

## **Debate and Analysis: How can general practice respond to the needs of street-based prostitutes?**

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### **Article**

The Health Inequalities RCGP publication in 2015<sup>1</sup> reflected on evidence from the 2010 Marmot Review<sup>2</sup>, which concluded that in England, people living in the poorest neighbourhoods will, on average, die seven years earlier than people living in the richest. Furthermore, the average difference in disability-free life is 17 years; thus, people in poorer areas not only die sooner, but they will also spend more of their shorter lives with a disability.

Health inequalities are not simply a difference in health outcomes, but a difference in health outcomes *combined with* barriers to accessing the health care system. In addition to physical barriers such as opening hours, location and transport, there are other barriers contributing to this exclusion, including patient perceptions of services and expectations of what will be offered if they seek help, staff attitudes to patients, and communication difficulties.

Women involved in street-based prostitution (SBP) are an under-served group and their health is a source of international concern<sup>3</sup>. These women are a high-risk population, and street-based workers are at greater risk than their parlour-based counterparts due to an increased prevalence of intravenous drug use and poorer engagement with healthcare<sup>4</sup>. Women have specific health needs relating to their lifestyle and occupation<sup>5</sup>, as they are more likely to use drugs, have a less stable home environment, and experience occupational violence<sup>4</sup>. Women involved in SBP often have chaotic lifestyles and complex socioeconomic backgrounds<sup>5,6</sup>, factors that may have initially led them into prostitution<sup>7</sup>. The standardised

mortality ratio for those involved in prostitution in the United States is three times greater than that of the general population<sup>8</sup>. Women commonly experience social exclusion and stigma related to their occupation<sup>6,9</sup>, and belonging to a marginalised group subject to socioeconomic disadvantages is in itself detrimental to health<sup>2</sup>.

Women involved in SBP also suffer physical, as well as the better-documented psychosocial, co-morbidities<sup>10</sup>. We reported that women involved in SBP have poor knowledge of their physical conditions and how to optimally manage them. Their chaotic lifestyle, and limited perceptions of the seriousness of their health problems, resulted in help-seeking at a time of crisis and often resorting to the use of unscheduled care. Their help-seeking, however, was also influenced recursively by previous negative experiences at a number of different levels. Access to primary care was described as difficult due to barriers in the system (the need for an address, the telephone system) and in personal interactions with GPs. Women felt both that the ten minute consultation did not allow for the discussion of multiple problems and that they were judged negatively by the GP, often fearing the disclosure of their occupation. Women described the valuable support obtained from third sector support workers, who, as well as responding to needs associated with their occupation, acted as advocates in help-seeking for their physical and mental health needs. Such workers provided help and advice through supporting the navigation of a complex healthcare system.

The RCGP publication<sup>1</sup> made two recommendations that are particularly relevant to improving the care of women involved in SBP:

*Focus on incentivising ways of working that promote continuity of care in areas where patients would benefit most from a continuous therapeutic relationship with their GP — particularly areas where a high number of patients are living with multiple morbidities.*

*Fund outreach programmes to help often excluded groups such as those with mental health problems, learning disabilities and the homeless to access general practice.*

Few women in our study<sup>10</sup> reflected positively on relationships with general practice, or described an on-going therapeutic relationship with one supportive GP. Primary care was failing these women.

The concealed nature of the industry makes commissioning specific services for this patient group challenging, and women may not wish to access a service which would mean disclosure of the nature of their work; however, being able to access a specific service might improve access to care, enabling women to avoid disclosure to all but a specialist team of practitioners.

Much of the work that GPs can do to make a difference in reducing health inequalities needs to be taken forward in collaboration with, or sign-posting to, other professionals. This should include the third sector (or so-called 'voluntary services'), which plays a key role in supporting people in groups from under-served populations, but which all too often are commissioned on a short-term basis, and thus work in a state of uncertainty<sup>11</sup>.

In the report by the Primary Care Workforce Commission<sup>12</sup>, the message was clear that 'primary care needs to change. It will still be based around the GP practice holding responsibility for the care of its registered patients, but practices will have a stronger population focus and an expanded workforce. Many existing healthcare professionals will develop new roles, and patients will be seen more often by new types of healthcare professional such as physician associates... When needed, healthcare professionals will be able to spend more time with their patients to discuss and plan their care'. Much was made in this report of strengthening the role of pharmacists, increasing recruitment to practice nurse and physician associate posts, and highlighting patient demographics with particular needs. However, there was little focus on the role the third sector plays in supporting patients. Proposed new workforce models have not included third sector services, and without these some patients will not be served appropriately by primary care.

However, the recommendations around better use of technology to promote access and increasing the length of primary care consultations would potentially offer currently under-served groups (such as women involved in SBP) the opportunity to access improved and more acceptable care. Taking into account the important role of third sector organizations and integrating them within the broader primary care teams suggested by the Commission document would provide innovative, accessible services for patients with a broader range of needs.

Can primary care rise to the challenge of offering acceptable, patient-centred care to currently under-served groups, such as women involved in SBP? Will clinical commissioning

groups forward plan sufficiently to ensure integration of responsive health, social and third sector services?

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