Health and Primary Care

open access text

Case Report ISSN: 2515-107X

# Redressing health inequality through social prescription programme

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## Abstract

There is a growing evidence about the role of social prescription on health and wellbeing [1-3]. Social prescription programme can act as a primary or secondary intervention for a range of public health issues including obesity, mental health, parenting skills, life skills and address inequality in health and wealth.

Using the innovative "Gym for Free" [4] case study, this paper re visited the impact and outcome of this pilot public health policy initiative in promoting health and redressing inequality in an inner- city deprived area in Birmingham.

In addition, there is not enough information available about the process and challenges of translating research findings into policy and practice. This paper will describe the process, and outcomes of translating the findings of this research into implementation of "*Be Active*" a social prescription policy for the population in Birmingham, UK.

## Background

Physical inactivity as one of the risk factors leading to obesity and other non-communicable diseases is well recognised worldwide [5,6] and the situation in UK is not very different [7-9]. Obesity is increasing globally [10], in the UK 1 in 3 adults are overweight and obese [9]. The increase trend in the obesity pattern is in part due to changes in the environmental and lifestyle issues and an imbalance between the energy intake and energy expenditure [9,10].

Physical inactivity is a burden both to health and economic of a nation [11]. Facilitating an environment inducive to exercise and increasing physical activity not only supports obesity prevention, and would have a positive impact on overall health and wellbeing, but also reduces the economic burden by spending less on treating the adverse health outcome [12,13].

A strong link between the physical inactivity and socioeconomic gradients has been highlighted globally [14-16]. Uptake of the exercise specially in the leisure centres is closely linked with the level of disposable income of the individual and household [4,17]. During the economic hardship money spend on the leisure activities tend to be replaced with meeting the basic needs of the family members.

Social prescribing is a range of non-clinical programmes /activities designed for individual or group at community level; sometimes is also called community referral [18,19]. It recognises the wider social, economic and environmental determinants of health, and is underpinned by the Ottawa Charter of Health Promotion [20]; aiming on achieving equity in health and enabling people to take greater control of their own health.

To address some of the issues mentioned above an innovative social prescription "Gym for Free" pilot Scheme was jointly funded between one of the Primary Health Care Trust and City Council leisure centres in one of the deprived locality in Birmingham for six months in 2008. The aim was to find out if cost was a determinant factor on the uptake of the leisure facilities and could this scheme prevents and improves the obesity rate in adult population of this deprived constituency. This paper re examines the impact and outcome of this project as a case study and argues the essential role of post research activities through advocacy and lobbying in the implementation of the research findings and contribution to public health.

## Methods and Materials

A mixed methods study design was employed; utilising a survey of 256 users of the scheme and 3 focus group interviews with users and provider of the service. The evaluation explored its short-term effectiveness in relation to access, utilization, perceived benefits and sustainability [4].

## Results

Findings highlighted multiple positive short-term impact of this innovative public health policy on the physical, mental and social wellbeing of residents in an economically deprived constituency in Birmingham. The scheme has increased the uptake of exercise, but also widened participation among an ethnically diverse population particularly for women from Pakistani and African-Caribbean ethnic backgrounds within this innercity area. A marked difference was also identified in the frequency of the use of leisure facilities ($p<0.05$). The result indicated that nearly one third of the respondents (n=73) never used the leisure facilities prior to the introduction of the Scheme. This

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***Key words:*** *social prescription, health inequality, health and wellbeing, advocay*

**Received:** August 02, 2018; **Accepted:** August 20, 2018; **Published:** August 23, 2018

clearly suggested a link between the cost and the frequency of use and increased in uptake of this free service.

