



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



INSTITUTE *of*
HEALTH EQUITY



ABOUT THE UCL INSTITUTE OF HEALTH EQUITY

The Institute is led by Professor Sir Michael Marmot and seeks to increase health equity through action on the social determinants of health, specifically in four areas: influencing global, national and local policies; advising on and learning from practice; building the evidence base; and capacity-building. The Institute builds on previous work to tackle inequalities in health led by Professor Sir Michael Marmot and his team, including the Commission on Social Determinants of Health, Fair Society Healthy Lives (the Marmot Review) and the Review of Social Determinants of Health and the Health Divide for the WHO European Region. www.instituteofhealthequity.org

ABOUT THIS REPORT

This report was written for the World Medical Association by Sara Thomas of the UCL Institute of Health Equity. The author is grateful to all of those who contributed to the programme of work and commented on the report. In particular Professor Sir Michael Marmot, Dr. Vivienne Nathanson and Dr. Jessica Allen.

The aim of this report is to contribute to Professor Sir Michael Marmot's Presidency of the World Medical Association and to support the WMA's Declaration of Oslo on the Social Determinants of Health.

This report explores evidence and case studies to highlight the ways in which doctors, national medical associations and the World Medical Association (WMA) can act on the social determinants of health and improve health equity. These actions include high level advocacy and advice, shaping policies at local, national, regional and international level, partnering and collaborating with sectors outside health, and doctors' individual interactions with patients during clinical encounters.

A strategy for the WMA and national medical associations is outlined, as well as practical approaches for medical professionals and their associations to incorporate the social determinants of health into their everyday practice and broader societal roles.

Effective change requires a system-wide, multilevel approach. The context, organisation and structure of countries and health bodies will empower or limit what can be done in different settings. Actions by medical professionals and medical associations are constrained by national and global economic factors, by health system constraints and by political will.

This report takes the same view as the World Health Organisation's *Review of social determinants and the health divide in the WHO European Region: final report*: do something, do more, do better:

- If countries have very little in place in terms of policies on social determinants of health, the capacity of health professionals and associations to affect systematic change is limited, but effective action can still be taken – *do something*.

- Where there are existing policies, doctors can work towards or advocate for more improvements to reduce wide and persistent health inequities – *do more*.
- In countries that have a track record of acting on the social determinants of health and acting to improve health equity, there is still much scope to do better on these inequities and doctors can influence, and in some cases lead this – *do better*.

TABLE OF CONTENTS

INTRODUCTION	5		
Global health inequities	6		
Regional differences	6		
Within-country inequities	6		
The social determinants of health	9		
Life course in a social determinants approach	10		
Wider society	10		
Macro-level context	10		
Systems	10		
Social determinants of health and the wma	11		
Current guidelines for health professionals on the social determinants of health	12		
1 Understanding the issue and what to do about it: education and training	14		
Incorporating the social determinants of health into the education curriculum	16		
Criteria for admission	16		
Competencies	19		
Undergraduate and postgraduate	19		
Continual professional development	22		
Channels	22		
Career pathways	24		
2 Building the evidence: monitoring and evaluation	26		
National level	28		
Local level	29		
Using technology	31		
3 The clinical setting: working with individuals and communities	35		
Consultations	37		
Consultation times	37		
Consultation format	37		
Interventions	39		
Social history	39		
Working with patients	41		
		Care planning	41
		Social prescribing	42
		Doctors and the community	45
		Working with indigenous communities to improve health outcomes	45
		Working with aboriginal communities in Canada	45
		Working with aboriginal communities in New Zealand	46
		Systems which support doctors to take action on social determinants of health	48
		4 Healthcare organisations as employers, managers and commissioners	50
		The health service and the social determinants of health	52
		As employers	52
		As managers	55
		As commissioners	55
		5 Working in partnership: within the health sector and beyond	59
		Partnerships outside the health sector	61
		Working with communities	63
		Community leaders/faith leaders	65
		Partnerships with voluntary, and charitable organisations	65
		National partnerships	66
		International partnerships	67
		6 Health professionals as advocates	69
		Advocating for individuals and communities	71
		Advocating for the working conditions of doctors and other health staff	73
		International advocacy	73
		National advocacy	75
		Doctors as advocates for policy change	75
		Students as advocates	76
		CONCLUSION	77
		References	79
		Case study index	85

Introduction

Global health inequities	6
Regional differences	6
Within-country inequities	6
The social determinants of health	9
Life course in a social determinants approach	10
Wider society	10
Macro-level context	10
Systems	10
Social determinants of health and the wma	11
Current guidelines for health professionals on the social determinants of health	12

GLOBAL HEALTH INEQUITIES

In 2013 average global life expectancy was 68 years for men and 73 years for women and there is a global trend of increased life expectancy. Between 1990 and 2013 global life expectancy increased by seven years from 64 to 71 years. [2] These gains were seen across countries in different income groups, and were largest in low-income countries. [2] Despite these overall improvements, large differences in life expectancy and health outcomes can still be seen within and between countries.

These inequalities in health are not only about poor health in the poorest countries and good health for everyone else: there are clear, persistent and systematic differences in health between social groups in all countries, low-, middle- and high-income. No matter where in the world, the lower an individual's socioeconomic position, the higher the risk of poor health and greater the likelihood of premature death. To illustrate this, we have looked at differences in life expectancy or mortality rates, between and within countries.

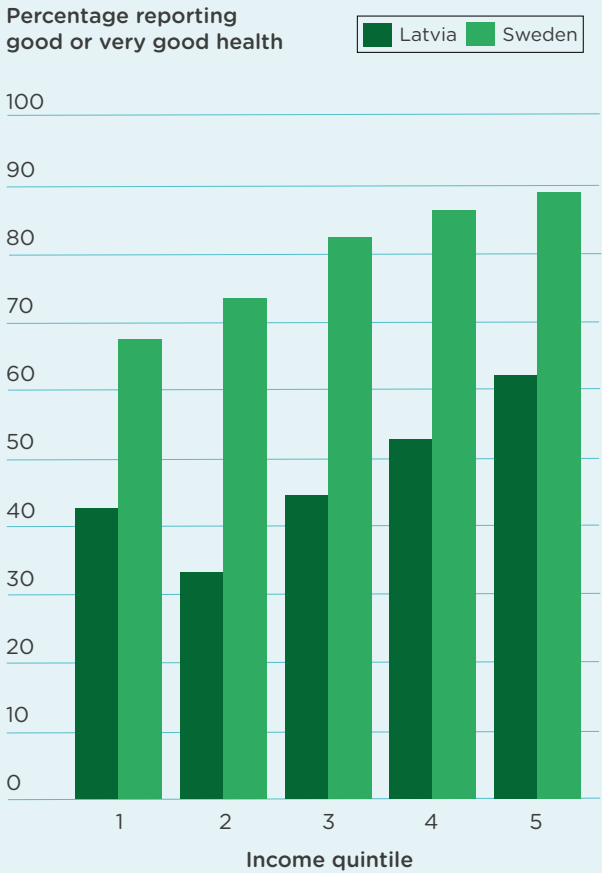
REGIONAL DIFFERENCES

In 2013, the region of the Americas had the highest life expectancy at 77 years, the European Region and Western Pacific Region followed with a life expectancy of 76 each, followed by the Eastern Mediterranean Region and South-East Asia Region at 68. Africa had the lowest average life expectancy at 58, with many countries within the continent having life expectancies in the fifties. [2]

WITHIN-COUNTRY INEQUITIES

For all countries for which data exists there is a gradient in health according to socioeconomic status (SES): health outcomes worsen with greater levels of social disadvantage as measured by, for example, income, education, social position and employment. [3] Figure 1 illustrates this by plotting the gradient in self-reported health by income in Latvia and Sweden.

FIGURE 1: PERCENTAGE REPORTING THEIR HEALTH AS BEING “GOOD” OR “VERY GOOD”, BY HOUSEHOLD INCOME QUINTILE, LATVIA AND SWEDEN, 2011



Source: Emese Mayhew, Jonathan Bradshaw, University of York, UK, personal communication, 2012 (from European Review)

The average life expectancy at birth in England in 2011-13 was 79.4 years for males and 83.1 for females. This average, however, obscures important differences in life expectancy between population groups, as shown in Figures 2 and 3. When neighbourhood deprivation is examined, the median level of inequity across all local authorities in England was 7.9 years for males and 5.9 years for females. The gap between neighbourhoods is even larger when healthy life expectancy (the number of years an individual can expect to spend in very good or good general health) is considered. In 2011-13 healthy life expectancy for males was 54.9 years in Blackpool, the most deprived area in England based on the 2015 classification, while it was 71.4 in Wokingham, the least deprived area – a 16.5-year difference. For females the respective figures were 58.3 and 69.9 years – an 11.6-year difference. In England, people from more deprived areas not only die sooner, but they also spend more of their shorter lives with poor health. [4]

FIGURE 2: MALE LIFE EXPECTANCY AND DISABILITY-FREE LIFE EXPECTANCY (DFLE) AT BIRTH IN 1999-2003 AND 2009-13, BY NEIGHBOURHOOD DEPRIVATION

