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Australasian Faculty of
Occupational and Environmental Medicine

Employment, Poverty and Health: Evidence Review

April 2019

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Contents

Employment, Poverty and Health: Evidence Review.....	0
Contents.....	1
Acknowledgements.....	2
Overview.....	3
Key Findings.....	3
Appendix A – List of documents.....	7
Appendix B – Key Data.....	11

About the Australasian Faculty of Occupational & Environmental Medicine (AFOEM)

The Australasian Faculty of Occupational and Environmental Medicine (AFOEM) of the Royal Australasian College of Physicians is the peak medical body for Occupational and Environmental Physicians, comprising over 500 medical specialists in Australia and New Zealand, who understand the relationships between health and good work, manage the physical, social and mental wellbeing of workers and provide medical expertise to organisations to optimize productivity.

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Overview

To support the Employment, Poverty and Health Statement of Principles, the RACP Policy and Advocacy Unit conducted a desktop search to identify documents related to employment, poverty and health and the social determinants of health (SDoH) more broadly from other medical Colleges and organisations in Australasia and abroad, which could help to guide future work by the College in this area.

The aim of this review was twofold:

- To identify key areas of action where physicians can have the most impact; and
- To identify practical strategies employed by relevant stakeholders in this area.

A total of 18 relevant documents were identified through that search as listed in Appendix A. A more detailed exploration of the findings of these documents is captured in Appendix B.

Key Findings

The evidence review unveiled five key action areas where physicians can have the most impact on SDoH:

1. Clinical practice – Doctors as clinicians
2. Employment – Doctors as employers
3. Advocacy – Doctors as health advocates
4. Supervision of students and trainees – Doctors as supervisors
5. Joint working/collaboration – Doctors as collaborators

These are presented in the table below along with practical strategies doctors can take under each key action area extracted from the document review:

Key areas of action for doctors	Practical strategies doctors can take under each key area of action
1. Clinical practice – <i>Doctors as clinicians</i>	<p><i>General measures</i></p> <ul style="list-style-type: none"> • Regularly reassess own practice to ensure treatment decisions contribute to health equity for individuals and communities • Focus practice on health conditions most affected by SDoH • Increase awareness of health inequities in general • Address potential bias in medical treatment decisions • Encourage those developing practice and clinical guidelines to reduce health inequities and support disadvantaged groups <p><i>Patient-centred care/practice:</i></p>

	<ul style="list-style-type: none"> • Positive strengths-based approach • Values the patient experience • Improve self-management • Shared decision-making • Screen patients regularly for relevant risk factors including social and economic circumstances • Integrate considerations of social and economic conditions into treatment planning • Take social history • Care planning and social prescribing • Use motivational interviewing and behavioural change techniques <p><i>Accessible practice:</i></p> <ul style="list-style-type: none"> • Access to specialists outside hospitals • Home visits • Co-locations of services including social and health care • Provide culturally safe and appropriate care and train support staff • Consider health literacy of patients: Develop plain language resources for patients especially on chronic disease management • Rethink format and times of consultations to make them more accessible • Provide advanced access and same day scheduling • Develop clinics for marginalised groups <p><i>Link/refer to appropriate supports</i></p> <ul style="list-style-type: none"> • Link patients with supportive programs • Identify local groups that provide peer-to-peer support • Signpost patients to useful resources and programs and provide practical support for patients to access supportive programs (e.g. have relevant forms available at the practice) • Provide bi-lateral referral pathways with local service providers <p><i>Evidence-based practice</i></p> <ul style="list-style-type: none"> • Collect and utilise data on local population: Mapping by SES and/or other indicators to identify differential outcomes amongst different economic groups: <ul style="list-style-type: none"> ○ Can be used to plan health services better identify needs of local population ○ Can also be used for advocacy • Monitor theirs and their colleagues physical and emotional wellbeing, and seek early assistance when required.
<p>2. Employment – Doctors as employers in both private practice and hospitals (e.g. as medical directors or directors of pre-vocational education and training)</p>	<p><i>Provide a supportive work environment</i></p> <ul style="list-style-type: none"> • Provide good work to own employees • Recruit people from different backgrounds and from local community – equitable recruitment • Have an active occupational health policy • Provide a sustainable working environment • Train staff in culturally safe and appropriate care • Undertake training to manage employees returning to work after sickness <p><i>Procurement measures</i></p> <ul style="list-style-type: none"> • Use commissioning and procurement decisions to increase action on inequities

	<ul style="list-style-type: none"> • Implement best practice principle throughout procurement chain <p><i>Ensure health inequities are part of the focus, expertise and management of clinical practice</i></p> <ul style="list-style-type: none"> • Provide dedicated time and resources to tackle inequities in clinical settings • Give status to health equity at all levels of the organisation • focus on equity and fairness • Value new professional and non-professional roles as sources of expertise
3. <i>Advocacy – Doctors as health advocates</i>	<ul style="list-style-type: none"> • Advocate for funding to address SDoH • Advocate for increased focus on SDoH for undergraduate and postgraduate medical education • Advocate on behalf of individual patients and communities (e.g. letter writing to housing associations on behalf of patients and their families) • Advocate for medical input into decisions taken within non-health sectors such as education, employment, transport, etc (Health in All Policies) • Advocate to governments and authorities for policies that improve the environmental, economic and social conditions of patients including reducing income inequality, supporting equitable and progressive taxation and expanding the social safety net • Collaborate with organisations to make advocacy more effective • Advocate for good quality work/good working conditions for doctors and other health staff, particularly lower paid professions including carers and volunteers • Demand training in monitoring, evaluation and advocacy around SDoH
4. <i>Supervision of students and trainees – Doctors as supervisors</i>	<ul style="list-style-type: none"> • Provide students and trainees with experiential learning about SDoH • Support and encourage students to be advocates • Develop and implement policies that support the entry and completion of medical studies by students from disadvantaged groups
5. <i>Joint working/collaboration – Doctors as collaborators</i>	<ul style="list-style-type: none"> • Collaborate with other organisations both within and outside the health sector, in particular with community organisations and programs to share best practice and knowledge • Collaborate/link up with experts in public health - Collaboration between clinical doctors and public health is very important –clinicians should be given the opportunity to remain involved in public health and vice versa via CPD, etc

The table below outlines practical strategies that medical organisations have used to address the SDoH. These fall under the areas of governance, education and training, and policy and advocacy.