Multiple benefits perceived from the use of this valuable public health policy scheme including: ***physical benefits; mental and emotional benefits; social networking and other lifestyle changes.***

***Changes in the pattern of snacking*** *"We eat lots of fruit in the house now. ....when I come back from the gym we go for bananas, I used to go for a cup of tea and a biscuit. And even the kids have seen me eating fruit now and the kids just say 'bring more fruit home Mom', which in the beginning we never had this much fruit in the home. It was like 'packet of crisps Mom', now its Mom can I have an apple"( B1.f).*

***Changes in the amount of alcohol consumption and smoking*** *" I tend not to drink that much now, whereas I used to go out on a Friday night and it was like 'oh it doesn't matter you lie in on Saturday' but now its like 'no I've got to go to the gym in the morning' so just like the last couple of weeks I just haven't, maybe a glass of wine at home. And my smoking I don't smoke as much"(A2.f).*

***Impact on body weight "****My Dr told me to come, as I was 14 stone. In 6 months I am now 13 stone, and I am feeling very better" (A2.m)*

***Other percieved benefits****: "The medication I'm on for the postnatal depression is half now. And the doctor said it is just due to me doing the exercising. When I was told about the scheme I thought I could do more days and the more days I did the more better I felt and the more people I met and got into more conversations and that made me feel great…and he said keep it up don't stop"(B3.f).*

or

*"I come every day after work before I go home it just de-stresses you, it is not just because it is free, it de-stresses you, you are healthy, you look good, you feel good (C2.f).*

## Discussion

Although the scheme had no direct public health activities planned to facilitate changes in other aspects of lifestyle, participants highlighted changes they have made as the result of using the scheme. Changes in the pattern of food intake including snacking, reduction in body weight, alcohol consumption and smoking as well as benefiting from the social networking, social connectedness, managing stress and depression were some of the findings from this study and its impact on promoting health and wellbeing [4].

These findings clearly indicated that the benefits of this community-based intervention programme are far reaching and as argued by South and colleagues [21] Social Prescription "can provide the missing link" or as suggested by Brandling and House [22] can add "meaning to medicine" .

The link beteen social isolation and poor health is well established [23-25]. Holt-Lunstad and colleagues [24] argue that "actual and perceived social isolation are both associated with increased risk for early mortality". Evidence also indicates that loneliness can contribute to elevated blood pressure [25], depression [26], reduced physical activity [27] and may even alter immune response increasing inflammation and the risk of illness inflammatory diseases including cadrovascular disease [28]. The impact of the "Gym for Free" Scheme in overcoming social isolation through sharing experience and promoting health was therefore an added value.

Furthermore the "Gym for Free" Scheme as a social policy innovation programme taken a step towards addressing health inequality in access and widening participation in exercise with multiple physical, mental and emotional benefits. Similar to our findings, Higgerson and colleagues [17] found the positive impact of free access to leisure facility on health inequalities in physical activity.

Extending the "Gym for Free" Scheme across the whole of the city was one of the recommendations, together with the need to embark on a long-term evaluation of its effectiveness and sustainability to establish a firm evidence base. The principal investigator was extensively involved in post research activities which included:

A) Working with the funding body and the users of the Scheme to develop supporting material including DVD to participate in some of the national awards for best practice to improve health and reduce health inequalities.

B) Dissemination of the results of this study to various stakeholders and policy makers including Directors of Public Health of various Primary health Care Trusts.

C) Lobbying extensively for the importance of making this scheme freely available for the Birmingham population.

Based on dissemination of the findings of this pilot social prescription project "Gym for Free" won the following national awards for its policy innovation and short term impact on health and wellbeing:

- Local Government Chronicle Award winning project for Health and Well-Being 2009
- National Health Communicators Awards for social marketing and best overall scheme 2009
- Guardian Public Services Awards 2009 - Diversity and Equality award and Overall winner
- Health Service Journal Best Social Marketing Project and Secretary of State's Award for Excellence 2009

Following the national recognition and as the result of continued lobbying, advocacy and dissemination of the results to various local, regional, national meetings and conferences and the political will of the stakeholders the scheme now called "*Be Active"* became available free of charge to all adult population of Birmingham, through the passport to leisure scheme. This community- based social prescription programme is available between 9 a.m. and 5 p.m. on weekdays and a limited time on weekends. The time limitation imposed, particularly during the weekend as highlighted in our paper [4], could be viewed as limiting the uptake of the service by working people, nevertheless the scheme has taken an important step towards improving the health of those most in need.