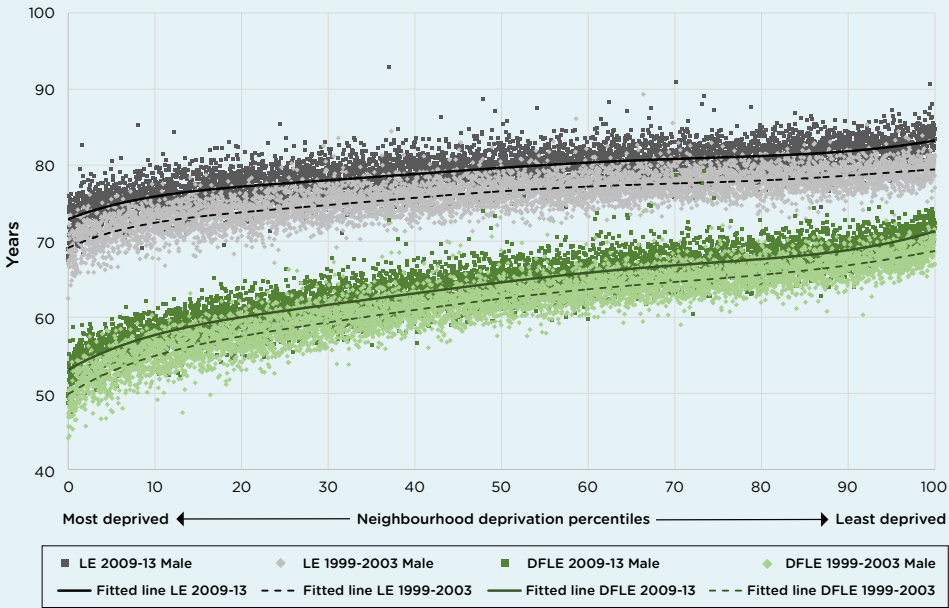
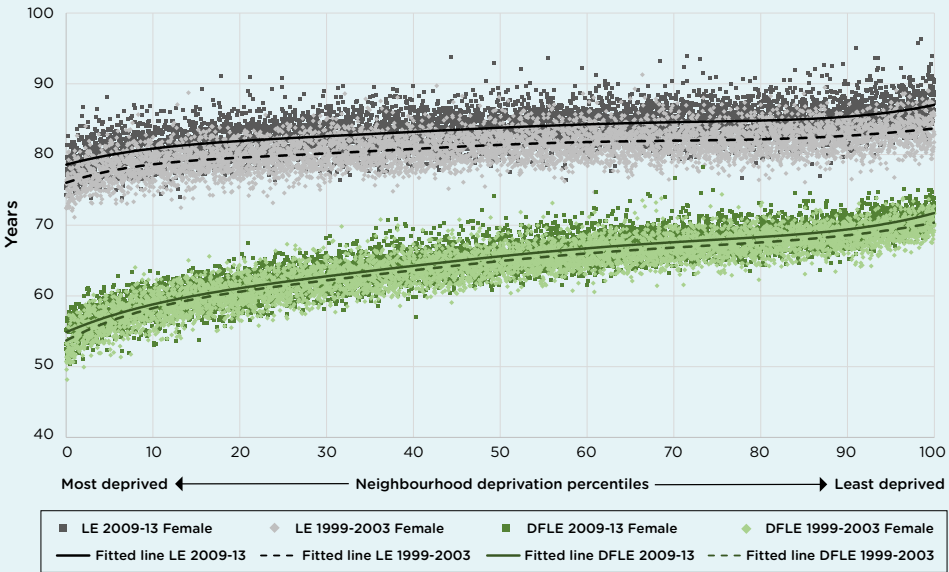
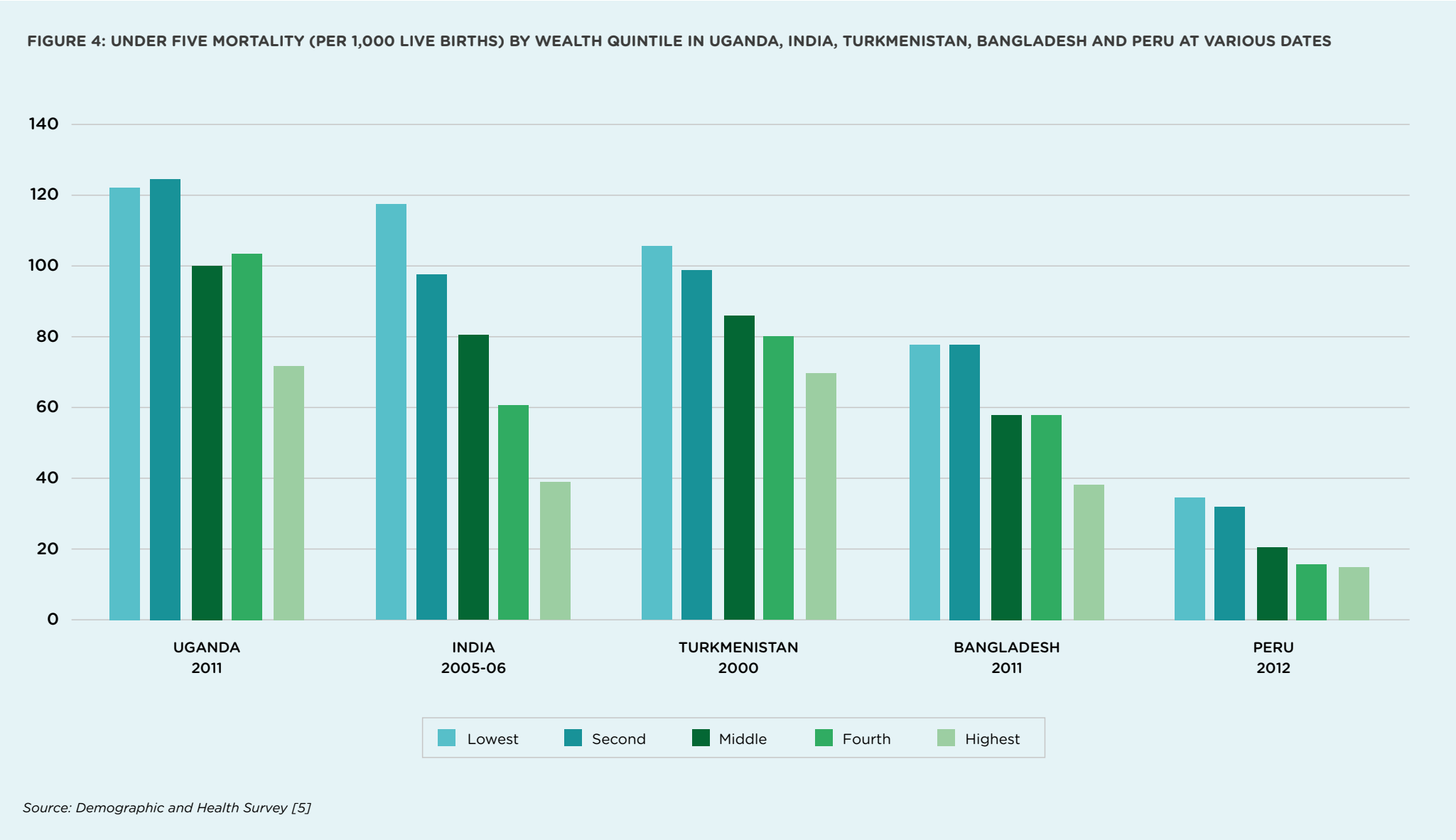


FIGURE 3: FEMALE LIFE EXPECTANCY AND DISABILITY-FREE LIFE EXPECTANCY (DFLE) AT BIRTH IN 1999-2003 AND 2009-13, BY NEIGHBOURHOOD DEPRIVATION



Source: Marmot Indicators 2015 [4]

Life expectancy by socioeconomic status is not routinely measured in all countries; however, data on the social gradient in under-five mortality can often be found. In low and middle-income countries, a clear gradient can be seen in under-five mortality, as shown in Figure 4 below.

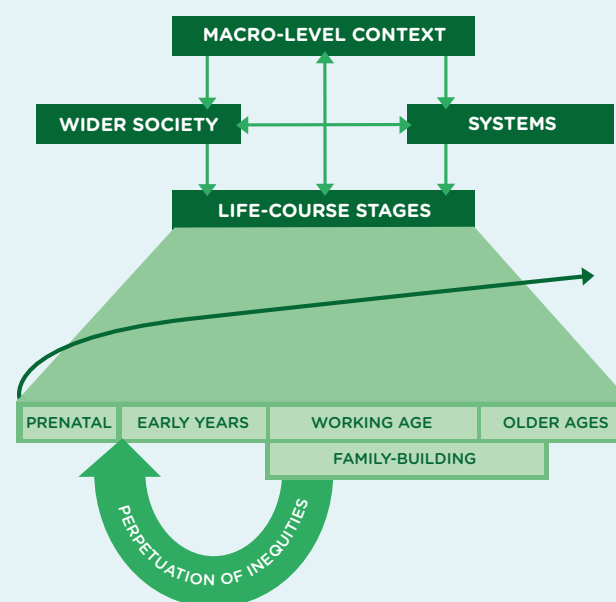


THE SOCIAL DETERMINANTS OF HEALTH

Health inequalities are caused by differences in individuals' exposure to health-damaging (and health-promoting) conditions that accumulate throughout their life. These conditions are influenced by the context in which those individuals live, including the macro-level context (global, socioeconomic and political context); wider society (cohesion and resilience in communities, at the local and national level) and the systems and institutions that interact with individuals and society such as the healthcare system, education and judicial system. [1]

Exposure to these health-damaging (and health-promoting) effects are closely related to an individual's social position, which is influenced by their education, occupation, income and other characteristics such as gender and ethnicity. For example, in New York City the rate of premature death (under 70 years) is 50% higher among black men than among white men. [6] Figure 5 outlines the broad mechanisms that impact on the health of individuals and populations.

FIGURE 5: CONCEPTUAL FRAMEWORK FOR THE SOCIAL DETERMINANTS OF HEALTH, BASED ON THE HEALTH DIVIDE



Source: WHO European Review of Social Determinants of Health [7]

The three principles of action highlighted to tackle the SDH were to improve the conditions of daily life; tackle the inequitable distribution of power, money and resources and to expand the knowledge base through measurement and evaluation.

Twin high priorities for societies generally and in particular health professionals, health systems, governments and civic society, should be to improve the average health of the population and to reduce health inequalities. To do this effectively it is essential to bring the health of less-advantaged people closer to the level of the most-advantaged by tackling the root causes of inequities. The social determinants of health approach looks beyond provision of healthcare to a wide range of social, economic, political and cultural factors that influence people's exposure to health-damaging or health-promoting conditions at each stage of an individual's life. [3] By applying the SDH approach, healthcare could be delivered in a way that more effectively tackles inequalities in health.

While the role of health professionals and health systems has traditionally been seen as influencing individuals and the healthcare system, a growing body of evidence

suggests that health professionals, and the healthcare system, have the levers and influence to improve health for the whole population and help reduce inequities. This report draws on the conceptual models in the Commission on the Social Determinants of Health [3] and the Review of Social Determinants and the Health Divide in the WHO European Region, [7] as outlined in Figure 5 above.

LIFE COURSE IN A SOCIAL DETERMINANTS APPROACH

The life course perspective looks at people's lives and the structural context in which they live over the course of their life. [8] These events can have positive or negative effects on an individual's health and wellbeing. These effects accumulate throughout an individual's life, beginning at gestation and early years development, through educational experiences, reproductive ages and relationship building, to the labour market and income generation during normal working ages, and into later years. Many of these advantages and disadvantages are transmitted across generations from grandparents and parents to children – the 'intergenerational transmission' of inequalities. The life-course perspective should be used to understand the context of patients' lives and is an effective way to plan partnerships and action on social determinants of health appropriately, at every stage of life.

WIDER SOCIETY

At the societal level, actions that generate societal cohesion and mutual responsibility will have the greatest impact on health equity. This includes influencing societal norms and fiscal policies such as social protection, to ensure it is distributed according to need. Even small improvements in legislated social rights and social spending are associated with improved health. [7]

Cultural and societal norms can have a profound effect on an individual's health. For example, the level of trust and support, sometimes referred to as 'social capital', in society is linked to mortality related to coronary heart disease. [9] The lower people are on the socioeconomic gradient, the more likely they are to live in areas of deprivation and have reduced access to social capital. Many vulnerable groups face exclusion and discrimination in society. For example, Europe's Roma people face powerful social, economic, political and cultural exclusionary processes, including prejudice and discrimination, which adversely affects their human rights and self-determination. [10]

The influence of wider society on health means the health system must work closely with other sectors to improve health including work with communities and representative organisations as well as advocate for vulnerable groups who face exclusion.

MACRO-LEVEL CONTEXT

Global and national forces such as global economics, the nature of trade, aid, international agreements and environmental policies, all play an integral role in populations' exposure to health-damaging (and health-promoting) conditions. They affect individuals' and communities' vulnerabilities (and resilience). Factors affecting health and health inequity are often the very same factors determining environmental quality, for example. The poorest are the most likely to experience harm from poor environmental conditions and thus to benefit from interventions that create a healthy environment and more equitable healthcare system. There is a need to integrate health with other social and environmental policies. This points to the need for doctors and medical associations to be aware of this macro-level context, its impact on health and to be empowered to advocate on behalf of communities and individuals whose health is negatively affected by it. For example, there should be awareness of the negative health effects of climate change on individuals in poorer countries and in poorest areas. [11]

SYSTEMS

Health systems and health professionals deal with many health outcomes which are the result of actions in other sectors including that of national and local governments, multinational organisations, foundations, civil society and nongovernmental organisations, academic institutions and corporations. Coherent actions are needed across these sectors to effectively tackle the social determinants of health and reduce health inequities. This has led some countries, such as Finland, to adopt a Health in all Policies Approach (HiAP), [12] which is supported by the WHO. [13] Such action should include a strong focus on health equity, and many have suggested that Health Equity in All Policies should be adopted. [14]

Health systems should be designed and governed to reduce the social gradient in health inequity by following the principle of proportionate universalism. Often efforts to improve health equity focus only on the most excluded, who have the worst health; however, this means only a small proportion of those suffering unfair health inequities will benefit. The clear social gradient in health in countries across the world, for a range of health outcomes, shows that health inequities affect everyone to some degree, except perhaps, those at the very top. Therefore, efforts to increase health equity need to focus on lifting and flattening the gradient. This requires universal effort, for the whole population, but proportionate to need across the whole social class gradient – with those groups with the worst health and most disadvantaged having the most support. For doctors and health systems, this suggests that health services and community interactions should be designed in a way which is universal but proportionate to need. This concept is called proportionate universalism.