These key areas of action are mapped below against examples practical strategies medical organisations have taken under each:

Key areas of action for medical organisations	Practical strategies for medical organisations
1. Governance	<ul style="list-style-type: none"> • Including goal of tackling SDoH and health inequity in organisation's strategic role • Develop and implement policies that support the entry and completion of medical studies by students from disadvantaged groups
2. Education and training including CPD	<ul style="list-style-type: none"> • E-learning modules • Case studies • Dialogue days • Exposure to different socio-economic groups in training • Including clinical cases in exams with a focus on tackling health inequalities • Developing practical tools for physicians: e.g. Guiding framework for advocacy: CanMEDS-Family Medicine Physician Competency Framework which describes the knowledge, skills, and abilities that family physicians need to improve patient outcomes; Ontario College of Family Physicians' Poverty Intervention Tool • Development/modification of clinical practice guidelines to integrate social and economic factors in medical care • Clinical handbook on working with vulnerable patients
3. Policy/Advocacy	<ul style="list-style-type: none"> • Consensus statements • Position statements • Dialogue days • Surveys to identify barriers, facilitators and best practice • Case studies • Developing or disseminating practical tools for physicians • Development/modification of clinical practice guidelines to integrate social and economic factors in medical care • Developing local databases of community services and programs (health and social)

Appendix A – List of documents

Country	Organisation	Title of document	URL/location of document
Australia	Australian Medical Association	AMA Position Statement: Social Determinants of Health and the Prevention of Health Inequities (2007)	https://ama.com.au/system/tdf/documents/AMA_Position_Statement_on_the_Social_Determinants_of_Health_and_the_Prevention_of_Health_Inequities_2007_0.pdf?file=1&type=node&id=40625
Australia	Australian Medical Association	The Role of Physicians and National Medical Associations in Addressing the Social Determinants of Health and Increasing Equity – Speech to BMA symposium – A/Prof Brian Owler (2015)	https://ama.com.au/media/social-determinants-health-australian-perspective
Australia	Public Health Association of Australia	Health Equity Policy Statement (2016 reviewed)	https://www.phaa.net.au/documents/item/1705
Australia	Public Health Association of Australia	Health Inequities Policy (2001)	https://www.phaa.net.au/documents/item/691
Canada	College of Family Physicians	Best advice Social Determinants of Health 2015	http://patientsmedicalhome.ca/files/uploads/BA_SocialID_ENG_WEB.pdf
Canada	Diana Daghofer,	Effective action by physicians on the Social	https://stage.divisionsbc.ca/CMSMedia/WebPageRevisions/PageRev-12760/Evidence%20scan%20-

Country	Organisation	Title of document	URL/location of document
	Wellspring Strategies	Determinants of Health: An environmental Scan (2016)	%20Physician%20Leadership%20on%20SDH%20-%20Final%20-%20April%2022,%202016.pdf
Canada	Canadian Medical Association	Health Care Transformation in Canada: Physicians and Health Equity: Opportunities in Practice (2013)	https://www.cma.ca/Assets/assets-library/document/en/advocacy/Health-Equity-Opportunities-in-Practice-Final-e.pdf
International	World Health Organization (WHO)	CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.	http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf
International	World Medical Association (WMA)	WMA Declaration of Oslo on Social Determinants of Health (2011)	https://www.wma.net/policies-post/wma-declaration-of-oslo-on-social-determinants-of-health/
International	World Medical Association (WMA)	Doctors for health equity - The role of the World Medical Association, national medical associations and doctors in	https://networks.sustainablehealthcare.org.uk/sites/default/files/resources/WMA2016SocialDeterminantsOfHealthInMedicalEducation.pdf

Country	Organisation	Title of document	URL/location of document
		addressing the social determinants of health and health equity (2016)	
New Zealand	University of Otago and New Zealand Medical Association	Fact and action sheets on health inequity (2011)	http://www.otago.ac.nz/wellington/otago023745.pdf
New Zealand	New Zealand Medical Association	Health Equity Position Statement (2011)	http://www.hauora.co.nz/assets/files/Tools/NZMA%20Health%20Equity%20Position%20Statement%20(2011).pdf
UK	British Medical Association	Social Determinants of Health – What Doctors can Do (2011)	https://www.bma.org.uk/-/media/files/pdfs/working%20for%20change/Improving%20health/socialdeterminantshealth.pdf
UK	Royal College of Physicians	How doctors can close the gap: Tackling the social determinants of health through culture change, advocacy and education (2010)	https://www.rcplondon.ac.uk/news/doctors-can-promote-fairness-and-equality-health
UK	University College London - Institute of Health Equity	Working for Health Equity: The Role of Health Professionals (2013)	http://www.instituteofhealthequity.org/resources-reports/working-for-health-equity-the-role-of-health-professionals/working-for-health-equity-the-role-of-health-professionals-full-report.pdf
USA	American Academy of Family	Social Determinants of Health Policy	https://www.aafp.org/about/policies/all/social-determinants.html

Country	Organisation	Title of document	URL/location of document
	Physicians (AAFP)		
USA	American Academy of Family Physicians (AAFP)	Poverty and Health - The Family Medicine Perspective (Position Paper) (2015)	https://www.aafp.org/about/policies/all/policy-povertyhealth.html
USA	American College of Physicians	Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians Position Paper (2018)	https://www.acponline.org/acp_policy/policies/addressing_social_determinants_to_improve_patient_care_2018.pdf

Appendix B – Key Data

<p>Australian Medical Association Position Statement: Social Determinants of Health and the Prevention of Health Inequities (2007)</p> <p>Australia</p>
<p>This document outlines the various Social Determinants of Health (SDoH) including the social gradient, stress, early life, social inclusion and exclusion, education, employment/occupation, unemployment, earnings/disposable income, social support, addiction, food and nutrition, transport, race and culture, disability, criminal records and incarceration.</p> <p>It states that all health practitioners have a responsibility to address equity in their work.</p> <p>The statement outlines a number of exacerbating factors negatively impacting on equity in the health system, including issues with access to primary care in lower socio-economic areas, attitudinal barriers from doctors, and other inequities in treatment. 20 recommendations are made to Australian Governments, and provides some recommendations aimed at medical professionals:</p> <p>17. The Australian Medical Association encourages doctors to regularly reassess their own practices to ensure that their treatment decisions contribute to improving health equity for both individuals and communities. The Australian Medical Association encourages doctors to be passionate and informed advocates for equity and to be mindful of the social determinants that are in play in a patient’s life during consultations.</p> <p>18. The Australian Medical Association encourages medical colleges and professional societies to increase their members awareness of health inequities in general, and potential bias in medical treatment decisions. This can be done by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curricula, in medical journals, at professional conferences, and as part of professional peer review activities.</p> <p>19. The Australian Medical Association encourages those involved in medical education to develop and implement policies that support the entry and completion of medical studies by students from disadvantaged groups.</p> <p>20. The Australian Medical Association encourages those involved in developing practice and clinical guidelines that reduce health inequities and support the needs of disadvantaged groups.</p>
<p>American College of Physicians – ‘Addressing Social Determinants to Improve Patient Care and Promote Health Equity: An American College of Physicians’ Position Paper (2018)</p>
<p>In this position paper, the American College of Physicians acknowledges the role of social determinants in health, examines the complexities associated with them, and offers recommendations on better integration of social determinants into the health care system while highlighting the need to address systemic issues hindering health equity. The ACP puts forth recommendations to empower stakeholders to advocate for policies aimed at eliminating disparities and establishing health equity among all persons.</p>
<p>The Role of Physicians and National Medical Associations in Addressing the Social Determinants of Health and Increasing Equity – Speech to BMA symposium – A/Prof Brian Owler (2015)</p> <p>Australia</p>
<p>This speech focuses on Indigenous Australians and the gap in health outcomes compared with non-Indigenous Australians.</p>

Public Health Association of Australia - Health Equity Policy Statement (First adopted 2001, last revised 2016)

Australia

Aimed at Australian governments at all levels, policy makers, program managers, industry, civil society organisations and public health practitioners and organisations.