Measuring the cost effectiveness of "*Be Active*" programme has also been funded by the Birmingham City Council in 2011, and it has been assessed by another research team [29]. The result indicated that this programme offers a "good value for money", is cost effective and has cost benefit; the findings have further strengthen the justification to continue with this programme. Therefore, despite reduction of a number of services due to austerity measures the "*Be Active*" scheme which is an extension of 'Gym For Free'( http://beactivebirmingham.co.uk/about-us) is still running free of charge in Birmingham.

The scheme currently has over 400,000 members, which represents about 1 in 3 of the entire population. To become a member of "*Be Active*" is simple. All one needs is to complete an application form and take it into their local leisure centre, along with two documents which shows name and address and then a Leisure Card will be issued.

http://www.birmingham.gov.uk/beactive

The vision "*Towards a new public health*" since the Ottawa Charter [20] has been based on a number of interrelated goals including "creating a supportive environments, building healthy public policy, and shifting towards primary care". To achive these goals required a shift in mindset and taking a broader social prespectives on health inequalities. The universal acceptance about the links between socio-structural fators and health inequalities in the last decade constructed a social and political responsibilities for those engaged in the field of public health [30,31].

Advocacy, despite its multiple and often conflicting definitions and usages has been defined as a key strategy in promoting health [32,33]. The health advocy concept utilised during the post research activities of "gym for free" Scheme was based on Carlisle's [33] "Social policy reform" seeking to redress social structural of health inequalities through influencing policy and policy makers. Removing the cost barrier of "*Be Actice*" through Social prescription is a an example of a social poicy reform focusing on primary health care, working towards health equity and social justice [34]. Based on the success of the uptake of "be Active" and a commitment to focus on primary health care to improve health and wellbeing through leisure and physical activities the "Be Active" programme has now been extended to incorporate 50 different activities in gyms, pools, community parks and other venues across the city under the umbrella of Birmingham Wellbeing service.

## Conclusions

Social prescription programmes improve health and reduces health inequalities [18,19,35]. Time spent on advocacy, lobbying and campaigning post research activities was challenging and required dedication to promoting health, and a commitment to translating the research findings into practice and policy. This was only possible as the principal investigator was on a permanent employment position, a further challenge for those working in short time research contracts / funded projects.

Provision of time for this types of public health activities should therefore be built as part of the applied research funding grants. Skills such as lobbying, advocacy and campaigning to facilitate translating the research findings into policy and practice should form an integral part of public health research training programme.

## Conflict of Interest

There was no conflict of interest.

## Funding

The original evaluation of the "Gym for Free" was funded by one of the Primary Health Care Trust and Birmingham City Council leisure centres in Ladywood Constituency.

## Acknowledgement

I would like to thank Anne Robbins and Maryam Khan the research team and my co-authors of "Gym for Free" evaluation project [4], as without their delegation and hardworking the research for the project wouldn't have been completed. Special thanks to all Directors of Public Health and the City Council policy makers in Birmingham for their vision and commitment to reduce inequality. Last but not least my gratitude to all members of the community who worked with me in campaigning and advocacy for free access to local authority's leisure facilities for all in Birmingham.