SOCIAL DETERMINANTS OF HEALTH AND THE WMA

Health professionals are witnesses to inequalities and see the outcomes on a daily basis. However, doctors' potential impact on these inequalities, through action on the social determinants of health is often under-developed. The World Medical Association (WMA) is an independent confederation of 111 national medical associations. As the only organisation representing the voice of the medical profession globally, it plays a key role in setting standards and advocating on behalf of doctors and medical students and for a healthy society.

At the World Health Assembly in May 2009 the WMA, on behalf of the World Health Professions Alliance (WHPA), presented a statement welcoming the WHO Commission on the Social Determinants of Health report for its holistic approach to healthcare but called into question the lack of emphasis on the role of health professionals in tackling health inequalities. [15] At the WMA General Assembly in Delhi, 2009, the WMA formally recognised the importance of SDH [16] and made the following recommendations:

- Recognise the importance of health inequity and the need to influence national policy and action for its prevention and reduction.
- Identify the social and cultural risk factors to which patients and families are exposed and plan clinical activities (diagnostic and treatment) to counter their consequences.
- Advocate for the abolition of financial barriers to obtaining medical care.

- Advocate for equal access to healthcare services irrespective of geographic, economic, social, age, gender, religious, ethnic or economic differences, or sexual orientation.
- Require the inclusion of health inequity studies (including the scope, severity, causes, health, economic and social implications) as well as the provision of cultural competence tools, at all levels of academic medical training, including further training for those already in clinical practice.

This commitment was reinforced at the 2011 WMA General Assembly, at which the role of doctors as informed participants in the debate and advocates for action was stated. [17] The WMA defined its role as being to:

- understand what the emerging evidence shows and what works, in different circumstances
- help doctors to lobby more effectively within their countries and across international borders, and ensure that medical knowledge and skills are shared

- gather data on examples of good practice from its members and promote further work in these areas
- help to engage doctors and other health professionals in trying new and innovative solutions
- work with national associations to educate and inform their members and put pressure on national governments to take appropriate steps towards minimising the root causes of premature ill health.

At the WMA Council meeting in 2015 it was agreed to formally adopt a declaration on the social determinants of health. The Declaration of Oslo was given support by the General Medical Assembly in Moscow in 2015. [18] This report aims to use the best evidence to support and develop this declaration and to support nmas and the WMA to plan action on the SDH. A number of national medical associations around the world are enthusiastic about working on SDH; this report provides evidence and examples of how doctors and related organisations can tackle SDH effectively.

CURRENT GUIDELINES FOR HEALTH PROFESSIONALS ON THE SOCIAL DETERMINANTS OF HEALTH

While the WMA's primary focus for addressing the social determinants of health has been on fostering and supporting national policy changes by government, there is growing recognition of the need to also target the "lived experience of inequalities" [19] in healthcare settings. [20]

For example, a child with asthma living in a damp home requires remedial action on the causes of the poor health – the cold, damp home. Doctors may request that appropriate housing is found or improvements to the home made. A doctor could also advocate with housing providers and commissioners about the likelihood that damp housing will lead to more cases of asthma in the community, draining healthcare resources, impacting on children's education, wellbeing and activity levels.

However, clear guidance on how doctors can influence and improve the social determinants of health has been minimal. A forthcoming review of recommendations internationally for doctors to tackle the SDH [21] demonstrated that only 13% of all recommendations were 'downstream' (actions that could be taken at the local level) and many provided limited practical guidance for adopting practices. Of these, only 14 were published by national medical associations and colleges, mostly in developed countries, Australia, Canada and the UK. Guidance on what health professionals can do in resource-poor settings has been lacking.

This report builds on the Institute of Health Equity's Working for Health Equity report, [22] which included commitments

to action from a number of health professional bodies in England. Recommendations focused on six core areas:

- Workforce education and training
- Working with individuals and communities
- Health service organisations – as managers, employers and commissioners
- Working in partnership
- Workforce as advocates
- The health system – challenges and opportunities

Twenty-one health professional organisations and medical royal colleges in the UK participated in the Working for Health Equity report, including midwives, paramedics, dietitians, physiotherapists and speech and language therapists. Each organisation provided statements about actions that health professionals could take in their practitioner roles, and made a series of commitments for future work. Since then, numerous positive actions have been taken by a range of professionals. For example the Royal College of Physicians of London (RCP) published the report The Future Hospital Commission, [23] 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). [24]

Another example is the Royal College of GPs' Social Inclusion Commissioning Guide, produced with the University of Birmingham in England. [25] 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]

Health professionals and medical associations are already involved in a range of inspiring and positive actions. This report aims to highlight what is happening internationally, and to set out a strategy for the

WMA, national medical associations and medical professionals on how to better incorporate the social determinants of health into their work. The approaches set out for this strategy are categorised according to the following sections:

GUIDELINES FOR DOCTORS: TACKLING THE SOCIAL DETERMINANTS OF HEALTH (SDOH)

UNDERSTANDING THE ISSUE AND WHAT TO DO ABOUT IT: EDUCATION AND TRAINING

- Improve access to medical training and education
- teach the practical skills and competencies to address health inequality.
- using different channels, such as e-learning and community involvement to teach health professionals
- develop the social agency of doctors

THE CLINICAL SETTING: WORKING WITH INDIVIDUALS AND COMMUNITIES

- rethinking consultation times and formats
- taking social history, care planning and social prescribing
- creating networks in neighbourhoods

HEALTH PROFESSIONALS AS ADVOCATES

- for individuals and communities
- for working conditions of doctors and other health staff
- doctors as advocates for health changes nationally and internationally
- supporting students as advocates

BUILDING THE EVIDENCE: MONITORING AND EVALUATION

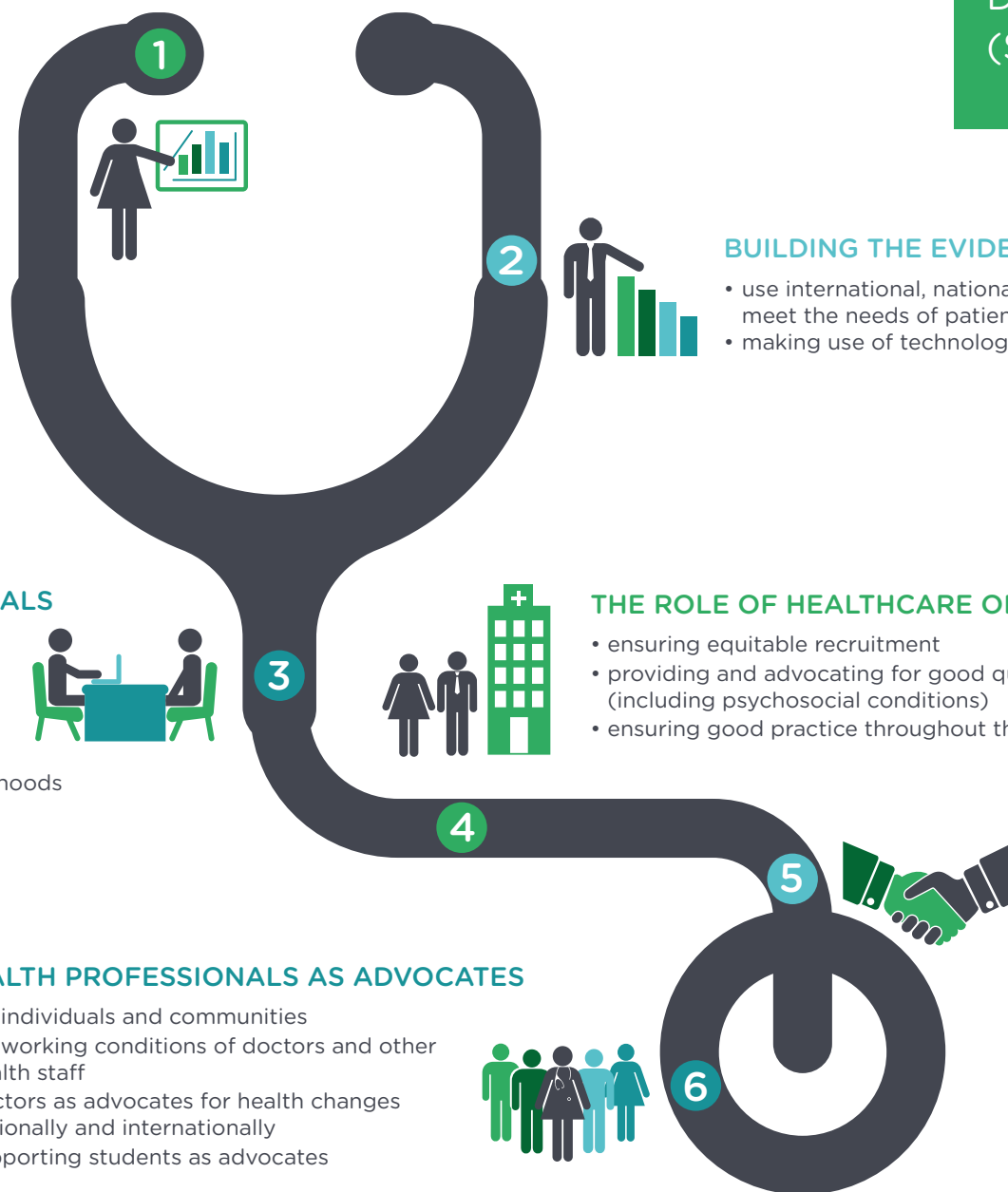
- use international, national and local level data to help design services to meet the needs of patients and communities
- making use of technology to capture data