“Community, professional, commercial, educational, cultural and legal institutions and organisations should:

- a. Be aware of the influences arising in their regular practices which impact on health equity;
- b. Advocate for policies in their fields and sectors which would promote health equity;
- c. Hold governments accountable for implementing such policies;
- d. Support social and political movements working to create the conditions for health equity, locally, nationally and internationally.”

Public Health Association of Australia - Health Inequities Policy (First adopted 2001, last revised 2012)

Australia

The policy is aimed at Australian governments at all levels (federal, state and territory and local), policy makers and program managers, industry, and civil society organisations. Recommends providing public health and health care services, especially to those most in need and disadvantaged communities, by:

- Enabling the participation of disadvantage groups across the continuum of health care including prevention;
- Providing comprehensive Primary Health Care; and
- Providing a high quality, accessible, culturally competent and safe publicly funded health system that includes access to essential medicines and holistic care, particularly for vulnerable, excluded or disadvantaged population groups.

College of Family Physicians Canada (CFPC) - Best advice Social Determinants of Health (2015)

Canada

Aimed at GPs and allied health professionals, the CFPC’s commitment to action on the SDH is demonstrated through our vision for family practice known as the Patient’s Medical Home (PMH). The PMH is a **patient-centred family practice** identified by its patients as the home base or central hub for the timely provision and coordination of all their health care needs. **Barriers to addressing SDoH in primary care practice** as identified in interviews with family physicians:

- Time constraints
- Remuneration concerns
- Fee-for service billing as a disincentive to work with patients to improve their SDoH
- Inadequate training and education at undergraduate and postgraduate level → health professionals ill-prepared to deal with complex social support systems or to take the social history of a patient
- Other less commonly identified challenges included: attitudinal issues particularly stigma on the part of providers (e.g. prejudice toward people in poverty or stigma around poverty precluding individuals’ comfort in discussing the living conditions and income), feeling of powerlessness (despite increased knowledge of SDOH, doctors may not see it as an area in which they can intervene).

Three levels of action for family physicians to incorporate SDOH into their practice:

- **Micro:** in the immediate clinical environment, work done on a daily basis with individual patients and predicated on the principles of caring and compassion
- **Meso:** In the local community, including the patient's community, the community of medical providers, and the 'civic community' in which health professionals are citizens as well as practitioners (also includes education, training and continuing professional development CPD)
- **Macro:** In the humanitarian realm, where physicians are concerned with the welfare of their entire patient population and seek to improve human welfare through healthy public policy (such as reducing income inequality, supporting equitable and progressive taxation, and expanding the 'social safety net')

Micro – in practice:

- **Regularly screen patients for poverty**, and intervene where necessary [see Ontario College of Family Physicians' Poverty Intervention Tool] – noting it is unethical to screen for something for which you are unable to provide an intervention → enable doctors to connect patients to programs that can help improve their living conditions
- **Ensure your practice is accessible to all patients**, especially marginalised populations
- **Offer advanced access and same-day scheduling**
- **Build an antipoverty team** that is shaped around your community's needs
- **Understand and provide forms for provincial/territorial social assistance programs**

Meso – in communities:

- **Collect and utilise data** on your local population's health and well-being
- **Provide undergraduate and postgraduate experiential learning** on social determinants of health
- Act as a **Health Advocate** and utilise the CanMEDS-FM Framework as a guide
- **Provide on-site care** for those who cannot make it to a physical clinic

Macro – Looking upstream:

- **Join or create an organisation to advocate** both with and on behalf of communities
- **Engage with medical, health care, and social service organisations** to provide organisational advocacy for improved social determinants of health
- **Advocate for remuneration arrangements and funding** that incentivises SDOH care
- **Collaborate with other organisations** to establish broad intersectoral support for healthy public policies that address upstream determinants of health
- **Advocate for increased focus and exposure to SDOH** in undergraduate and postgraduate medical education

Effective action by physicians on the Social Determinants of Health: An environmental Scan (2016)

Canada

Practice-level recommendations are as follows:

1. **Regularly screen patients for poverty**, and intervene where necessary (using a Poverty Intervention Tool and other tools designed to intervene and support patients.)
2. **Provide physicians with tools** to determine the impact of social and economic causes of ill health on treatment design.
3. **Adopt equitable practice design**, such as collaborative team-based practice.

4. **Ensure that all patients are treated equitably and practices are accessible to all patients**, especially marginalized populations. Offer advanced access and same-day scheduling (as per PMH “Timely Access” guide 40).
5. **Build an antipoverty team** that is shaped around your community’s needs. Team-based care should reflect the demographics of the patient population and focus on their health needs.
6. Ensure that **clinical practice guidance and treatment plans incorporate considerations of patients’ social and economic circumstances**. (Including, for example, asking patients if they can afford prescriptions written for them.)
7. **Use knowledge of the local area to identify areas of disadvantage and multiple SDH risk factors**.
8. **Link patients to supportive programs**, including provincial/territorial social assistance programs and community services. Local databases of community services and programs (health and social) should be developed and provided to physicians.
9. **Advocate on behalf of individual patients**.

Focus on clinician champions

This approach proposes identifying those already addressing the SDH in their practices, **supporting and promoting them**. Such champions should be given opportunities to address and train their peers in medical departments, as well as members of support organisations.

Focus on health conditions most affected by SDH

Some disease conditions are affected by SDH more than others, including diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and mental health. A focus on these can be effective, both because they are more prevalent among low-income groups, and because they are **more amenable to intervention**. Efforts often result in **better outcomes for the patient**, as well as reduced health costs through, for example, fewer hospital visits. **Physician clinics** can take place to address focus diseases, such that **specialists are available to see patients in doctors’ offices, rather than at the hospital**.

Focus on populations/geographic areas to identify areas where focused attention may be required. Mapping by SES and other indicators helps identify geographic regions where focused attention may be required.

Acting as community leaders

Since most action on the SDH must take place outside the health system, it is important that **physician leaders work beyond their profession in the broader community**. **Building respectful relationships with community organizations** is critical to identifying partners who can provide the support services required of high-needs patients, as well as being important sources of local data.

1. **Collect and apply data on your local population’s health and well-being**, first by defining your patient population (through rostering, as described in Patient Rostering in Family Practice 47) and gathering data on your patient population, preferably using an electronic medical record (EMR).
2. **Provide undergraduate and postgraduate experiential learning** on the social determinants of health.
3. **Act as a Health Advocate to improve the social and economic circumstances of the community**, using the CanMEDS-FM Framework⁴⁸ as a guide.
4. **Provide on-site care for those who cannot make it to a physical clinic**. In other words, make house calls.

