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Practitioner's blog

The changing face of vulnerability

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> Charity begins at home, and justice begins next door.
> (Charles Dickens, *Martin Chuzzlewit*)

Diversity in healthcare takes on many different forms, and demands that healthcare workers have knowledge, vision and a flexible mindset to accommodate and cater for patients' needs in whatever form they present.

The founding principle of the NHS, and one of which we are justifiably proud, is the delivery of fair and equitable care that is free at the point of need. The NHS came into being in 1948 when the infrastructure in Britain was just beginning to recover and be rebuilt after the Second World War. The economic circumstances and social and healthcare needs of the public at the time were very challenging. Healthcare free at the point of delivery was, without doubt, one of the greatest social achievements of the 20th century. It was also an enormous relief for many who would not otherwise have had access to healthcare because they could not afford to pay for it.

Since its brave inception the NHS has sailed through many stormy waters, but staff and indeed public loyalty to its founding aspirations and ideals remains unshakeable. To this end, unpopular and perceived unfair decisions in relation to health funding have lost many a health minister his or her portfolio. The current unprecedented global economic downturn and the austerity demanded to balance the books have challenged this commitment and made many of us question our sense of fair play and what is equitable in health and social care. Attitudes of entitlement which seem to work in favour of some to the detriment of others are becoming more apparent, and in some cases are quite stark in a system that has to cut its cloth in a way that has no precedent.

I recently cared for a young woman who had injured her knee and was walking with a knee brace. She attended the Emergency Department because she had developed severe pain in her hip, which was clearly caused by the fact that she was having to walk with the knee brace and could not use crutches as she also had an 8-month-old baby in a pushchair. This woman was well educated and, prior to having her baby, had been made redundant from her job. Her husband had also lost his well-paid job in the city, but had found another job which paid much less and required him to work long hours. Following the birth of their baby the woman had developed postnatal depression, and was only just recovering from this when she injured her knee.

Her state benefit payments were stopped as, under new rules about entitlements, she was deemed fit to work. This left the couple so short of money that they were now receiving food parcels from their church, much to their embarrassment and indeed shame. They had used their last £10 to get a taxi to the hospital because the young woman could barely walk due to the pain in her hip and knee. She was very tearful, and feared that she was slipping back into depression. At the same time she was terrified that she would not be able to care for her baby if she needed to have an operation on her knee, as had been suggested by her GP. Her husband could not take any time off work as they were so dependent on what he earned just to pay the rent. She had no family who could help her out, and her friends, who all had young babies of their own, were helping as best they could. Her GP had written a number of letters requesting that her benefit payments be reinstated until she was better, but had not received any response to these. The woman was quite horrified when I asked her whether she had considered calling an ambulance to bring her to hospital, as she was struggling to walk and clearly in a lot of pain. Her response was that ambulances were only for 'emergencies', and she did not think that she warranted this service.

My next patient arrived by ambulance after having sprained her ankle at home. This woman had recently moved to the UK from a developing country, and was fulsome in her praise of a welfare system that had provided housing and state benefit payments for herself and her family. She did not consider it inappropriate to have called an ambulance for a simple sprain, and indeed she had money for a taxi home. Moreover she was able to walk with minimal assistance and required only a bandage for support.

I was struck by the sharp contrast in the perceptions and attitudes of these two consecutive patients, and in truth quite dismayed by the distressing plight of the first and the sense of entitlement of the second.

Although I would never wish to deny care to any patient, and I am only too well aware of the difficulties that migrants and especially minorities sometimes face in accessing healthcare, I sensed a distinct imbalance and inequality of provision in these two cases. Over the years we have become more culturally competent in identifying the health needs of our immigrant communities, many of whom experience much poorer health than those born in this country. These skills and the good-quality care that we deliver are to be applauded, but there has to be a balance. Care provision must be fair. We must make sure that we do not overlook the needs of indigenous people, some of whom are currently facing real hardship and are increasingly vulnerable. In an effort to change our ways we have perhaps tended to overlook their needs, leaving them feeling disenfranchised by a system to which they have paid their contributions as a protection against difficult times.

My first patient was well presented and quite articulate, and without probing it would never have occurred to me how desperate she felt and how fearful she was for her own well-being and that of her family. She had no sense of entitlement, and felt a great sense of shame about receiving food parcels, and a loss of dignity. Sadly, she is unlikely to be alone in her predicament, as there are currently well over 2 million unemployed people in the UK. It is a well-recognised fact that unemployment has a very detrimental effect on health and well-being (Bartley, 1994; Hintikka *et al*, 2009; Minton *et al*, 2012). As we face increasing austerity and uncertainty, it is essential that we, as healthcare providers who are versed in the needs of diverse groups, are equally vigilant in looking out for the subtle and sometimes obscure signs of need and vulnerability in our indigenous population, many of which, because of feelings of pride and also shame about their predicament, remain hidden from view.

After years of plenty, encountering such need is disconcerting, but it is not a new phenomenon. At a time when Britain was the major economic and political power of the world, Charles Dickens highlighted the plight of the forgotten poor and disadvantaged, and was recorded as writing '*Charity begins at home, and justice begins next door*' (Charles Dickens, *Martin Chuzzlewit*, 1844). The poor and disadvantaged in our society have never gone away, although their needs may not be immediately apparent. As health and social professionals we are in a position to identify the new hidden poor and try to ensure that justice and not just charity begins at home for all our patients.

REFERENCES

Bartley M (1994) Unemployment and ill health: understanding the relationship. *Journal of Epidemiology and Community Health* 48:333–7.

Hintikka J, Lehto S, Niskanen L *et al* (2009) Unemployment and ill health: a connection through inflammation? *BMC Public Health* 9:410 doi: 10.1186/1471–2458–9–410.

Minton JW, Pickett K and Dorling D (2012) Health, employment, and economic change, 1973–2009: repeated cross-sectional study. *British Medical Journal* 344. doi 10.1136/bmj.e2316.

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