THE ROLE OF HEALTHCARE ORGANISATIONS

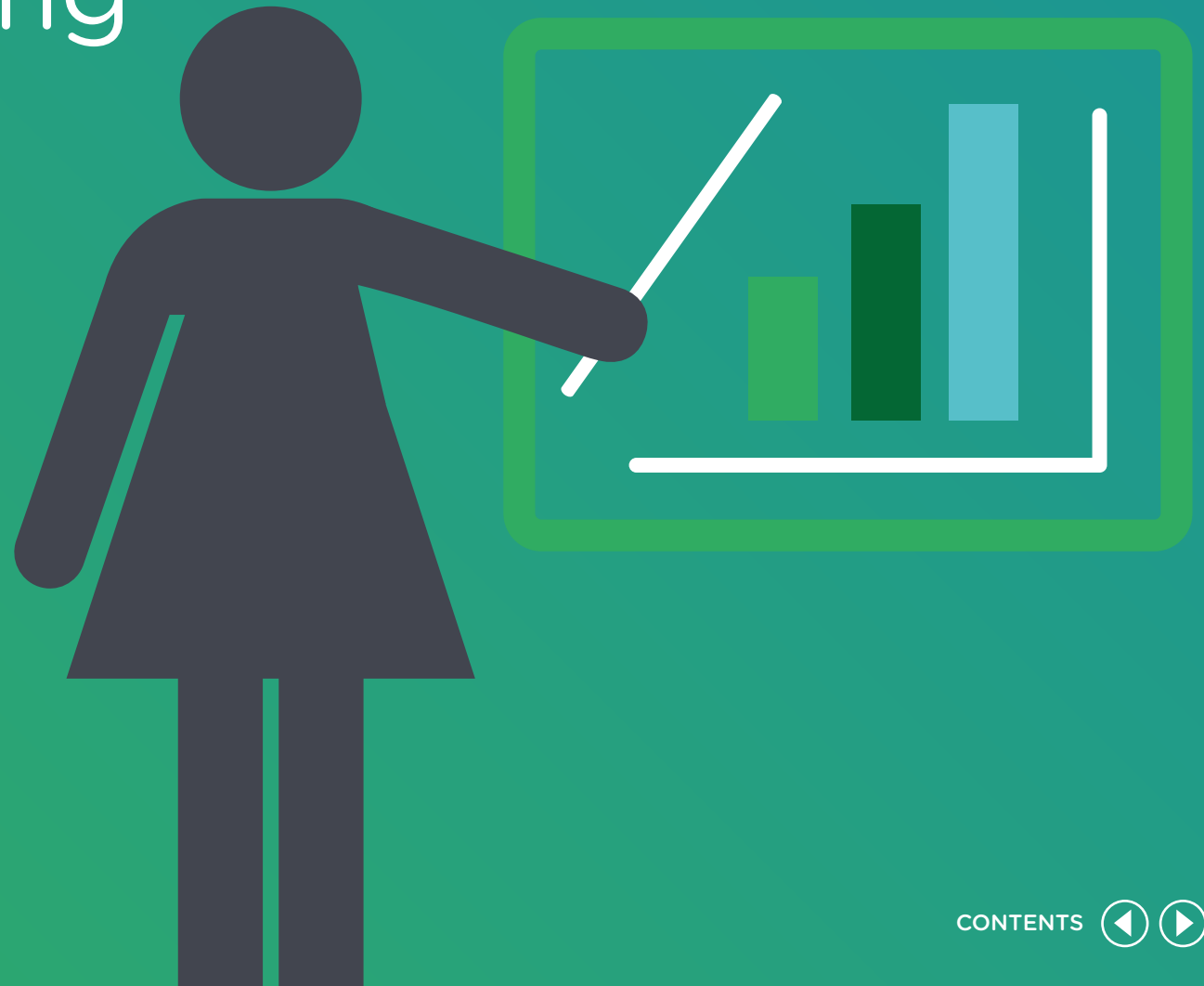
- ensuring equitable recruitment
- providing and advocating for good quality employment (including psychosocial conditions)
- ensuring good practice throughout the procurement chain

WORKING IN PARTNERSHIP: WITHIN THE HEALTH SECTOR AND BEYOND

- form partnerships both inside and outside the health service
- work with a range of local organisations and services
- work across government sectors such as education and environment, to ensure the health implications of decisions are considered



1 Understanding the issue and what to do about it: education and training



In order for medical professionals to improve the social determinants of health, and achieve success in reducing health inequalities, the right education and training is essential.

In many countries the education of health professionals does not include any focus on the social determinants of health – the real drivers of poor health and inequity. While professionals are comfortable with interventions around individual level factors that affect health, training in broader community and social factors is generally lacking, meaning professionals are less experienced with this type of intervention. [27] This has led some national medical associations to call for the social determinants to be included in the curriculum for health professionals. For example, 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. [28]

This report shows ways of bolstering education around these issues, to improve understanding among health professionals and to lead to greater embedding of appropriate practices and advocacy roles.



INCORPORATING THE SOCIAL DETERMINANTS OF HEALTH INTO THE EDUCATION CURRICULUM

One of the purposes of the education of doctors, at both undergraduate and postgraduate training level, should be to enhance the performance of health systems to meet the needs of people and populations in an efficient and equitable manner. The Commission on the Education of Health Professionals categorised the challenges to health professional education according to the 'four Cs', which have the potential to reduce health inequality if adopted [29, 30]

- **Criteria for admission:** Professional students are disproportionately admitted from the higher social classes and dominant ethnic groups. Efforts should include upstream criteria such as social equity in admissions and scholarships for disadvantaged students.
- **Competencies:** Students should be trained on competencies that tackle the social determinants of health such as communication, partnership and advocacy skills.
- **Channels:** Efforts should be made to mobilise all learning channels to their full potential, for example through lectures, small student learning groups, team-based education, early patient or population exposure, different worksite training bases, long-term relationships with patients and communities, and IT.

- **Career pathways:** While not every professional graduate needs to be a social reformer, artificial barriers should not be constructed to block the social agency of professionals. As Frenk, states: "Health professions should be exposed to the humanities, ethics, social sciences, and notions of social justice to perform as professionals and to join in public reasoning as informed citizens". p.1946 [29]

These categories are useful to explore how the social determinants of health can be better integrated into the education of doctors.

CRITERIA FOR ADMISSION

Access to the medical profession by minorities and people from lower socioeconomic groups is a growing concern in many countries. For example, in the UK only 6.3% of medical students studying in 2013 grew up in the most deprived areas of the UK, [31] and 20% of secondary schools provide 80% of applicants to medicine. [32] Individuals from lower socioeconomic groups are less likely to apply and have lower acceptance rates due to a number of disincentives such as the cost of training. [33] Only 4% of US doctors are African American, compared with 13% of the population, and the number of African American medical school graduates has not increased noticeably in the past decade. [34]

Improving access to the medical profession can impact on social determinants of health in a number of ways. Firstly, considering the strong evidence of the positive impact of good quality work on health, increasing employment opportunities for people from lower socioeconomic groups has the potential to improve health and reduce the social gradient. There is also evidence that people from more deprived areas are more likely to work in deprived areas, [35] which are traditionally underserved by the health service internationally. [36] [37] Finally, an increased diversity in the workforce should lead to a more culturally competent workforce, with the knowledge, skills, attitudes, and behaviour required of a practitioner to provide care to persons from a wide range of cultural and ethnic backgrounds. [38]

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. [28] In the UK, the Medical Schools Council (representing undergraduate medical schools in the UK) produced a number of guidelines to widen participation and access to medical education for people from lower socioeconomic groups, [32] with a series of ten-year targets to monitor progress.

These recommendations include:

- the expansion of outreach activity
- the provision of more work experience for students from disadvantaged backgrounds in the health system
- the use of more 'contextualised' admission processes.

A number of universities are working towards implementing this, such as the University of Glasgow, as outlined in case study 1.

In 2013 (ELAM) was the largest medical school in the world, enrolling approximately 19,550 students on full scholarships from 110 countries.

CASE STUDY 1: WIDENING OPPORTUNITIES FOR ALL TO STUDY MEDICINE, UNIVERSITY OF GLASGOW, SCOTLAND [39]

The University of Glasgow has seen a substantial increase in the average number of entrants to its Medical School from the 40% most deprived areas from an annual average of 10.6 students in 2009–11 to an average of 19.6 students between 2012 and 2014. This was achieved through a number of activities:

- adopting the Reach Programme: a national project to raise awareness of and encourage, support and prepare secondary school students wishing to pursue professional degrees.
- applying contextual information in considering applicants and adopting related flexibility, which allows many candidates to progress to interview who would otherwise not have reached that stage.
- applying a broad definition of 'work experience' to enable all applicants to be considered, irrespective of ability to obtain direct experience in the health sector.
- considering applicants' flexibly under 'extenuating circumstances' and accepting students from this process on an annual basis.
- involving a significant number of student ambassadors in recruitment and admissions activity to represent the diversity within the student body.
- not issuing interviewers with application forms, to minimise preconceptions during the process.
- forging close working relationships in the university and externally.
- implementing a Certificate of Higher Education (Pre-med, Pre-dent) for government sponsored international students, to further increase the opportunity for student diversity.

UNIVERSITY OF GLASGOW...



Many lower and middle income countries (LMICs) are developing education programmes to train health professionals, given shortages of healthcare professionals, as discussed in Section 4. For example, the Rwandan Ministry of Health has developed Human Resources for Health, a long-term strategy and implementation plan to increase the quantity of health professionals in the country, as well as the quality and diversity of their training. [40] Zambia has developed a one-year community health worker course for individuals and local communities with the hope that many will progress to higher positions in the health profession such as nurses (see case study in section 4). Cuba has developed an innovative medical school for individuals from LMICs, discussed in case study 2.

Education on the social determinants of health should be a mandatory core element of all undergraduate courses.

CASE STUDY 2: ESCUELA LATINOAMERICANA DE MEDICINA (ELAM) (LATIN AMERICAN SCHOOL OF MEDICINE), CUBA [41]

ELAM was established in 1999 to provide medical education to individuals from LMICs, and in 2013 it was the largest medical school in the world, enrolling approximately 19,550 students on full scholarships from 110 countries. It is officially recognised by the Educational Commission for Foreign Medical Graduates (ECFMG) and the World Health Organisation. While initially only students from Latin America and the Caribbean could enrol, it is now open to candidates from low income or medically under-served areas in Africa, Asia and the United States .

Preference is given to applicants who are from lower socioeconomic groups and/or people of colour who show the most commitment to working in their disadvantaged communities – 80% of graduates end up working in poor rural communities.

The full scholarship includes medical education in general medicine. All doctors interested in specialising must first serve two years working in primary care, and graduating doctors are not driven to specialise by salary incentives. [42] The scholarship also includes full tuition, dormitory housing, three meals per day at the campus cafeteria, textbooks in Spanish for all courses, school uniform, basic toiletries, bedding and a small monthly stipend.

In 2012 Cuba sent more doctors to assist in developing countries than the entire G8 combined, according to Robert Huish, an international development professor at Dalhousie University who has studied ELAM for eight years. [43]

COMPETENCIES

‘Competencies’ refers to the development of practical skills. For the education of health professionals to address health inequity, it needs to go beyond a theoretical understanding of the nature of the social determinants of health, to include non-medical practical competencies that can reduce inequity through action on the social determinants. These skills could include taking social histories, communicating in an advocacy role, working in effective partnerships, and commissioning services equitably. The section below on working with individuals and communities goes into more detail about how to harness these skills to reduce inequalities.

The Royal College of Physicians of London has stated that training on the social determinants of health needs to be embedded as a ‘vertical thread’ at every stage of the education curriculum and training. [22] Examples of how this can be achieved are outlined below.

UNDERGRADUATE AND POSTGRADUATE

Education on the social determinants of health should be a mandatory core element of all undergraduate courses. [22] This should include identifying the inequitable impacts of social determinants on health outcomes seen in patients, understanding inequalities in population health, reflecting on the impact at individual, family and community levels. The curriculum should include evidence on what works in practice and provide specific steps that can be taken. The Royal College of Physicians (London) suggests that strong and active role models are needed in training, not only medical practitioners but from other sectors such as social work, the third sector and childcare specialists. [44] Maryon-Davis (2011) suggests that rotations in community-based specialities, such as general practice, community paediatrics and public health, should be considered and that shared learning programmes

and placements between clinical specialities and public health could be productive. [45] The Royal College of Physicians recommended that an element of primary care and/or public health should be included in the foundation training of all junior doctors to allow them to work more directly with health inequalities issues.

A community health centre serving a Latino immigrant population, Puentes de Salud, in Philadelphia, USA, introduced a service-learning course called the Health Scholars Program (HSP). It includes didactic instruction, service experiences and opportunities for critical reflection. The HSP curriculum also includes a longitudinal project where students develop, implement and evaluate an intervention to address a community-defined need. Medical students who had completed the course said they had learnt more about health inequalities in the HSP than in their formal medical training and many stated a long-term desire to serve vulnerable communities as a result. [46]

O'Brien and colleagues point to the need to develop and monitor community level outcomes. [46] Medical schools should develop a coherent strategy to teach the social determinants of health, exploring both didactic teaching elements and other channels such as community services, although this should incorporate the need to define and monitor community level outcomes. A number of case studies of universities that have incorporated the social determinants of health into their education are included in case study 4.