Looking at the medical community specifically, delegates to the 2015 Global Symposium on the role of physicians in addressing SDH suggest the following actions for health care providers:

1. **Arrange for co-location of services.**
2. **Provide a healthy living wage to employees of the health service.**
3. **Plan health services better: look to identify the needs of the local population and provide services accordingly. Recruit people from different backgrounds to train as health professionals and encourage them to return and practise in their communities.**
4. **Provide dedicated time/resources to tackle inequities in the clinical setting.**
5. **Use the power of commissioning and purchasing to increase action on inequities.**

Acting as advocates

Beyond the community, action is often required at the policy level to enact changes that will help those living in poverty. Advocacy can be a complicated affair, but it starts by having a credible voice, something physicians can certainly bring to the issue. **The right individual, with the right data, can make compelling arguments for social support to decision-makers, if that argument is framed correctly. CFPC advises that physicians seek to improve the welfare of their entire patient population by influencing policies to reduce income inequality, support equitable and progressive taxation, and expand the 'social safety net'.**

Additional suggestions include:

1. **Join or create an organization to advocate both with and on behalf of communities.**
2. **Engage with medical, health care and social service organizations** to provide organizational advocacy for improved social determinants of health.
3. **Advocate for remuneration arrangements and funding that incentivizes SDH care.**
4. **Collaborate with other organizations to establish broad intersectoral support** for healthy public policies that address upstream determinants of health.
5. **Advocate for increased focus and exposure to SDH in undergraduate and postgraduate medical education.**

Acting as researchers

Baseline data on the patient population has been described as critical to moving forward on SDH. Depending on how it is gathered, **data can identify a population group (census data) or individuals (personal survey) that require a more focused approach to practice.** Aggregating individual data can begin to build a **good picture of broader community conditions to better plan services and care.** Clear, standardized data on health inequities, including health outcomes and use of the health system, is a critical in promoting health equity.

The document also includes information about general resources, education and development and tools which are Canadian based.

Canadian Medical Association - Health Care Transformation in Canada: Physicians and Health Equity: Opportunities in Practice (2013)

Canada

This document is based on interviews with 32 physicians in 29 separate interviews with health equity champions. These physicians represented eight provinces and two territories and were drawn from family medicine, emergency medicine, paediatric, psychiatry and public health.

Physicians were asked to identify **common areas of intervention for addressing health equity within practice**. The most common answers in descending order were:

1. Linking patients with supportive community programs and services
2. Asking questions about a patient's social and economic circumstances
3. Integrating considerations of social and economic conditions into treatment planning (i.e. cost of medications)
4. Advocating for changes to support improvements in the social and economic circumstances of the community (i.e., advocating for reductions in child poverty)
5. Undertaking advocacy on behalf of individual patients (i.e., letters about the need for safer housing)
6. Adopting equitable practice design (i.e., flexible office hours, convenient practice location)
7. Providing practical support to patients to access the federal and provincial/territorial programs for which they qualify

Physicians identified certain **barriers** to this work. The most common were:

1. Payment models (in particular 100% fee-for-service)
2. Attitudes that lead to stigmatized environments and prevent public action
3. Absence or lack of clinically-oriented information about the programs and services available for patients
4. Ability to find the time necessary to address these issues within practice
5. Lack of integration between health and community-based services
6. Lack of knowledge and skills to undertake this type of work
7. Practice design
8. Lack of services and supports in the community (in particular in rural and remote communities)
9. Lack of evidence and research on effective interventions for physicians
10. Personal attitudes that include powerlessness in the face of patients' social and economic barriers

Areas of Interest:

Clinical practice

- Development/refinement of health equity/social determinants of health assessment tool
- Development/modification of clinical practice guidelines to integrate social and economic factors in medical care
- Development of resources for physicians on programs and services for patients
- Development of resources for physicians on accessing provincial/territorial and federal programs including forms and referral pathways, etc.
- Development/consolidation and dissemination of plain language resources for patients on chronic disease management

Education

- Support and encouragement of the integration of the social determinants and health equity in medical schools
- Support and encouragement of service learning in medical schools and residency training
- Development of an accredited continuing medical education program for practicing physicians

Compensation (i.e. salary and billing codes for complex patients)

- Identification of effective compensation models for health equity in Canada
- Development of these models for other jurisdictions and practice settings

Research

- Support of continued research on physician interventions in health equity
- Help to assemble the evidence base and best practices and facilitate knowledge translation across Canada and internationally

Advocacy and communications

- Develop a national network of health equity physicians
- Develop an advocacy strategy for health equity in Canada
- Develop an advocacy map/tool for clinicians
- Explore the development of health equity and advocacy training resources for physicians

Strategies for addressing SDoH in practice:

- Taking a **social history** of all patients to identify poverty within the practice
- Using **community-level data** to help physicians understand the needs of their practice and what interventions may or may not be helpful. Local data can also be used to conduct equity assessments → **Integrate information into planning about treatment decisions**; take social and economic factors into account when planning treatment protocols and include barriers to adherence when planning treatment (e.g. cost of medication, access to fresh fruit and vegetable and exercise).
- Linking **patients with supportive programs** within the communities. For e.g. assist patients in accessing assistance programs such as disability assistance, extra funding for food, safe housing, etc.
- **Advocating for improvements in the social and economic conditions within their communities** → system-level advocacy
- **Advocating for patients on an individual level** e.g. writing letters to housing agencies, social prescriptions
- **Flexible office hours** outside of the traditional 9–5
- **Addressing health literacy for patients** including information that was appropriate for all patients. **Programs to support those who did not speak English** were also necessary. **Culturally safe care**, especially when working with Canada's Aboriginal peoples, was a key support.
- **Offices needed to be located in areas that were convenient for patients** - Some suggested locating clinics in areas where patients already were such as schools or early education centres. In some clinics, outreach workers went directly to the patients to ensure access.
- **Setting up practices that integrated many services under one roof** was seen as a key facilitator. One of the groups that faces the biggest barriers to health access are the homeless.

Royal College of Physicians - Doctors for health equity - The role of the World Medical Association, national medical associations and doctors in addressing the social determinants of health and health equity

Royal College of Physicians of London (RCP) published the report The Future Hospital Commission, advocating for a **holistic, patient-centred approach to care, with specific attention given to some of the most marginalised patient groups**. Through the Future Hospital Programme, RCP is supporting **more joined-up ways of working across the local health and social care economy, including doctors working in the community**. They are also developing an **e-learning module on the role of physicians in tackling health inequity**, which they aim to have accredited for continuous professional development (CPD).

Another example is the Royal College of GPs' Social Inclusion Commissioning Guide, produced with the University of Birmingham in England. The College is **reviewing clinical cases in the MRCGP exam** (the examination to ensure core competencies to be a member of the RCGP and recognised as ready for independent practice) **from a perspective of tackling health**

inequalities. It has published a **clinical handbook on working with vulnerable patients** for those undergoing GP training. [26]

Australian Medical Association (AMA) Social Determinants of Health and the Prevention of Health Inequities (2007)

Australia

The **Australian Medical Association** encourages medical colleges and professional societies to **increase their members' awareness of health inequities in general, and of potential bias in medical treatment decisions.**

Recent research has demonstrated the benefits of moving towards a partnership approach to consultation in a wide range of settings from acute mental health to musculoskeletal support groups to health trainers working in pulmonary rehabilitation. A UK study found that **successful interventions** have the following in common:

- **Valuing patient experience and new professional and non-professional roles as sources of expertise**
- **A flexible approach to the format of the consultation** according to what is most useful to the patient, not most convenient to the institution
- Moving the conversation towards a focus on patients' goals and outcomes by creating care plans across an entire pathway and a system of referral
- **Social prescription** incorporating nonmedical provision.

