Tropical Medicine and International Health doi:10.1111/j.1365-3156.2011.02876.x

VOLUME 17 NO 1 PP 139–141 JANUARY 2012

Viewpoint

Inclusive health

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Abstract We propose the concept of *Inclusive Health* to encapsulate the *Health for All* ethos; to build on the rights-based approach to health; to promote the idea of inclusion as a verb, where a more proactive approach to addressing distinctive and different barriers to inclusion is needed; and to recognise that new initiatives in human resources for health can offer exciting and innovative ways of healthcare delivery. While *Inclusive Education* has become a widely recognised and accepted concept, *Health for All* is still contested, and new thinking is required to develop its agenda in line with contemporary developments. *Inclusive Health* refers both to who gets health care and to who provides it; and its ethos resonates strongly with Jefferson's assertion that 'there is nothing more unequal, than the equal treatment of unequal people'. We situate the timeliness of the *Inclusive Health* concept with reference to recent developments in the recognition of the rights of people with disability, in the new guidelines for community-based rehabilitation and in the World Report on Disability. These developments offer a more inclusive approach to health and, more broadly, its inter-connected aspects of wellbeing. A concept which more proactively integrates United Nations conventions that recognise the importance of difference – disability, ethnicity, gender, children – could be of benefit for global healthcare policy and practice.

keywords Health for All, social inclusion, inclusive

Background

The Community-Based Rehabilitation (CBR) Guidelines (WHO 2010) were launched in Abuja at the end of October 2010. They are intended to contribute to improving the lives of the estimated 1 billion people living with a disability (WHO 2011), the vast majority of whom live in low-income countries and most of whom are very poor (MacLachlan & Swartz 2009). The CBR guidelines have evolved over 6 years and through intensive consultation with the International Disability and Development Consortium (IDDC, a global consortium of 25 international NGOs), UNESCO, ILO and the WHO's Disability and Rehabilitation Team. The Guidelines seek to promote improvements in and between five major components: health, education, livelihood, social development and social empowerment. One of the guiding principles outlined in the health section is the idea of 'inclusive health' which is being promoted 'to ensure health systems recognise and accommodate the needs of people with disabilities in their policies, planning and services delivery' (WHO 2010). The concept of inclusive health may resonate well with the new CBR guidelines and with the World Report on Disability (WHO 2011) but it also has the potential to offer a new ethos for global health more generally.

Discussion

Inclusive health is about health for all humankind; it requires health services that are efficacious and equitable, as well as affordable. *Efficacious* means that the health services actually work – they produce gains in people's health and wellbeing and seek to prevent both disease and social conditions that detract from health (Commission on the Social Determinants of Health 2008). *Equitable* means that services are provided on the basis of people's needs – that those most in need can access the service as easily as those least in need. *Affordable* – both to the individual and the community – means that services are provided in the most cost-effective way possible. *Inclusive health* also resonates with a right-based approach to health including 'political, social, economic, scientific and cultural actions that we can take for advancing the cause of good health for all' (Sen 2008).

Health for All is still a good idea, but one that has struggled to get traction. In contrast, the idea of *Inclusive Education* has become a much more widely recognised and accepted concept and is increasingly being implemented in education systems throughout the world. The *Health for All* concept sought to attain health as part of overall development, starting with primary health care based on 'acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford' (Alma-Ata Declaration 1978). A core value of *Health for All* is equity. Health policies built on equity will prioritise vulnerable and socially marginalised groups (Mannan *et al.* 2011). Vulnerable groups are 'social groups who experience limited resources and consequent high relative risk for morbidity and premature mortality' (Flaskerud & Winslow 1998), and this may include disability, ethnicity, gender, age, class, caste, socio-economic status, religion, sexual orientation, geographical location and immigrant/refugee status, among others.

While we have a plethora of 'culturally sensitive', 'gender appropriate', 'disability aware', 'child friendly' etc., policies and practices, we lack a broader recognition that what marginalises many vulnerable groups is often not the intrinsic features that characterise membership of those groups, but instead their position in, and positioning by, larger society (MacLachlan 2006). Burke and Pupulin (2009) argued that many biases and prejudices derive from social hierarchies and that there is an urgent need for 'building equitable, more inclusive societies based on respect, equality, human rights and the full participation and benefit of all people'. In the context of global health, such hierarchies also play-out in relationships where one party is more dominant than another, where a sense of injustice is felt and identity undermined (MacLachlan *et al.* 2010). Thus, *Inclusive Health* refers also to the nature of the relationships between people - not just whether they exist 'for all' – but whether they can be seen to be genuinely empowering so that vulnerable and marginalised 'voices' are included in social discourse and policy. While health policy documents may refer to 'all people', or 'all citizens' or 'everybody'; they often go on to name some groups but not others, thus privileging 'some' over 'all' (Mannan *et al.* 2011). *Inclusive health* recognises that for every group that is marginalised and/or vulnerable, there may need to be strategies to address its particular needs in such a way to overcome their particular barriers to health. This was succinctly recognised by Thomas Jefferson two centuries ago: 'There is nothing more unequal, than the equal treatment of unequal people'. For health to be more inclusive, we therefore need to be more proactive in reaching out to specific groups and identifying and addressing their particular needs. For *Inclusive Health*, the world 'inclusive' is a verb.

Inclusive health differs from *Health for All* not just in terms of access to health - who gets it - but also in terms of the delivery of health – who provides it. Since as the idea of *Health for All* new initiatives in Human Resources for Health mean that health care can extend to a greater variety of service delivery mechanisms than was envisaged several decades ago at Alma-Ata. Thus, inclusive health delivery means allowing for a range of health practitioner cadres to be involved in providing an acceptable quality of care in the most efficient and cost-effective manner. Often health professions strive to attain stringent demarcation of their areas of competence. Where these are necessarily associated with achieving a certain quality of care, this is quite justified. However, where this is not the case, or where there is an insufficient number of certain health professionals, the development of alternative cadres may be an important way of achieving more comprehensive and inclusive service delivery. For instance, the effectiveness of clinical officers trained for 3 years compared with obstetricians trained for many more years has now been demonstrated for emergency obstetric care, in several African countries (McCord *et al.* 2009; Kruk *et al.* 2007). This greater provision of care has the potential to promote not only greater coverage, but also coverage of a more diverse population, many of whom face significant barriers to accessing health care.

Healthcare facilities, their infrastructure, activities and programs must be sensitive to all vulnerable groups. In broader terms, the *Inclusive Health* philosophy also promotes more horizontal programs, rather than vertical, segregated and defragmented programs across various healthcare facilities. Similarly, inclusive healthcare resonates with the idea of inter-sectoral, inter-ministerial and inter-disciplinary working which is at the core of the Bamako Call for Research on Health (2008).

Conclusion

Inclusive Health, as a term, is an attempt to help people to think a bit more and perhaps, a bit differently, about what health care is for, how it is delivered and who deserves to get it. *Inclusive Health* seeks to build on the idea of *Health for All* and to strengthen it through the rights-based approach; to stress the need for more active inclusion by recognising that particular groups have particular needs and that particular barriers have to be overcome to address these needs; and to utilise a much greater range of healthcare delivery options embodied in a greater variety of human resources for health. To finish

with another quote: 'The world changes according to the way people see it, and if you alter, even by a millimetre, the way … people look at reality, then you can change it'. (James Baldwin) As a concept, *Inclusive Health* is a modest increment. However, a small step in the right direction may help to open doors for vulnerable and marginalised groups, enhancing their access to health care, both through facilitating demand from a broader range of people and through facilitating supply from a broader range of service providers.

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