CASE STUDY 3: UCL MEDICAL SCHOOL SOCIAL DETERMINANTS OF HEALTH MODULE [47]

The Social Determinants of Health Module at University College London (UK) aims to educate undergraduate medical students about the social determinants of health and train them to integrate and apply this knowledge to every clinical problem and each individual patient they encounter during their studies and throughout their medical careers. This is incorporated throughout their undergraduate education, as described below:

Year 1: Focus on theory and evidence regarding the effects of the social determinants on everyday medical practice, and variation in causation and outcomes of ill health – locally and globally; linked to community and GP placements and community visitors.

Year 2: Focus on doctor-patient communication, health promotion, and individual experience of health and healthcare; linked to community visitors, disability workshops and community/GP placements.

Year 4: Focus on access and equity in healthcare, disease prevention and health promotion; and population and individual perspectives, especially vulnerable people.

Year 5: Focus on public health dimensions of horizontal modules (communicable diseases, drugs and alcohol, and mental health); health systems case studies – local, national and global; and transnational threats to health. Introducing the Global Health and Electives Portfolio.

Year 6: Completion of Global Health and Electives Portfolio.

This is achieved through a combination of lectures, workshops, GP placements and community visitors and assessed through exam questions, reflective reports and as part of an online portfolio.

CASE STUDY 4: UNIVERSITIES INCORPORATING THE SOCIAL DETERMINANTS OF HEALTH IN MEDICAL TRAINING

Leeds School of Medicine (UK) has incorporated the social determinants of health and health inequalities into its teaching: [48]

- There is emphasis on the importance of communicating effectively and working in partnership with patients, carers and their family members.
- Patients and carers are involved in the teaching of students through the Patient Carer Community based at the university.
- First and second year medical students arrange a community visit to a voluntary group to allow them to think more holistically and learn of the importance of the voluntary sector as potential partners in healthcare delivery.
- A podcast is delivered for students on poverty and the social determinants of health.

The Centre on Social Disparities in Health at the University of California, San Francisco, School of Medicine (UCSF) (US) [49] incorporates the following:

- Second year students are required to take the course 'Determinants of Health'.
- Students have an immersion experience with a community service organisation and reflect on how their personal assumptions about marginalised racial and socioeconomic groups might shape their practice of medicine.

At the University of Pennsylvania Perelman School of Medicine (US) [49]:

- Trainee physicians work in multidisciplinary research teams which include economists, sociologists, anthropologists, nurses, business faculty and physicians, who work together in the local community to understand the social determinants of health.
- Ongoing pilot projects are hosted to help patients maintain health after a hospitalisation by connecting them with community resources. For example, medical students used a peer-mentoring model to help black men manage their diabetes, leading to substantial improvement in the men's diabetes care.

The University of New Mexico Health Sciences Centre and New Mexico state (US) have developed the Health Extension Rural Offices (HEROs) program [49]:

- Twelve health extension agents identify priority areas in specific communities (such as school retention, food insecurity and local economic development) and link the needs with university resources in education, clinical care and research.
- A pipeline programme for medical students to visit tribal areas has been established.
- Health extension agents have trained community health workers who are now in one-third of New Mexico counties, and HEROs plans to train more.

The Culturally Competent in Medical Education (C2ME) project includes 11 medical schools in the European Union, which has defined a set of knowledge and skills (for example, basic knowledge of ethnic and social determinants of health):

- Skills to teach in a non-judgmental way
- Skills to engage, motivate, and encourage participation of all students
- Skills that all teachers need in order to incorporate cultural competence topics into their teaching. [50]

CONTINUAL PROFESSIONAL DEVELOPMENT

Continual Professional Development (CPD) should be “flexible, practice based and work based”. (p. 56) [22] It should also be free, universally available and provide incentives to professionals to take part. CPD should provide a broad assessment of the social and economic conditions that affect health, and of strategies and successful practices that can reduce inequalities. Typical opportunities include certificated modules in public health, an MSc in public health-related subjects, work-based learning networks and structured seminars, workshops and conferences. Medical associations often provide CPD for public health professionals and there is room for them to develop CPD on health inequalities and the social determinants of health.

CASE STUDY 5: E-LEARNING ON THE SOCIAL DETERMINANTS OF HEALTH: ROYAL COLLEGE OF PHYSICIANS AND THE ROYAL COLLEGE OF MIDWIVES, UK [24]

The Institute of Health Equity is working with both the Royal College of Physicians and the Royal College of Midwives to develop an online learning tool on the social determinants of health that will be CPD-certified. This course will be interactive and include key information and skills that will help physicians to tackle the social determinants of health in their everyday work life.

CHANNELS

‘Channels’ are defined in this report as all of the learning channels that can be used to effectively teach health professionals about the social determinants of health and to reach populations and groups who do not have physical or financial access to major education centres. This can include different worksite training bases, long-term relationships with patients and communities, reflective learning and online courses. Case studies that incorporate wider determinants of health not traditionally employed in medical education can also be used to explore doctors’ role in reducing health inequity, this was done in South Africa, as discussed in case study 6.

CASE STUDY 6: INCORPORATING ENVIRONMENTAL DETERMINANTS OF HEALTH INTO MEDICAL TRAINING AND LINKING RESEARCH TO TRAINING AND PRACTICE, UNIVERSITY OF CAPE TOWN, SOUTH AFRICA [51]

The University of Cape Town employs a novel case study to teach medical students of the importance of doctors engaging in wider determinants of health; in this case, the use of pesticides. Many low socioeconomic communities face large burdens from domestic pests, common in many developing countries, leading to the wide use of pesticides sold in unregulated markets. As a result, childhood pesticide poisoning due to the presence of toxic chemicals used for domestic vermin control is a common but unreported problem.

Research in the Division of Environmental Health in the School of Public Health and Family at the University of Cape Town found that intervening by providing informal vendors to replace the highly toxic pesticides sold illegally on the streets with mechanical rat traps was effective in reducing small children’s exposure to chemicals and was well received by township residents as a safer pest control method. Linked to this research was the development of a point chart and cell phone app to assist in the identification of pesticide agents, improve diagnosis and enhance reporting for surveillance purposes. This research is used in teaching to illustrate how

important environmental determinants of health are for students in the health professions. This includes:

- Medical students learning to identify and list the environmental exposure risks relevant for patients’ socioeconomic status.
- Training all medical students on how to conduct an ‘environmental history’ with patients as part of their diagnostic screening tools, particularly using the mnemonic CH2OPD2 – community, home, hobbies, occupation, personal habits, diet, and drugs. [52]
- Improving the notification of medical notifiable conditions linked to environmental factors by training students to identify and link environmental linked diseases.
- Training medical students to identify pesticide exposures and poisonings, particularly linked to products that are unlabelled and decanted. [53]
- Participating in 2015 and 2016 in an International Association for Medical Education (AMME) symposium on building environmentally accountable curriculums for medical students and medical schools.
- Providing medical students with an understanding of climate change impacts on health, opportunities for improving health through climate change mitigation measures, and illustrating the active role medical students and future doctors can play.



Experiential training is important and placements with community groups, charities and social care networks allow students to understand how a variety of social situations affect the health of the people living within them, enabling students to develop a sense of social responsibility. [54] [55] The University of Hong Kong is piloting a 'service learning' programme in partnership with local NGOs, targeting populations that are socially disadvantaged. Students will work on site in both medical-related and non-medical work. [56]

CASE STUDY 7: COMMUNITY DIAGNOSIS PROGRAMME, KATHMANDU MEDICAL COLLEGE, NEPAL [57]

The Community Diagnosis Programme (CDP) is a community-oriented approach to the education of doctors, nurses and dentists. Second-year medical students visit a nearby community with a number of objectives, including the identification of the various socio-cultural, economic and environmental factors that underlie the health problems in the community and to find solutions to them. A review of the programme in Gundu Village, Bhaktapur, Nepal, demonstrates that students benefit from the integrated training in clinical skills and public health in real-life situations, as well as gaining a deeper understanding of the problems facing communities. The community also benefited from an increased awareness of health-related matters and there was evidence of behavioural changes towards healthier lifestyles being made.

Technology and the internet open up a number of ways to educate a wide group of health professionals on the social determinants of health with the most up-to-date research and evidence of good practice, as case study 8 demonstrates.



CASE STUDY 8: WHO EBOOK [58]

The WHO eBook on integrating a Social Determinants of Health Approach into Health Workforce Education and Training will provide a framework that articulates and demonstrates the relevance of the SDH approach to transformative health workforce education and training.

It aims to draw together the best global resources on SDH, illustrated with cases studies drawn from around the world, and is designed to be used on multiple platforms. [59]

CAREER PATHWAYS

The education of medical professionals needs to go beyond the acquisition of knowledge and skills to include the development of professional attributes such as behaviour, identity and values. This professionalism should promote quality and teamwork, have a strong foundation in ethics and be centred on the interests of patients and populations. [29] A rights-based approach to health has been promoted as a means of educating professionals on equitable policies and programmes. [60]

Medical students often enter the profession with a passion and commitment to tackle the SDH and health inequity, and are highly mobilised to do so. For example, the International Federation of Medical Students Associations (IFMSA) staged 'white coat die ins' around the USA to protest against health inequity experienced by African Americans. [61] More generally, IFMSA has developed a Global Health Equity Initiative; see case study 9. This interest is not driven or developed by its core curriculum, but by non-taught activities. Students should be given the opportunity to develop this interest and necessary skills within their professional training and national medical associations should work with student groups that are mobilised to tackle the social determinants of health. Some of these initiatives are outlined in case study 10.

CASE STUDY 9: THE INTERNATIONAL FEDERATION OF MEDICAL STUDENTS ASSOCIATIONS (IFMSA) GLOBAL HEALTH EQUITY INITIATIVE [62]

The IFMSA Global Health Equity Initiative was established to provide:

- Institutional voice for global health equity within IFMSA
- Accessible information, capacity-building tools and technical guidance on global health equity for IFMSA members
- A dynamic forum for exchange and dialogue
- A key platform for advocacy and campaign for global health equity within the Federation and to the larger global health arena

CASE STUDY 10: AUSTRALIAN MEDICAL STUDENTS ASSOCIATION CAMPAIGN TO INFLUENCE AUSTRALIAN MEDICAL SCHOOLS [63]

The Australian Medical Students Association campaigned for medical schools to adopt medical curricula that were adapted to local contexts, and equip all students with the skills to deal with health inequities. This would require graduates to demonstrate:

- A social accountability to the local and global communities they serve
- A sound knowledge of the social determinants of good health and of health inequities
- The ability to place individual patient care within the context of globally integrated systems
- Skills for patient and global health advocacy such as: leadership, policy analysis and social change theory.

The education of medical professionals needs to go beyond the acquisition of knowledge and skills to include the development of professional attributes such as behaviour, identity and values.

WHAT THE WMA CAN DO

The WMA has no direct influence on the education of medical professionals at any level (undergraduate or postgraduate). However, as the only organisation representing the voice of the medical profession globally, it has a large influence on gathering consensus of best practice in the medical profession. The following is a list of our recommendations for what it can do.

- Issue a declaration on the need for mandatory core elements of SDH in education
- Promote that declaration internationally and to its membership
- Produce training material for professional development including e-learning materials, meetings and workshops
- Work with student groups and educational bodies to issue a statement on core knowledge and skills that should be taught around the SDH
- Learn from low and middle-income countries, and from students and junior doctors there who have a huge wealth of experience about what needs to be done to tackle poverty and exclusion

WHAT NATIONAL MEDICAL ASSOCIATIONS CAN DO

As with the WMA, the power of national medical associations to influence the undergraduate and postgraduate curriculum is limited, but they could still influence education at a number of levels, as the following examples show.