Constraints to moving towards this model include **consultation times** as discussed, and **support within and outside the healthcare system.**

For a physician to be able to assist a patient in addressing social and economic factors that may be impacting on their health, it is essential that they know what these are. The simplest way to do this is to **ask the patient.**

p.25 – Education and training

- **Educate** themselves and colleagues on what the social determinants of health are, and the **necessary skills** to tackle them
- **Promote and advocate for the SDH approach to be included in education training**
- As managers and teachers **ensure that SDH is a required component of progression**, including through the development of specific skills such as **taking social histories and motivational interviewing**
- **Advocate for a greater focus on the SDH in practice and education** for all health professionals

p.34 – Building the evidence: monitoring and evaluation

- **Expand social histories.** This could be as simple as asking patients if they have had trouble making ends meet in the last month, or could include taking detailed social histories (annually), by the doctor, support staff, or through IT systems. Where appropriate, assessments should be followed by **interventions** (for example, **signposting individuals who have trouble paying their bills to appropriate advice services**).
- **Demand training in monitoring and evaluation** at all levels of medical training including CPD
- **Share experiences with other physicians** and with other healthcare professionals
- **Consider the information obtained from monitoring systems including apps, in particular for usefulness beyond the care of individual patients.**

p.49 - The clinical setting: working with individuals and communities

Individual relationship with patients

- **Provision of culturally appropriate care** is important. Staff must be recruited with this in mind and adequate training provided
- Patient-doctor relationship: **take social histories of patients and incorporate this information into discussion and decisions about patient's treatment.** For patients with long term conditions, use **care planning** to work with the patient and consider '**social prescribing**' to meet the needs of the patient.
- **Designing the clinic around the needs of the patient**, not expecting the patient to fit around what is convenient to the clinic: Provide care that is culturally appropriate, safe, in the right location, at the right time; for example, during out of office hours, in a location convenient for the community.
- **Individual advocacy:** write letters to housing associations, schools and other services on behalf of patients and their families
- **Reflective practice:** Encourage doctors to examine their own prejudices as these might impact on assumptions they make about patients.

Relationship with communities

- In working with the community, make **social prescribing to local services available where appropriate**, linking patients to supportive community programmes. If this is not available, request provision of information about community support organisations and discuss with patients
- **Make tackling health inequalities a component of the health services role as a local community employer.** Employing members of the community is mutually beneficial. Local staff have a wealth of knowledge about the community and know culturally appropriate ways to engage people. It also brings employment to the community and therefore improves health and community capacity.
- **Use positions of influence and trust to improve the social and economic and environmental conditions of the community and reduce health inequalities** in the local area
- **Conduct community engagement with members of the community** with healthcare professionals demonstrating that they are themselves part of the community.

p.58 Healthcare organisations as employers, managers and commissioners

- As commissioners: Often healthcare systems choose the low cost option in awarding contracts and do not consider the potential impact on social value. When commissioning primary care and community clinics, and hospitals, **commissioners** should look for more than just medical care. They **should focus on improving the social conditions of local areas and through that the health of deprived communities** and also look for providers that could respond to the wider needs of the community, for instance health trainers and community-based services.
- Support staff: **Advocate for good quality work within the profession and where possible advocate for the working conditions of lower skills, low paid professions in healthcare, including those of carers and volunteers.**
- As managers of hospitals: **Include patients' social status, living conditions and complexity as a component of ward budgets;** have the **goal of health equity at all levels;** **develop expert clinics for marginalised groups** such as migrants; ensure hospitals have an **active occupational health policy.**
- As **community members as well as medical practitioners: get involved in local outreach**

p.68 Working in partnership: within the health sector and beyond

- **Work with others**, including non-health workers, to create networks based on **empowering patients and communities**
- **Share experiences of what works in action on social determinants**
- **Encourage buy in within the health sector for the development of partnerships outside the health sector**

p.76 Health professionals as advocates

- **Use the available evidence to demonstrate why the SDH matter and to promote their inclusion at the heart of policymaking**
- **Advocate for healthy policy at national policy level** to promote policies that aim to improve population health and reduce inequalities
- **Advocate for SDH to be more incorporated into medical education, in practice with individual patients, their local community, and those employed within the health sector**
- **Advocate on behalf of individual patients and for improvements in relation to improving environmental, economic and social conditions**
- **Insist on their member organisations undertaking advocacy on SDH at a national level**
- Provide materials including **case studies to inform advocacy**
- **Advocate for community based improvements**, such as access to parks and public spaces and reduced air pollution and water contamination for instances

Addressing the SDoH in medical practice requires action in the following areas:

1. **The education and training of doctors**, to inspire and equip doctors with the necessary skills to improve social determinants for individuals and at national level.
2. **Effective monitoring and evaluation of programmes**, to better understand the impact of the social determinants of health at the local and national level, to evaluate impact of actions and policies and, importantly, to provide an imperative for action.
3. **Working with individuals and communities**, re-evaluating the patient–physician relationship, and the relationship of doctors in the community, so that health services can be better designed to meet the needs of those most in need.
4. **Tackling inequity within the health system**, a large source of employment the world over, by setting an example as a provider of good quality work to everyone it employs and considering the broader social impact of procurement by the health service.
5. **Working in partnership** to ensure that community organisations, other sectors and the health and public health services are effectively taking action on social determinants.
6. **Extending doctors’ responsibility to advocate on social determinants** on behalf of patients and communities and at national level and international level.

World Medical Association (WMA) Declaration of Oslo on Social Determinants of Health (2011)

This policy declaration sets out how the WMA and the medical profession more broadly can be advocates for action on those social conditions that have important effects on health:

The WMA could add significant value to the global efforts to address these social determinants by **helping doctors, other health professionals and National Medical Associations understand what the emerging evidence shows and what works, in different circumstances**. It could help doctors to **lobby more effectively within their countries and across international borders, and ensure that medical knowledge and skills are shared**.

The WMA should help to **gather data of examples that are working, and help to engage doctors and other health professionals in trying new and innovative solutions**. It should work with national associations to educate and inform their members and put pressure on national governments to take the appropriate steps to try to minimise these root causes of premature ill health...The WMA should **gather examples of good practice from its members and promote further work in this area.**”

British Medical Association: Social Determinants of Health - What can doctors do? (2011)

UK

This report details a number of areas in which doctors can take action on SDoH:

- **Treating patients**
- **Community leadership**
- **Advocacy**
- **Research**

[Fair Society, Healthy Lives 2010 \(The Marmot Review\)](#) recommended action on 6 policy objectives:

1. Give every child the best start in life
2. Enable all children, young people and adults to maximise their capabilities and have control over their lives
3. Create fair employment and good work for all
4. Ensure healthy standard of living for all
5. Create and develop healthy and sustainable places and communities
6. Strengthen the role and impact of ill health prevention

Royal College of Physicians - How doctors can close the gap: Tackling the social determinants of health through culture change, advocacy and education (2010)

UK

This document synthesises policy dialogues aimed at identifying what roles doctors play in reducing health inequality by acting on the social determinants of health, and how they can best be trained to do this.

