If holistic healthcare is the answer what is the question? A take on healthcare inequality

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The Covid-19 pandemic has highlighted inequalities that exist in our society today. Over the course of this pandemic, select groups have been disproportionately impacted. Notably, those from deprived backgrounds, people with learning disabilities and BAME communities have suffered the brunt of this healthcare crisis. (1) Now more than ever, it is critical that healthcare inequality is actively tackled through practical and effective action plans to reduce the widening gap.

The World Health Organisation (WHO) defines health as 'A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. (2) Health is determined by biology, lifestyle, environment, and the health service. Lifestyle factors such as smoking, alcohol, nutrition and physical activity all influence a person's overall health, but does inequality fuel these behaviours? In more affluent areas, access to healthier food and outdoor spaces for exercise is easier. Additionally, those with better education have higher health literacy and are therefore less likely to smoke, drink excessive alcohol and engage in risky behaviours. (3) Finally, the services offered in different parts of the UK do not correlate to the areas where it is most needed. The Ottawa Charter in 1986 outlines the resources needed for good health. (4) How well is our government and healthcare service meeting these needs?

Healthcare inequalities are defined as 'avoidable, unfair and systematic differences in health between different groups of people'. (5) It is important to define firstly who is impacted and secondly how they are impacted. Due to the complex nature of this topic, this list is not exhaustive.

Who is impacted? (6)	How are they impacted?	Causes of healthcare inequalities (7)
• Ethnic minorities • People in areas of social deprivation i.e., unemployed, low income, poor housing, poor education • Those with protected characteristics i.e., disability, age, race, sex, sexual orientation	• Inequalities in life expectancy • Inequalities in healthy life expectancy • Inequalities in preventable mortality • Inequalities in long-term conditions • Inequalities in mental	• Access to services • Experience of services • Social values towards equity and fairness • Income • Wealth • Power • Education • Housing

• Inclusion groups i.e., migrants, traveller communities, homeless people and sex workers • People impacted by geographical location	ill-health	• Environment • Health literacy • Lifestyle behaviours • Social and cultural norms • Discrimination

The UK life expectancy at birth in 2019 was 80 for males and 83.7 for females. (8) Disability-free life expectancy was estimated 2 decades shorter than normal life expectancy. As life expectancy has increased, the gap in life expectancy has also increased. For both females and males, those living in the 10% least deprived areas in England live 8-10 years longer. (8) Additionally, men in more deprived areas spend on average 9 years longer in poor health. This value equates to 12 years for women. According to 2017-2019 statistics, life expectancy is 8 years lower for males and 7 years lower for females living in the North of England compared to the South. Homeless males and females live more than 30 years less than the average population. Those with learning disabilities live more than 20 years less than the average population. (8)

The affect of Covid-19 on different population groups is further evidence of disproportionate health outcomes. Life expectancy between 2019 and 2020 fell by 2 years in males from lower socio-economic backgrounds compared to 1 year in males from more affluent areas. (8) Similarly, life expectancy fell by 1.6 years in women from more deprived areas compared to 1 year in richer areas. The mortality rate from Covid-19 was 1.5 times more in those with a learning disability and 10-50% higher in ethnic minority groups. (9) Understanding the root causes behind these disparities can help tailor action plans dedicated to reducing them.

The causes of current health inequalities in the UK is multifactorial; the NHS Health Scotland have categorised these into fundamental and wider causes. (7) It states an unequal distribution of income, wealth and power has a significant impact on health. (7) Additionally, it acknowledges that wider determinants of health from housing, education, and access to health services also contribute to inequality. Shifting from the paternalistic, biological-based approach of healthcare to a more holistic, patient-centred, biopsychosocial approach is key to addressing these health inequalities.

Separating the medical management of physical and mental health problems from the socio-economic factors influencing them is not conducive to improving health outcomes in targeted population groups. Therefore, holistic healthcare, which acknowledges the physical, emotional, social, economic and spiritual

needs of the patient, needs to be adopted in practice. (10) The concept of holistic medicine existed during the Hippocratic era so why is it only recently that this approach is finally gaining traction? (11) Implementing a holistic approach to medical practice benefits patients, the healthcare team, and the healthcare service.

A series of interviews conducted helped shine a light on how to actively practice holistic care. (12) One participant stated they would listen to patients' religious beliefs and encouraged patients to pray if they felt this would benefit them. Another participant mentioned the importance of referring patients to social support groups and signposting patients to receive financial advice. (12) More anecdotal examples on how to provide holistic care needs to be readily available for healthcare professionals to use as a guide. Whilst the ideals of holistic care are well described, the integration of it into everyday practice is not well supported and is an area for future research. Barriers to holistic care include inadequate training, workload, and management. (13) In a qualitative study interviewing 14 nurses, some felt they did not have capacity to provide holistic care due to a heavy workload and that managers disproportionately emphasised the importance of routine tasks compared to holistic care. (13) Tackling these barriers can therefore make the practice of holistic care more feasible within a stretched NHS.

Having defined the concept of healthcare inequalities and holistic care, we can now ascertain whether holistic care can be the solution to reducing inequalities. The Centre of Progressive Policy (CPP) reported 80 million life years are lost due to socioeconomic inequality. (14) The CPP encourages investing in preventative health measures such as smoking cessation, obesity reduction and lowering air pollution to tackle wider determinants of health. Currently, only 5% of the health budget focuses on prevention. (14) Increasing the preventative services available helps tackle the root causes of ill-health. Holistic care is not just about prescribing and managing medication, it is about signposting patients to services that can improve their overall wellbeing. It is about managing health before it becomes a problem. The more we encourage patients to use preventative and lifestyle support services, the more empowered patients will be in taking control of their own health. Social prescribing, which is a vital aspect of holistic care, cannot occur without ensuring the capacity of services offered meet the demands of people who need it. Reducing healthcare inequality is therefore two-fold: Firstly, to make holistic care via social prescribing more of a norm within practice, and secondly to increase funding for these services.

The NHS long-term plan outlines actions that can be taken to tackle healthcare inequality. Its suggestions align with holistic values. (15) For example, it recognises that better support to those living in care homes can reduce emergency hospital admissions. (15) 'Better' support is achieved through stronger social and community support which proves that medical management alone is not enough. In recent times, the role of the NHS has been revised. It now takes on responsibilities to improve social care, housing, employment, and economic development in partnership with the government. (15) Schemes such as providing internships to

people with learning disabilities and helping those with mental illness gain employment are some examples of how the NHS has adopted a holistic approach to health.

The Healthy London Partnership is paving the way for holistic care. It focuses on health as physical, mental, and social wellbeing through encouraging healthy eating and exercise, improving health conditions at work, promoting self-care, and redirecting services to where they are needed most. (16) This is the cornerstone for holistic care as it focuses on all dimensions of health. Most importantly, it reinstates the need for personalised care and disregards the one-size-fits-all method. It ensures services are integrated, patient preferences are considered, and the community sector is utilised to provide good quality healthcare. Providing personalised care by allowing for shared decision making, tailored social prescribing, and even assisting with health budgets are all ways in which holistic medicine can be implemented in practice. (16)

Local communities around the UK can all follow to ensure healthcare inequalities are tackled with the urgency they deserve. Holistic care is a valuable tool to address a national problem; reducing the gap in healthcare can only be done by putting in place systems that support the wider determinants of health. All these steps forward can help reduce the disparity in health outcomes which benefits not just select groups of society, but society overall.

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