- Review the existing arrangements medical schools have on the SDH and work nationally to influence the curricula by:
 - Encouraging those involved in medical training to develop and implement policies that support the entry and completion of medical studies from disadvantaged groups.
 - pressing those regulating medical education to include social determinants as a core element of the curriculum
 - liaising with and encouraging medical schools to embed a greater understanding of the SDH and skills training throughout undergraduate and postgraduate training
 - ensuring that education providers are competent and capable to educate on the SDH
 - advocating that specific skills training on working with individuals and communities are incorporated into education, including cultural sensitivity training
- Work with student groups and young professionals to empower them to advocate for the teaching on the SDH to be included at their universities
- Produce training materials for professional development, and encourage members to participate in training.

WHAT DOCTORS CAN DO

- 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 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.

2 Building the evidence: monitoring and evaluation



“
To make
people
count, we
first need
to be able
to count
people
”

Dr Lee Jong-Wook,
Former Director-General WHO [64]

Health inequity monitoring is the process of tracking the health of a population according to key socioeconomic variables. It is an important tool for providing information for policies, programmes and practices to reduce health inequity. While evidence shows the social determinants of health to have a huge influence on the health of populations, in many settings standard data collection often fails to take the SDH into account. By failing to capture this information, an accurate understanding of the impact of key health determinants over time is not possible, nor is an informed appraisal of the likely impact of policies and programmes on the social determinants. This also means that health professionals will not be able to accurately serve their communities based on their needs.

There is also a need to evaluate interventions to learn and share best practice at the local, national and international level. This will help to build momentum for change. Health professionals and national medical associations could be key players in achieving this by advocating for national monitoring systems. At a recent symposium on the role of health professionals in tackling health inequity [65], the importance of data collection was raised by many professionals as a vital component to understand what works in different contexts. It is therefore a key aspect of what the WMA, national medical associations and doctors can do to develop the agenda on the social determinants of health.

Best practice information-sharing on how to tackle the social determinants of health should be encouraged and centralised at the national and international level, and should be a key component of the work of the WMA, national medical associations and of individual doctors.

Data collection should directly inform planning at the individual, community and national level. Strategies to collect information should feed into personalised patient care, programme design, commissioning and policy decisions. The Robert Wood Johnson Foundation [66] suggests that evidence collection should:

- 1 build a shared value of health that incorporates the role of social cohesion so that individuals feel a sense of community and the role of collective action
- 2 foster collaboration to improve wellbeing across sectors (for example, hospitals, other healthcare institutions schools, government, business and community based-organisations)
- 3 create healthier and more equitable community environments by building a science around the policies and practices that measurably reduce health inequalities
- 4 transform health and healthcare systems.

Monitoring and evaluation should happen both at the national and local level. SDH should inform monitoring in two ways. Firstly, there is a need to evaluate social interventions more accurately to ensure that these programmes are accurately and effectively designed to reduce health inequity. SDH should also be used as indicators in health services to monitor at-risk populations. At the individual level, an example can be found in Section 3, where we discuss the Ontario College of Family Physicians' Primary Care Interventions in Poverty, [67] a tool for physicians to monitor for poverty but which importantly also signposts patients to appropriate services and ensures they received all the benefits to which they were entitled.

NATIONAL LEVEL

To understand health inequalities at a regional and national level, there is a need to have accurate monitoring systems in place. These systems should incorporate health outcomes such as life expectancy and morbidity with wider society level data that are known to impact on health, for example, housing situation, employment, education, ethnicity and social protection. These national and local level data can help practitioners to prioritise action where need is greatest and to evaluate the success of their strategies.

CASE STUDY 11: PRODUCTION OF SDH INDICATORS, ENGLAND

The UCL Institute of Health Equity produces SDH indicators in England for every local government authority. They give a picture of how England is doing overall for each indicator and how each local authority is doing in relation to the England and regional averages. This enables identification of good practice, outliers and changes over time. [68]

The Public Health Outcomes Framework developed by Public Health England provides a more general overview of public health at the national and local level, and has some specific indicators to measure the wider determinants of health. [69]

Both of these tools could be utilised by health professionals for advocacy purposes and for understanding local health and health equity profiles.

In the Netherlands, the Ministry of Health surveyed general practice to reveal the associations between educational status and some diseases. The data helps general practice understand their local populations and likely health risks.

CASE STUDY 12: DUTCH NATIONAL SURVEY OF GENERAL PRACTICE (DNSGP), NETHERLANDS [70]

The Dutch Ministry of Health has conducted a series of National Surveys of General Practice (DNSGP1 and DNSGP-2) to monitor public health and health inequalities in the Netherlands through general practice. In the Dutch healthcare system almost all Dutch residents are registered with a GP, who are based in communities, and the accessibility of general practice is considered good.

The data include background information on patients collected via a census, approximately 12,000 health interview surveys per time point and more than one million recorded contacts of patients with their GPs in two survey years. The results clearly showed that while low educational attainment played no part in presenting health problems to the GP in the Netherlands, it was associated with the development of chronic conditions and self-reports of good health. This was particularly evident for diabetes and myocardial infarction.

LOCAL LEVEL

Many health services and doctors regularly engage with social interventions that could positively impact on the SDH. However, these interventions are rarely monitored and evaluated. For example, a review in the UK of social prescribing (as discussed in Section 3) found that 60% of the reviewed programmes had not been subject to any formal means of assessment. [71]

There are many advantages to setting up SDH-based interventions with methods of evaluation in place from the beginning, to compare baseline measures. However, there is no universal evaluation methodology that should be applied as this depends on a number of factors such as budget, expectations of funders and available resources as well as suitable outcome measures and needs of participants. An example of a well evaluated intervention is outlined in case study 13.

CASE STUDY 13: WELL LONDON – A CLUSTER RANDOMISED TRIAL AND LONGITUDINAL QUALITATIVE EVALUATION, UK [72, 73]

Well London is a multicomponent community-engagement programme promoting healthy eating, physical activity and mental wellbeing in deprived neighbourhoods of London.

To evaluate outcomes of the interventions, a cluster randomised trial (CRT) was conducted that included a longitudinal qualitative component. The evaluation considered impact at the levels of individual participant, project, programme, community and whole population. The first phase of the programme included 14 interrelated projects in 20 neighbourhoods using a co-production approach. The programmes focused on physical activity, healthy eating, mental wellbeing, local environments, and arts and culture, aiming to build community capacity and cohesion. Phase two expanded the project into a further nine neighbourhoods.

The primary objective outcomes of the interventions were changes to healthy eating, physical activity and mental wellbeing. These were measured respectively by the number of individuals eating five portions of fruit/vegetables a day, the number doing five 30-minute moderate-level physical activities a week, and mental wellbeing through the surveys

the General Health Questionnaire (GHQ-12) and the Warwick-Edinburgh Mental Well-being Scale (WEMWBS).

The CRT compared the 20 targeted neighbourhoods with 20 matched control sites which did not receive any interventions beyond routine public health interventions. Individuals were randomly selected (approximately 100 in each neighbourhood) and surveyed before and after the intervention across all sites, giving a sample of around 4,000. Qualitative interviews and an environmental audit were also conducted to capture neighbourhood characteristics and qualitative information.

While there were no statistically significant differences in the primary measures of outcomes, two secondary outcomes were significant: the intervention group ate more healthily and thought that people pulled together more to improve the local area, compared with controls. Low participation and population churn were highlighted as potential issues which may have compromised impact, however.

Qualitative analysis highlighted some key characteristics that modulated any benefits. Highest levels of change were found in the presence of:

- social cohesion (pre-existing and cohesion facilitated by Well London activities)
- personal and collective agency
- involvement and support of external organisations.

In places where the physical and social environment remained unchanged, there was less participation and fewer benefits.

A key lesson for the study was the limitation of using area-based census-defined neighbourhoods, as opposed to natural communities as sites for intervention. During phase two of this project this lesson was employed for future sites. Phase 2 also explored how these interventions can be scaled up to a system-wide healthcare intervention.



At the hospital level, collecting data on social determinants of health enables hospitals to focus resources where they are needed.

As outlined in case study 14.

CASE STUDY 14: BAYLOR HEALTH CARE SYSTEM, DALLAS, TEXAS, USA

Baylor Health Care System (BHCS) is an integrated system that includes 26 hospitals, more than 100 ambulatory facilities and more than 4,500 affiliated physicians who serve northern Texas. In 2006, BHCS established the Office of Health Equity (OHE) with the purpose of reducing variations in healthcare access, care delivery, and health outcomes that arose from:

- Race and ethnicity
- Income and education (i.e., socioeconomic status)
- Age
- Gender
- Other personal characteristics (for example, primary language skills).

Since 2009, patients have self-declared their race, ethnicity and primary language at the point of service, and the data have been analysed to identify disparities in care. The equity measures are aggregated into several dichotomous variables:

- Race: white versus non-white
- Ethnicity: Hispanic versus non-Hispanic
- Socioeconomic status proxy: commercially-insured versus self-pay/Medicaid

OHE identifies and tracks these variations by producing the annual BHCS Health Equity Performance Analysis (HEPA).

The HEPA reports data on the following inpatient performance measures:

- Quality of care measures (Joint Commission core measures)
- Experience of care measures (patient experience/satisfaction)
- Outcomes measures (inpatient mortality and 30-day readmission)

It also reports on the following outpatient performance measures:

- Quality of care measures (diabetes, asthma, and chronic heart failure processes of care)

The annual HEPA report is used by the physicians' quality improvement committee to focus resources and efforts to reduce observed inequalities and improve the quality of care among the patients and communities it serves. These data became a powerful tool for creating organisational prioritisation and a momentum for improvement. The information allowed services to be designed along the principles of proportionate universalism, so that services could be targeted proportionate to the needs of specific groups.

For example, a persistent inequity in diabetes care was found in the percentage of non-Hispanic and Hispanic patients with superior diabetes control (levels of HgbA1c [glycosylated haemoglobin] less than 7%), with Hispanics meeting the management goal significantly less often than non-Hispanics. As a result, a successful pilot project, the Diabetes Equity Project (DEP), was launched. This provides diabetes self-management education and patient advocacy for some of the area's underserved populations. Early results have shown a significant increase in the number of non-white patients attaining superior diabetes control (HgbA1c of more than 7%). The project has since been scaled up to other areas, due to its success.

USING TECHNOLOGY

Data collection is changing due to technological advances including in low and middle income countries. There are 5.3 billion mobile phone subscribers worldwide, more than 330 million of whom live in sub-Saharan Africa. [74]



Although it is not fully understood how this will impact on health, mobile phone technology has the potential to help provide information and data, which can help shape policies and interventions to improve the social determinants of health and monitor the likely impact of policies on the determinants. For example, it allows health workers on the ground to collect current information on previously unrecorded populations and share it with healthcare providers, policy makers and the general public. [74] This can be used to build relationships with the local community and inform action on a number of levels. Case studies demonstrating innovative ways in which technology is being used to tackle the social determinants of health are outlined in case study 15.

CASE STUDY 15: AN APP FOR ASTHMA RESEARCH, ICAHN SCHOOL OF MEDICINE, NEW YORK, USA [75]

The Icahn School of Medicine at Mount Sinai, New York City, has created the Asthma Mobile Health Study App to create a personalised tool for patients to educate themselves and to self-monitor their asthma, tracking individual symptom patterns, promoting positive behavioural changes and adherence to treatment plans. The data from the app is also being used to better understand triggers for the disease and to design personalised treatment plans.