Recommendations are as follows:

- **All doctors should consider the impact on health inequalities of their day-to-day practice.** Key actors: All doctors
- **Senior medical figures and medical educators should legitimise, encourage and harness the power of student advocacy and action on the social determinants of health.** Key actors: Deans, course directors, undergraduate and postgraduate deans, royal medical colleges
- **Information-sharing on best practice** in the NHS and beyond concerning the social determinants of health should be encouraged and centralised. Key actors: Department of Health, Academy of Medical Royal Colleges (AoMRC)
- **Medical professionals should highlight and advocate policies and programmes that both have benefits for the physical and mental health of socially disadvantaged groups and result in reductions in greenhouse gas emissions.** Key actors: All doctors, NHS Sustainable Development Unit (NHS SDU), AoMRC
- **All medical professionals should be educated and informed about the implications of their healthcare decisions on greenhouse gas emissions.** Key actors: NHS SDU, strategic health authorities (SHAs), primary care trusts (PCTs), medical royal colleges, AoMRC
- **Clinical doctors and public health specialist teams should work together more closely in shaping services and developing programmes to promote and protect people's health,** prevent ill health and tackle health inequalities. Key actors: All doctors, local public health teams, local commissioning and planning teams.

American Academy of Family Physicians (AAFP) - Social Determinants of Health Policy

USA

This position statement sets out the AAFP's position on social determinants of health and the role of physicians in addressing them. The AAFP supports the assertion that **physicians need to know how to identify and address social determinants of health in order to be successful in promoting good health outcomes for individuals and populations:**

- In preparing students for practice, medical schools must foster **core competency in this patient-centric concept.** Physicians in training must develop awareness of the potential

obstacles patients confront when following treatment plans. Family medicine residents **develop competencies in the bio psychosocial model, cultural proficiency, evidence-based practice, quality improvement, informatics, and practice-based research.**

- Through education on the social determinants of health during residency, family physicians learn to:
 - **Identify crucial social determinants of health for their community of patients**
 - **Identify and partner with community resources that address social determinants of health**
 - **Consistently individualize patient care based on the patient's social determinants of health**
 - **Engage directly via community involvement to improve social determinants of health**
 - **Stay informed and act on local, state, and national policies affecting the social determinants of health of the populations that they serve.**
- Research conducted on social determinants of health should focus on effective interventions to reduce health inequities, including family physicians' roles in ameliorating social determinants of health.
- Family physicians take a leading role in addressing the social determinants of health by **partnering and collaborating with public health departments, social service agencies, and other community resources.**

American Academy of Family Physicians (AAFP) - Poverty and Health - The Family Medicine Perspective (Position Paper) (2015)

USA

Practical Approaches to Mitigating the Health Effects of Poverty:

- **“Provide a patient-centered medical home (PCMH) - Strong primary care teams are critical in the care of low-income patients. These populations often have higher rates of chronic disease and difficulty navigating health care systems. They benefit from **care coordination and team-based care that addresses medical and socioeconomic needs.****
- The rationale behind **alternative payment models, particularly regarding the care of lower socioeconomic populations, is that significant cost savings can be realized when care moves toward prevention and self-management in a patient’s medical home and away from crisis-driven, fragmented care provided in the emergency department or a hospital setting.** By recognizing and treating disease earlier, family physicians can help prevent costly, avoidable complications and reduce the total cost of care.
- **Practice cultural proficiency - PCMH team members can have a positive effect on the health of low-income individuals by creating a **welcoming, nonjudgmental environment that supports a long-standing therapeutic relationship built on trust.****
- Low-income patients may be unintentionally shamed by the care team when their behaviors are seen as evidence of being “noncompliant” (e.g., missing appointments, not adhering to a medical regimen, not getting tests done). These patients may not be comfortable sharing information about the challenges that lead to their “noncompliant” behaviors.
- For example, a low-income individual may arrive 15 minutes late to an appointment because he or she has to rely on someone else for transportation. A patient may not take a prescribed medication because it is too expensive. A patient may not get tests done because his or her employer will not allow time off from work. A patient may not understand printed care instructions because he or she has low literacy skills. Such patients may be turned away by staff because their tardiness disrupts the schedule, or they may even be dismissed from the practice altogether because of repeated noncompliance.

- Patients in lower socioeconomic groups and other marginalized populations rarely respond well to dictation from health care professionals. Instead, **interventions that rely on peer-to-peer storytelling or coaching are more effective in overcoming cognitive resistance to making positive changes in health behavior.** PCMH team members can identify **local groups that provide peer-to-peer support.**
- **Screen for socioeconomic challenges** - Family physicians **screen regularly for risk factors for disease; screening to identify patients' socioeconomic challenges** should also be incorporated into the practice. Once socioeconomic challenges are identified, we can work with our patients to design achievable, sustainable treatment plans.
- A patient's housing also has an effect on his or her health. The care team should ask the patient whether he or she has a home that is adequate to support healthy behaviors. For example, crowding, infestations, and lack of utilities are all risk factors for disease. Knowing that a patient is homeless or has poor quality, inadequate housing will help guide his or her care.
- **Set priorities and make a realistic plan of action** - As family physicians, we direct the therapeutic process by working with the patient and care team to identify priorities so that treatment goals are clear and achievable. In many cases, we may need to suspend a "fix everything right now" agenda in favor of a treatment plan of small steps that incorporate **shared decision making.** It is likely that a low-income patient will not have the resources (e.g., on-demand transportation, a forgiving work schedule, available child care) to comply with an ideal treatment plan. Formulating a treatment plan that makes sense in the context of the patient's life circumstances is vital to success.
- **The "best" medication for a low-income patient is the one that the patient can afford and self-administer reliably.** We can celebrate success with each small step (e.g., self-administering one dose of insulin a day rather than no insulin) that takes a patient closer to disease control and **improved self-management.**
- **Help newly insured patients navigate the health care system** - PCMH team members can help by providing orientation to newly insured patients within the practice. For example, PCMH team members can ensure that all patients in the practice know where to pick up medication, how to take it and why, when to return for a follow-up visit and why, and how to follow their treatment plan from one appointment to the next. Without this type of **compassionate intervention,** patients may revert to an old pattern of seeking crisis-driven care, which is often provided by the emergency department of a local hospital.
- **Provide material support to low-income families** - Local hospitals, health departments, and faith-based organizations often are connected to community health resources that offer services such as installing safety equipment in homes; providing food resources; facilitating behavioral health evaluation and treatment; and providing transportation, vaccinations, and other benefits to low-income individuals and families.
- **Practices can make a resource folder of information about local community services** that can be easily accessed when taking care of patients in need. **This simple measure incorporates community resources into the everyday workflow of patient care, thus empowering the care team.**
- **Participate in research that produces relevant evidence** - Much of the research that exists about the effects of poverty on health is limited to identifying health disparities. This is insufficient. **Research that evaluates specific interventions is needed to gain insight into what effectively alleviates poverty's effects on health care delivery and outcomes.**
- **Advocate on behalf of low-income neighborhoods and communities** - Family physicians are community leaders, so we can **advocate effectively for initiatives that improve the quality of life in low-income neighborhoods.** For example, a vacant lot can be converted to a basketball court or soccer field. A community center can expand

programs that involve peer-to-peer health coaching. A walking program can be started among residents in a public housing unit. Collaboration with local law enforcement agencies can foster the community's trust and avoid the potential for oppression.