## References

1. Bungay H, Clift S (2010) Arts on prescription: a review of practice in the U.K. *Perspect Public Health* 130: 277-281. [Crossref]
2. Langford K, Baeck P, Hampson M (2013) More than Medicine: New services for people powered health. Part of the Nesta People Powered Health series, Nesta.
3. Kimberlee R (2015) What is social prescribing? *assrj* 2: 102-110.
4. Rabiee F, Robbins A, Khan M (2014) Gym for Free: The Short Term Impact of an Innovative Public Health Policy on the Health and Wellbeing of Residents in a Deprived Constituency in Birmingham, UK. *Health Education Journal* 74: 1-5.
5. WHO (2010) Global recommendations on physical activity for health. World Health Organization Geneva, Switzerland.
6. Lee IM, Shiroma EJ, Lobelo F, Puska P, Blair SN, et al. (2012) Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *Lancet* 380: 219-229. [Crossref]
7. Murray CJ, Richards MA, Newton JN, Fenton KA, Anderson HR, et al. (2013) UK health performance: findings of the Global Burden of Disease Study 2010. *Lancet* 381: 997-1020. [Crossref]
8. Newton JN, Briggs AD, Murray CJ, Dicker D, Foreman KJ, et al. (2015) Changes in health in England, with analysis by English regions and areas of deprivation, 1990-2013: a systematic analysis for the Global Burden of Disease Study 2013. *Lancet* 386: 2257-2274. [Crossref]
9. PHE (2017) Health matters: obesity and the food environment. Public Health matters, Public Health England.
10. WHO (2018) Obesity and overweight. World Health Organisation.
11. Public Health England (2016a) Physical inactivity: economic costs to NHS clinical commissioning groups. Research and analysis.
12. WHO (2018) More active people for a healthier world: Global Action Plan on Physical Activity 2018-2030. World health organization.
13. Public Health England (2016b) Health matters: getting every adult active every day.
14. Cerin E, Eva L (2007) Socio-Economic Status and Perceived Barriers to Physical Activity. Active Living research.
15. WHO (2007) Steps to Health: A European Framework To Promote Physical Activity For Health. World health Organization: Copenhagen.
16. Farrell L, Hollingsworth B, Propper C, Shields MA (2013) The Socioeconomic Gradient in Physical Inactivity in England. Centre for Market and Public Organisation.
17. Higgerson J, Halliday E, Ortiz-Nunez A, Brown R, Barr B (2018) Impact of free access to leisure facilities and community outreach on inequalities in physical activity: a quasi-experimental study. *J Epidemiol Community Health* 72: 252–258.
18. The King's Fund (2016) What is social prescribing?
19. HEE (2016) Social prescribing at a glance: North West England. A scoping report of activity for the North West, Health Education England.
20. WHO (1986) The Ottawa Charter for Health Promotion, World Health organization.
21. South J, Higgins TJ, Woodall J, White SM (2008) Can social prescribing provide the missing link? *Primary Health Care Research & Development* 9: 310-318.
22. Brandling J, House W (2009) Social prescribing in general practice: adding meaning to medicine. *Br J Gen Pract* 59: 454-456. [Crossref]
23. Uchino BN (2006) Social support and health: a review of physiological processes potentially underlying links to disease outcomes. *J Behav Med* 29: 377-387.
24. Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D (2015) Loneliness and Social Isolation as Risk Factors for Mortality: A Meta-Analytic Review. *Perspective on psychological science* 10: 227-237.
25. Hawkley LC, Thisted RA, Masi CM, Cacioppo JT (2010) Loneliness predicts increased blood pressure: Five-year cross-lagged analyses in middle-aged and older adults. *Psychol Aging* 25: 132-141.
26. Cacioppo JT, Hawkley LC, Thisted RA (2010) Perceived social isolation makes me sad: 5-year cross-lagged analyses of loneliness and depressive symptomatology in the Chicago Health, Aging, and Social Relations Study. *Psychol Aging* 25: 453-63.

27. Hawkley LC, Thisted RA, Cacioppo JT (2009) Loneliness predicts reduced physical activity: cross-sectional & longitudinal analyses. Health Psychol. 2009 May;28(3): 354-363.

28. Whiteman H (2015) Loneliness alters the immune system to cause illness, study finds. Medical New today.

29. Frew EJ, Bhatti M, Win K, Sitch A, Lyon A, et al. (2011) Cost-effectiveness of a community-based physical activity programme for adults (Be Active) in the UK: an economic analysis within a natural experiment. *Br J Sports Med* 48:1-6.

30. WHO (2010) Equity, Social Determinants and Public Health Programmes. World health organization

31. Marmot M (2010) Fair Society: Healthy Lives. The Marmot Review. Strategic Review of Health inequalities in England Post 2010. The Marmot Review.

32. Baric L (1988) The new public health and the concept of advocacy. *Journal of the Institute of Health Education* 26: 49-55.

33. Carlise S (2000) Health promotion, advocacy and health inequalities: a conceptual framework. *Health Promotion International* 15: 369-376.

34. WHO (2008) Closing the gap in a generation: health equity through action on the social determinants of health. Geneva: World Health Organization.

35. Bickerdike L, Booth A, Wilson PM, Farley K, Wright K (2017) Social prescribing: less rhetoric and more reality. A systematic review of the evidence. *BMJ Open* 7: e013384. [Crossref]


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