This has the potential to tackle health inequity in a number of ways. Firstly, it could be used to empower patients and inform care plans, as discussed in Section 3. It can also be used to look at the wider determinants of the illness, which could be used to advocate for policy change. If health records, air quality reports, housing quality and information from schools were aggregated, a clearer view of the problem could be understood and the wider conditions which lead to or worsen asthma be improved. Physicians should look at research and treatment tools to consider whether the information and data they provide can be used beyond the treatment of individuals, for broader prevention work at a community level.



Civil registration of births and death are of vital importance to individuals and societies. For individuals, birth registration is basic to ensuring a child's legal status and, thus, basic rights and access to services as well as a defence against exploitation. [76] The vital statistics that are derived from civil registration systems are also public goods, allowing governments and programmes to generate comprehensive health data, especially when combined with accurate cause of death data, crucial for policy planning and evaluation in all sectors. Civil registration systems in low income countries are often very poor. Setel et al (2007) argue that the health sector should work closely with registration authorities, national statistics offices and other agencies to promote and maintain civil registration. In Tanzania a new collaborative project has been set up to enable birth registration through mobile phones, as outlined in case study 16.



CASE STUDY 16: BIRTH REGISTRATION BY TEXT MESSAGE IN TANZANIA

Tanzania currently has a weak central civil vital registration system (CVRS) and the second-lowest rate of birth registration in the Eastern and Southern African region. On average only 15 per cent of the Tanzanian population are registered with birth certificates and there is wide variation in registration by residence from 59 percent in Dar es Salaam to 5 percent or lower in Lindi, Tabora, Shinyanga, and Manyara. [77] There are large financial and distance barriers in registering your child. Parents have to pay 3,500 Tanzanian shillings (\$1.6) if they request a birth certificate within 90 days of a child's birth, or 4,000 shillings afterwards, as well as travel costs to the registry office, which is often far away. [78]

In response to this the Tanzanian government partnered with UNICEF, Registration, Insolvency and Trusteeship Agency (RITA), and the telephone provider Tigo to increase birth registration in the country for those under five. [79] The strategy is to integrate health services with birth registration. Health providers including community health workers can easily register a child for a birth certificate by sending an SMS with the baby's name, registration number, date of birth, mother's name and city of residence to a central database in Dar es Salaam. A birth certificate is then provided for free to the parent from the local health clinic or local authority.

The programme was initially trialled in the Temeke district in Dar es Salaam in 2012 and the Mbeya region in July 2013. [80] In the Temeke district pilot areas, there was an increase by 29 per cent of children under-five registered, jumping from only 15 per cent with birth certificates to 44 per cent. In Mbeya, the registration of under-fives increased from around 10 per cent of children to around 36 per cent. The programme is currently being rolled out nationwide. The aim is to register about a million children under the age of five before the end of this year, and 90 percent of all new-borns within the next five years.

WHAT THE WMA CAN DO

- Provide training in monitoring and evaluation
- Share information of best practice in tackling SDH
- Publish examples of data training programmes which focus on SDH
- Connect people designing and delivering training, enabling the sharing of resources

WHAT NATIONAL MEDICAL ASSOCIATIONS CAN DO

- Campaign for social determinants data to be collected through census and household surveys nationally, and to be used in policy planning both within the health sector and beyond.
- Promote recognition of the importance of monitoring and evaluation, including to national, regional and local government and other agencies
- Support physicians on the ground to monitor and evaluate SDH interventions through education, training and advocacy.

WHAT DOCTORS CAN DO

- 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 within 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



3 The clinical setting: working with individuals and communities





The consultation is often the first point of contact a patient has with the medical profession and its aim is to support and guide a patient through the healthcare system. The patient-physician relationship (PPR) is at the heart of medical practice, and is a key area where health professionals can tackle the social determinants of health. Many doctors see establishing a trusting relationship with patients as a natural part of doctor's role, and many patients have very good relationships with their doctors. The OECD captured patients' perspectives of their healthcare in up to 14 high-income countries. [81] It found that 87.1% of patients report that their regular doctor spends enough time with them in the consultation, 89.3% believe that doctors give them the opportunity to ask questions, 91.1% say their doctor provides easy-to-understand explanations and 86.1% believe that the doctor involves them in decisions about their care and treatment. This report will outline aspects of these successful relationships, and how they can be used to tackle the social determinants of health.

It is difficult to generalise about the relationship between patients and physicians, as it is dependent on context, purpose and expectations of the patient and physician, which are not easily universalised. Studies on effective behaviour change methodologies highlight the importance of working collaboratively with patients to empower healthier lifestyle choices, and of collectively exploring the wider social determinants of health. [82] This has meant that in many countries, the traditional paternalistic approach, where patients are seen as recipients of medical information, is being replaced with other models that view the patient-physician relationship as more equal. Recently, research has looked at how doctors can motivate patients and utilise the individuals', families' and communities' strengths. Specific skills and tactics include taking extensive social histories, motivational interviewing, care planning and social prescribing.

CONSULTATIONS

CONSULTATION TIMES

In order for physicians to discuss and address the social factors affecting the health of their patients, they need to spend adequate time with them. In 2002 Wilson and Childs reviewed available literature in English language journal papers and determined that doctors with longer average consultation lengths prescribed less, discussed lifestyle activities and preventative activities, dealt with more problems at once and exchanged more information with patients. They suggested that this may explain why some studies found longer consultation times were related to lower consultation rates, as they enabled the wider determinants of the patients' health to be dealt with. [83] Howie et al compared consultation lengths in Edinburgh, Scotland, and found that independent of doctor style, 'long' consultations (10 minutes or over) were associated with the doctor dealing with more of the psychosocial problems which had been recognised and were relevant to the patient's care, dealing with more of the long-term health problems which had been recognised as relevant, and carrying out more health promotion during the consultation. [84] In a study in the UK of general practitioners, where the median consultation time for the group studied was six minutes, an increase of consultation times to 10 minutes was associated with an increase in discussions of health promotion activities that were incorporated into their medical notes. [85]

Many high income countries have average consultation times far above 10 minutes: for example, Sweden (21 minutes), Switzerland (15.6 minutes) and Belgium (15 minutes). [86] However, as discussed in Section 4, low and middle income countries have fewer doctors and those who are present are often working in high-pressure environments. Therefore average consultation times are often shorter and consultation rates lower, as can be seen in the Asia Pacific region. [87]

Within countries, increasing socioeconomic deprivation may be associated with shorter consultations. [88] This is an aspect of the inverse care law, which states that the availability of good quality medical care is inversely proportional to its need. [89] In the Netherlands, patients with higher education have longer consultations on average than those who are less well educated, and both patients with higher education and their GPs talk more, with those patients being more involved in the decision-making process than their less educated counterparts. [90]

CONSULTATION FORMAT

Consultations can take many forms, for instance group consultations of more than one patient; with more than one clinician; over email or Skype; or with more flexible lengths of appointment according to a patient's needs. [91] Adaptations need to adequately address the needs of the patient, and a particular focus should be on meeting the needs of disabled and vulnerable groups, as the case study 17 demonstrates.



CASE STUDY 17: PROFESSIONAL SIGN LANGUAGE INTERPRETERS ENSURING EQUITABLE ACCESS TO HEALTHCARE FOR SIGNING DEAF PEOPLE, CAPE TOWN, SOUTH AFRICA [92]

Being able to communicate in the language of the patient is a basic necessity for health professionals. While South Africa should be obliged to provide interpreters to ensure accessibility to healthcare, in common with many other LMICs there are no professional interpreter posts in healthcare in the country. This is aggravated for vulnerable groups such as deaf people, who rely on South African Sign Language (SASL) for communication. SASL interpreters are rare in South Africa and the absence of SASL interpretation in healthcare is a major challenge for health professionals and patients. The consequences for health are serious.

In 2008, a research project piloted the first ever free-to-patient professional medical sign language interpreter service in healthcare in Cape Town. It started as a small project with one interpreter. By 2011, the project was averaging 15 clients per month which doubled by 2013 to an average of over 30 per month seen across services in the district. The project now also provides services for children. It has trained interpreters as well as deaf clinic assistants. The deaf staff are fully responsible for the regular monthly sign language interpreter service offered at the academic hospital ophthalmology clinic. Evaluations show that the service has been well received by patients and has been enthusiastically assessed by providers, who welcome the opportunity to abandon imperfect and cumbersome use of writing, or the ethically fraught problems of using family members as interpreters. It has been more difficult to measure cost-benefit of implementing new services but it would be expected that improved communication will reduce misunderstanding of conditions and treatment regimens.

The project is ongoing, linked to lobbying on policy makers to institutionalise SASL interpreter services. Professional associations can do much to advance small changes that make a big difference for the quality of care for disabled and vulnerable patients, including deaf people.

While changes to the structure of consultations, and use of technology, are interesting ways through which to tackle health inequity, this report will focus on changes to the relationship with the patient, what doctors ask patients, how they motivate patients, plan their treatments, and work with other healthcare staff and the community, as these interventions are not costly, yet can have a large impact on individuals' health outcomes and reduce health inequity.



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. [91]

In the Bromley by Bow Centre, London, discussed in Section 5 on partnerships, the majority of patient consultations lead to social prescriptions, as they say this is essential to provide the best care for patients.

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

INTERVENTIONS

SOCIAL HISTORY

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.

Many physicians have argued that taking a complete social history is as important as taking a complete medical history.

Behforouz et al (2014) recommend recording a more extensive social history than is commonly used, which incorporates more detailed questions in six categories: individual characteristics, life circumstances, emotional health, perceptions of healthcare, health-related behaviours and access to and utilisation of health care. [93] They recommend that this information is gathered over time, as a relationship of trust is built up, and that the doctors' own social history should also be reviewed, as unexplored prejudices may influence a doctor's ability to obtain or act on important information. Moscrop and MacPherson suggest that recording patients' income is a useful addition to medical histories. [94] Bloch et al have developed a simple tool to allow physicians to screen for poverty and, importantly, to intervene to reduce poverty as outlined in case study 18, and 19. [67] Médecins du Monde (Doctors of the World) takes detailed social histories of patients its staff work with marginalised individuals who are not accessing health services in a number of countries in Europe, outlined in case study 20. [95]

CASE STUDY 18: POVERTY TOOL: A CLINICAL TOOL FOR PRIMARY CARE, ONTARIO, CANADA [67]

In Ontario, Canada a Poverty Intervention Toolkit was developed in 2013, and work is underway to develop it further. It provides three simple steps to tackle health inequity:

- Screen for poverty
- Adjust risk
- Intervene

1: Screen for poverty

In a pilot study it was determined that the question Do you (ever) have difficulty making ends meet at the end of the month? was a good predictor of poverty (sensitivity 98%; specificity 60%) especially when combined with two additional questions about food and housing security (sensitivity 64.3%; specificity 94.4%; OR 30.2). [96] Eighty-five per cent of low-income respondents felt that poverty screening was important and 67% felt comfortable speaking to their family physician about poverty.

2: Adjust risk

This tool suggests that poverty should be considered in clinical decision-making to consider the evidence of the link between poverty and a number of conditions including: cardiovascular disease, diabetes, mental illness, some cancers (and cancer screening and mortality); having multiple chronic conditions; infant mortality and low birth weight. The tool kit developers suggest, for instance, if an otherwise healthy 35-year-old patient has no risk factors for diabetes other than living in poverty, the physician should consider ordering a screening test for diabetes.

3: Intervene

The tool suggests poverty interventions available to physicians in the context of Canada. These include ensuring that patients are receiving income benefits that they are entitled to and signposting those patients to relevant information and organisations that can help them apply for relevant benefits and support. This level of intervention would also be suitable for countries with similar welfare systems to Canada.