New Zealand Medical Association (NZMA) Fact and action sheets on health inequity (2011)

New Zealand

1. **"Equitable and fair fiscal and social welfare policy**, including progressive taxation, comprehensive and fair social policy, and ensuring that everyone has a minimum income for healthy living. Policy needs to be proportionate to need – what is termed **proportionate universalism** in the Marmot Review, or a balance of targeting and universalism.
2. **Maintain and enhance social cohesion, through ensuring all services are accessible by all**. This requires a whole of government response and far better coordination among every branch of government, from Ministerial level to service delivery.
3. **Maintaining and enhancing investment in early childhood**, including the need to for there to be a visible leadership that champions child health and wellbeing. Child poverty rates need to be reduced. There needs to be greater coordination among services for children, and a visible crossparty agreement that determines the strategy for improving the environment in which children live.
4. **Aligning climate change, sustainability and pro-equity policies**, including programmes such as warm and healthy housing in deprived areas to environmental, health and health equity win-wins such as increased walkability of neighbourhoods and financial incentives that both reduce carbon emissions and increase healthy compared to unhealthy food production.
5. **Health equity needs to be widely understood**. It affects everyone, whether as a prospective parent, employer, employee, political leader or welfare beneficiary. Everybody working in a service delivery occupation needs to be able to alter their practice to reduce health inequities.
6. **Ill-health prevention that addresses risk factors contributing to health inequities**, including making New Zealand Smokefree by 2025 (as per Parliament's response to Māori Select Committee), encouraging or ensuring healthy food formulation (e.g. salt content in breads and cereals, clear labelling of foods that are healthy and unhealthy, packages of taxes and subsidies to improve healthy eating), and stronger policies to tackle harmful alcohol consumption.
7. **Ensuring fair employment and safe and healthy workplaces**, extending to include greater access to work for beneficiaries and people with disabilities, a low unemployment rate, and strengthening of occupational health policies.
8. **Maintaining and enhancing Māori, Pacific and Asian policies and programmes**, including health promotion, screening and health care services models that are culturally specific or tailored.
9. **Ensuring health services are equitable, including ensuring a strong equity focus in prioritisation of health resource allocation, quality improvement policies and programmes, and improved information systems**. This means, among other things, transparent monitoring, smoothing out regional variations in access, and on-going provider education and support.
10. **Health equity research needs to continue and focus on 'what works'**, evaluating policies and programmes for equity impacts in processes and (eventually) outcomes such as mental health status and disease incidence.

New Zealand Medical Association (NZMA) Health Equity Position Statement (2011)

New Zealand

This position statement makes a number of recommendations specific to the health profession. The NZMA:

- “Urges all **medical practitioners** in the course of doctor-patient consultations to **discuss the underlying causes of ill health and signpost patients towards appropriate support and services, both inside and outside the health sector.**
- Urges the **medical colleges** to **consider the impact of social determinants on health, and health inequities, and introduce specific educational goals for their fellows and trainees.**
- **Urges clinical doctors and public health specialists to work together more closely in shaping services and developing programmes to promote and protect people’s health, prevent ill health and tackle health inequities, and address the broader social and environmental factors that are influencing individuals’ health, choices and behaviour.**
- **Calls for doctors to work more innovatively and collaboratively to develop systems to reduce health inequities.** Doctors must be given adequate resources including finances, information and time to do this.
- **Encourages those involved in developing practice and clinical guidelines to consider the reduction of health inequities as a key component of such work.”**

UCL Institute of Health Equity Working for Health Equity: The Role of Health Professionals (2013)

UK

This report is based on literature, case studies and other evidence about how health professionals and organisations can influence SDoH and address health inequalities in a systematic and effective way. Relevant organisations including medical colleges and medical student associations have provided input for this report. The report looks at six areas where actions will be effective to address SDoH:

1. **Education and training**
2. **Working with individuals**
3. **Action for NHS organisations**
4. **Working in partnership**
5. **Workforce as advocates**
6. **Opportunities and challenges within the health system**

Recommendations

p.9 [Workforce education and training](#)

Knowledge

A greater focus on information about the social determinants of health, and information on what works to tackle health inequities, should be included as a mandatory, assessed element of undergraduate and postgraduate education.

Skills

Communication, partnership and advocacy skills are all general areas that will help professionals to tackle the social determinants of health. There are also specific practice-based skills, such as taking a social history and referring patients to non-medical services, which should be embedded in teaching in undergraduate and postgraduate courses.

Placements

Student placements in a range of health and nonhealth organisations, particularly in deprived areas, should be a core part of every course. This will help to improve students’ knowledge and skills related to the social determinants of health.

Continued Professional Development

Both knowledge about the social determinants of health and skills to tackle these should be taught and reinforced as a compulsory element of CPD.

Access

Universities should take steps to ensure that students from all socio-economic backgrounds have fair access to health care careers.”

P.10 “Working with Individuals and Communities”

Relationships

Health professionals should **build relationships of trust and respect with their patients**. They should promote collaboration and communication with local communities to strengthen these relationships.

Gathering information

Health professionals should be **taking a social history of their patients as well as medical information**. This should then be used in two ways: to enable the practitioner to provide the best care for that patient, including referral where necessary; and at aggregate level to help organisations understand their local population and plan services and care.

Providing information

Health professionals should **refer their patients to a range of services – medical, social services, other agencies and organisations**, so that the root causes of ill health are tackled as well as the symptoms being medicated.”

p.11 “NHS Organisations”

Health professionals should utilise their roles as managers and employers to ensure that:

- **Staff have good quality work, which increases control, respects and rewards effort, and provides services such as occupational health.**
- **Their purchasing power, in employment and commissioning, is used to the advantage of the local population, using employment to improve health and reduce inequalities in the local area.**
- Strategies on health inequalities are given status at all levels of the organisation, so the **culture of the institution is one of equality and fairness**, and the strategies outlined elsewhere in this document are introduced and supported.”

p.12 “Working in Partnership”

Within health sector

Partnerships within the health sector should be consistent, broad and focussed on the social determinants of health.

With external bodies

Partnerships between the health sector and other agencies are essential – they should be maintained, enhanced, and supported by joint commissioning, data-sharing and joint delivery. They must, however, be well designed and assessed for impact.

Clinical Commissioning Groups

CCGs should make tackling health inequalities a priority area, and should measure their progress against this aim. They can do this via their role as commissioners, in partnership (particularly with Health and Wellbeing Boards), and as a local community employer and advocate.”

p.13 “Workforce as advocates

For individuals

Individual health professionals and health care organisations should, where appropriate, **act as advocates for individual patients and their families.**

For changes to local policies

Individual health professionals and health care organisations such as local NHS Trusts should **act as advocates for their local community, seeking to improve the social and economic conditions and reduce inequalities in their local area.**

For changes to the health profession

Individual health professionals, students, health care organisations such as NHS Trusts and professional bodies such as medical Royal Colleges and the BMA should **advocate for a greater focus on the social determinants of health in practice and education.**

For national policy change

Individual health professionals, students and professional bodies such as medical Royal Colleges should **advocate for policy changes that would improve the social and economic conditions in which people live, and particularly those that would reduce inequalities in these conditions.** They should target this advocacy at central government, and bodies such as the NHS Commissioning Board.”

