that public health agencies are in a position to promote. Better data will also help improve and evaluate how services can meet the needs of inclusion health groups. Better access to services, improved integration between them and appropriate training for health-care professionals should yield benefits for everyone, not just people who are socially excluded.

People who are socially excluded are unlikely to have enough power to advocate for themselves. Public health agencies have an important leadership role in advocating for the health needs of these groups and in informing and influencing policy. A focussed approach to inclusion health groups should run in parallel with approaches targeted at the needs of people with the protected characteristics, such as disabilities, and universal approaches,[3] both of which are fundamental for a comprehensive approach to health inequalities (table).

Public health agencies have to translate an overwhelming volume of evidence on health inequalities into actionable plans. Breaking responses down into a framework of universal and targeted actions can help focus activity and should lead to effective public health interventions that are available to all and adapted to some, particularly to those who face the most extreme forms of exclusion. Any successful approach to health inequalities must face up to and address this exclusion.

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