Actions hospital doctors could take-

As clinicians:

- **Ensure access to high quality health care is available to vulnerable groups by working in flexible ways**, for example by working:
 - outside the hospital setting or providing out-of-hours clinics, or
 - with voluntary organisations to raise the profile of health services and health need to disadvantaged groups
- **Develop bilateral referral pathways with local service providers and use clinical consultations as an opportunity to refer patients to appropriate support services** such as housing and debt advice services
- **Work with hospital managers to collect data on admissions relating to the social determinants of health.** These could be published to highlight “inequality attributable admissions” and inform trust and national level initiatives.

As advocates:

- **Work with public health specialist teams and other sectors** (for example housing, education, employment and environment) in advocating and developing services and programmes to encourage better outcomes for health, such as conducting **health equity audits**
- Sit on Health and Wellbeing Boards and/or actively contribute to the Joint Strategic Needs Assessment (JSNA), to address the fact that some people may not access primary care and thus their needs are not identified.

As managers and clinical leads:

- Work with hospital trust leaders to ensure that their trust is a **model employer and that all staff are well supported as employees, including developing appropriate working patterns, clear job roles and high quality appraisals**

- **Undertake training on how to manage staff returning from long-term sickness absence, and apply what they have learnt to support staff returning to work.**

As educators:

- **Ensure medical students and trainees have exposure to community placements that tackle broader social determinants and are guided to investigate the social factors contributing to the ill health of patients when they present to acute services.”**

The paediatrician’s role in tackling the social determinants of health

- Paediatricians take on a special dual-role of agent as the doctor is both the agent for the patient and for the parent or carer who has prime responsibility for the child. **The doctor is thus an advocate for the child and in child protection issues is fully aware that ‘interests of the child are paramount’.**
- **Paediatricians should be well-equipped not only to recognise problems that indicate child poverty and health inequalities, but also to intervene and treat these problems as early as possible to prevent long-term consequences to health.**
- It is clear, then, that **paediatricians have three general roles in reducing health inequalities: in improving their own awareness of the issue, in working to create public awareness and knowledgeable patients in regards to health inequalities, and in promoting changes within both the health profession and the government;** many actions are overarching and fall within more than one of these categories.
- All of these actions will contribute to decreasing the number of premature deaths as well as providing economic benefits in terms of saved health care costs. Most importantly, tackling these inequalities will help to give children the best possible start in life and the ability to maximise their capabilities.

Paediatricians should:

- **Adopt a holistic, multidimensional approach to the process of diagnostic assessment and intervention**, recognising all the biological, social and environmental influences on the evolution of the health and development of a child
- **Be aware of the concept of ‘readiness for school’**, the ability of the child to develop to his/her full potential and perhaps break out of an intergenerational cycle of poor achievement and socioeconomic deprivation, as well as the early years’ factors that influence this and how to promote good practices and available evidence-based interventions with individual families
- Also **be aware of the ‘millennial’ morbidities of childhood**, which are reflected in the current RCPCH policy objectives to tackle obesity and child mental health problems, with their strong life-course influences
- **Be trained about the factors that affect access to services** – not just geographical, financial and cultural, but also the attitude, educational level and physical and mental health of parents and other family members. They should be encouraged to use the social determinants of health model when evaluating a child’s health, not only focusing on physical health and overall wellbeing, but also recognising protective and adverse risk factors within the family and external environment
- **Be aware of how systems within their own influence might be altered and be able to develop procedures, for example for non-attendance of children, fast-tracking highly mobile populations such as migrants or traveller families, ensuring all patients seen in secondary care have been registered with primary care providers, making appropriate use of liaison health visitor services at the interface with A&E**
- **Partake in regular study days both at the College and locally. Exam questions should be required to assess paediatricians’ basic knowledge of health inequalities.** They should also be given new inductions (either by a consultant, health visitor or social worker) upon arrival to each new trust in order to **learn about services and demographics of the local area served by the unit**
- **Work across the health professions**, especially with obstetrics, as antenatal care, nutrition and parenting are also important aspects of health

- **Become aware of local projects and services**, such as the Child Poverty Intervention Project pilot or Teenage Parents Supported Housing pilot and local authority child poverty projects, by keeping up-to-date information
- **Recognise the child's right to be heard and encourage the patient's increasing involvement in decision-making throughout maturity and growth**
- **Take up opportunities for training in motivational interviewing and behavioural change as well as in advocacy skills** for influencing local and wider political structures.

Public and patient awareness

Paediatricians should:

- **Take every opportunity to explain in a nonjudgemental way the effects of parental behaviour on children's health.** This includes negative socio-emotional parenting, passive smoking, addiction, domestic violence and unregulated, constant television viewing
- **Adopt a positive, strengths-based approach** in order to promote those protective factors which mitigate against the effects of poverty in a particular family
- **Encourage parents to remain in contact with health visitors and key workers, as well as encourage regular health visitor follow-ups** for weight measurements and advice and regular immunisation
- **Inform patients of services** such as Sure Start Children's Centres and maternity grants, local children's centres that provide free activities and courses, library services (including toy libraries, storytime and rhymetime), FareShare (for food access), school breakfast clubs and after-school study clubs, as well as disability living and carers allowances
- **Contact social services, health visitors and GPs to make sure they are aware of the child and family.** They should work to **increase the public knowledge of the availability of these services**
- **Make better use of the personal child health record (PCHR or 'red book')** and information sheets given to parents of newborn children, in order to provide guidelines and advice on topics such as developmental support, nutrition, dental hygiene and immunisation
- **If caring for children with long-term conditions and disabilities, promote key worker schemes and parent support groups and provide easily accessible information, as well as give individual encouragement to parents,** with the aim that they learn to become good advocates for their children.

Promotion and advocacy

Paediatricians should:

- **Promote with policy makers the fact that children have their lifestyle choices made for them initially, and then adopt those they have grown up with, making the potential to change more difficult when fully independent**
- **Write to and engage with MPs to encourage a culture of integration of services for children, involving health, education and social services,** especially in times when structural changes brought about by the Health and Social Care Act may mitigate against this
- **Use as an example the presentation of data on the cost to the NHS of treating accidental injury in children, to develop with others injury prevention schemes, and encourage lobbying** – both individually and with organisations – for changes to the environment
- **Advocate for educational and environmental measures** to improve access to healthy exercise, knowledge of healthy diets and the adverse influence of advertising and marketing
- **Push for improvements within the health profession** such as further enhancement of the PCHR. Paediatricians should become familiar with local services and use their knowledge to signpost to such services and projects
- **Canvass for change by promoting and taking part in hospital audits,** which could be used to highlight health discrepancies and also as a measure to **highlight issues with MPs and government."**