CASE STUDY 19: ST. MICHAEL'S HOSPITAL, ONTARIO, CANADA [97] [98]

When patients enter St. Michael's Hospital in Ontario, the following socio-demographic information is collected onto a database:

- Language
- Immigration status
- Race/ethnicity
- Disabilities
- Gender identity
- Sexual orientation
- Income
- Housing

The hospital has a Social Determinants of Health Committee and employs a team to address the social issues that have been identified. The following staff who support patients flagged as needing support:

- Income Security Health Promoter (a role that provides individual income interventions, education and advocacy)
- Medical-legal partnership (staff working in individual legal services, health provider training, patient rights education and systematic advocacy)
- Community Engagement Specialist (an advocacy role to ensure the community's voice is heard during the planning of services, and in the community to ensure the community is aware of services provided by the hospital.

CASE STUDY 20: CONSULTATIONS WITH PATIENTS – MEDECINS DU MONDE (DOCTORS OF THE WORLD), EUROPE [95]

Médecins du Monde (MdM) provides free consultations with vulnerable groups such as migrants (regardless of their legal status), homeless people and sex workers in 25 European cities. The aim is to provide medical and social welfare advice for people who have 'fallen through the gaps' and to reintegrate them into the mainstream healthcare system. A key part of this is to provide patients with information about their rights and help them to exercise these rights. Examples of MdM's work include:

- In Mytilene, the capital of the Greek island of Lesbos, medical, psychological and legal assistance is offered to migrants arriving by boat and requiring international protection.
- In the UK, MdM runs a healthcare and advice clinic where volunteers, doctors, nurses, support workers and social workers offer primary healthcare to excluded groups, especially migrants and sex workers. A large part of the centre's work involves helping patients to register with a general practitioner, the entry point to the healthcare system and signposting them to social welfare support services.

- In the Netherlands, MdM offers undocumented migrants weekly advice clinics in Amsterdam and The Hague. People are provided with information about their rights and directed towards health professionals in the mainstream healthcare system, especially general practitioners, in order to guarantee continuity of care.

Many of the patients attending these clinics have a number of barriers to accessing care, based on their social and economic position. For example, 91.3% of all patients attending these clinics were living below the poverty line. In 2014, 84.4% reported having had at least one violent experience (for example from living in a country at war, violence by police or armed forces, sexual assault or rape). Of the pregnant women who attended consultations, 55.3% were living in an unstable housing situation and 30.3% said they had a poor level of moral support.

Asking patients about such issues is routine to all consultations and allows the team to acquire a full social history, and thus to signpost patients to appropriate services. This necessitates a large amount of time to be spent with the patients, usually up to an hour in the social consultation (with a non-clinician, support worker), then on average 45 minutes with a clinician. The support worker and clinician work together to make referrals for wider support, such as to immigration advice or peer support. [99]

WORKING WITH PATIENTS

Many of the key health behaviours – smoking, obesity, lack of physical activity and unhealthy nutrition – which are significant to the development of chronic disease follow the social gradient. Prevention requires interventions from a range of actors and should include partnership between health services, the voluntary sector, local government, communities and individuals (as discussed in Section 5). Supporting patients to change their behaviour should therefore be understood in the broader context of their lives. Patients with chronic conditions who fail to follow treatments cite lack of capacity, skills and knowledge as the main reasons for non-adherence. [100]

Research demonstrates that when patients' psychological needs for autonomy, competence and understanding are supported by healthcare practitioners they are more likely to choose to engage in treatment and demonstrate better outcomes over time.

Health professionals
should be taught
effective techniques to
motivate patients and
co-create care plans.

It is important to consider these as being key skills for physicians during their education or Continuous Professional Development. In the UK for example, the 'making every contact count' programme includes a competence framework to train health professionals on individual behaviour change, including motivational interviewing. [82] These techniques have been shown to be more effective than traditional information sharing. [22] For instance, motivational interviewing is an established method of interacting with patients to enhance behaviour change, with over 160 randomized clinical trials with patients with an array of medical conditions. [101] It is a style of consultation that is facilitative, building on the inter-personal relationship with the patient. Motivational interviewing elicits behaviour change by helping clients to explore and resolve ambivalence. [102]

CARE PLANNING

Care planning can help to provide a framework for a type of consultation that is more equal than the norm. While the medical professional brings professional expertise, clinical excellence and support, patients bring their own skills and knowledge about their social situation, lifestyle, strengths and goals.

Care planning (sometimes called pathway planning) is a process that involves assisting a patient to identify and compile their health and wellbeing goals, setting achievable targets for progress towards these and putting in place the support and resources to get there which often involve support in the community. These resources could involve social prescribing (discussed later on), peer support and advocacy. Often this process is done in collaboration with the patient; however, in some circumstances, such as in the case study 21 this is done privately by the patient first, before being discussed with health professionals.

CASE STUDY 21: TE AWA – A SELF-ASSESSMENT TOOL FOR ABORIGINAL PEOPLES IN NEW ZEALAND [103]

The Te Awa tool is a self-assessment or analysis tool that is given to aboriginal Māori individuals and families in New Zealand. It is a 50-item measure that consists of seven sections covering ethnicity, gender, how participants feel about wider aspects of their life, and the barriers to achieving health, wellbeing and success. It also asks how satisfied they are with the skills they have in various personal areas of their lives, and priority areas they would like to change or develop. These items encompass all the elements of wellbeing and health identified by Māori people, and recognise the interconnectedness of health, education, housing, justice, welfare, employment and lifestyle as elements of whanau (family) wellbeing. The tool enables these aspects to be measured, and offers self-directed actions with accompanying timely support. A health service provider also adds support, alongside referral information based on the responses.

The tool gives individuals and families an opportunity to self-identify areas of priority and creates buy-in to the change required for individuals and their whanau (extended family). Analysis conducted by the National Hauora Coalition found that the tool enables progress to be measured over time, and when combined for a population at the community level it can inform service planning and delivery. For example, if diet and nutrition are areas of concern for a large percentage of the community, wider scale interventions can be designed to address this.

Te Awa has been adopted by a number of agencies throughout the country over the past several years.

SOCIAL PRESCRIBING

Integrating referrals with a care planning process gives clinicians an explicit mandate to refer to services outside the health service, a process known as social prescribing. It involves identifying non-clinical needs of patients that impact on their health, and referring them to appropriate non-clinical support in the community with the underlying aim of impacting on the wider determinants of health. [104] These 'social prescriptions' can take many forms, such as arts on prescription, books on prescription, education on prescription and exercise on prescription. Some lesser known models include green gyms and other healthy living initiatives, information prescriptions, supported referrals, social enterprise schemes and time banks. [71] Social prescriptions can also include interventions that impact directly on financial support; for example, the poverty intervention tool referred people in debt to debt counselling services or various other support services.

To work effectively this should be a clear, coherent and collaborative process in which healthcare practitioners work with patients and service users to select and make referrals to community-based services. Such schemes typically have dedicated staff such as community development workers with local knowledge who are linked to primary healthcare settings. Brandling and House highlighted that patients are most likely to be referred by physicians if they display any of the following characteristics:

- A history of mental health problems
- Frequent attendance to primary care services
- Two or more long-term conditions
- Social isolation
- Untreatable or poorly understood long-term conditions such as irritable bowel syndrome and chronic fatigue syndrome
- Not benefiting from clinical medicine and drug treatment. [105]

Evidence suggests that social prescribing provides people with opportunities to build social networks and increases confidence, self-efficacy and engagement with weight loss and exercise programmes. [91]

Involves identifying non-clinical needs of patients that impact on their health, and referring them to appropriate non-clinical support in the community.



Programmes are more successful when they involve organisations from beyond the health service such as social enterprises and voluntary organisations. [91]

Because social prescribing can result in patients using a range of services, demonstrating impact and value can be difficult. It is important to ensure that there are systems in place to capture data on the outcomes of social prescribing.

CASE STUDY 22: ROTHERHAM SOCIAL PRESCRIBING, UK [106] [107]

The Rotherham Social Prescribing Service helps people with long-term health conditions to access a wide variety of services and activities provided by voluntary organisations and community groups in the town. GPs lead case management teams and are responsible for identifying patients who are eligible for the scheme. This model includes Voluntary and Community Sector Advisors (VCSAs) who receive referrals from 28 GP practices in Rotherham. Patients' progress towards social outcomes is measured through an 'outcomes star' style tool developed specifically for the service. Outcomes stars are a family of tools that aim to promote and measure behaviour change, and are used in a variety of contexts when working with vulnerable people. [108]

Initial analysis of this data by Sheffield Hallam University shows that patients are making positive progress: 78% made progress on at least one outcome after six months. The most common types of services that have been accessed are community-based activities, information and advice, befriending and community transport. Six months after the referral system was initiated, Accident and Emergency attendances declined by 21%, hospital admissions by 9% and outpatient appointments by 29%. Although it is not possible to directly attribute this change to the social prescribing intervention.

CASE STUDY 23: TRAINING HEALTHCARE STAFF ON INTIMATE PARTNER VIOLENCE IN THE DOMINICAN REPUBLIC: THE ROLE OF REFERRALS [109]

In the Resolution on Violence Against Women and Girls, the World Medical Association defines violence against women as a health determinant that doctors, national medical associations and the WMA should be tackling, as health services are well placed for identifying vulnerable women and offering them referral or support services when possible. [110] This requires that physicians educate themselves about the effects of violence and strategies for prevention, assess for risk during consultations, build relationships of trust with abused women and children and support global and local action.

In the Dominican Republic, Profamilia (an NGO with six reproductive health clinics and a mental health centre) works with health providers that have been sensitised and trained to recognise and respond to violence. All clients, unless they refuse, are screened by a physician for intimate partner violence (behaviour within an intimate relationship that causes physical, psychological or sexual harm). The physician uses a form with question topics ranging from emotional violence to childhood sexual abuse. About one in seven women responds positively to at least one of the screening questions; she is then informed that support is available but is not pressured to take action and fewer than half accept a referral. The woman is then provided with a psychologist or a counsellor. Other clinics in the area can also refer clients to this service. The referral system includes a referral network documented in a directory which contains information on services offered, the population served, and hours of operation and means of contact available to physicians. A two-part referral form is used: the physician fills in the first part with information on the client's needs, then the client takes the form to the provider, who describes the visit and the follow-up plan, which can be returned to the clinic, and allows physicians to monitor if action has been taken.

Profamilia's experience highlights that whole institutions should be involved in such referral work, involving sensitisation of all staff, including receptionists and security staff, modifying the physical space of clinics for privacy and confidentiality and developing protocols, an information system, and a strong network for referral.

CASE STUDY 24: SAFE ENVIRONMENT FOR EVERY KID (SEEK) PROJECT, UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE, USA [111]

The Safe Environment for Every Kid (SEEK) project is a practical approach to the identification and management of targeted risk factors for child maltreatment for families with children aged 0–5. The project aims to help prevent child maltreatment, improve children's health, development and safety as well as to strengthen families and support parents. It is fully integrated into paediatric primary care and includes a number of components:

- Training healthcare professionals to assess and address psychosocial problems. This includes skills to engage parents such as motivational interviewing, care planning and signposting to relevant services in the community. There is also online training and support for professionals.
- SEEK Parent Questionnaire (SEEK PQ). This includes 15 'yes/no' questions in a user-friendly format and takes about three minutes to complete. Completed by parents voluntarily, often while waiting to see the healthcare professional, the questionnaire attempts to screen for risk factors for child maltreatment including alcohol and substance abuse, intimate partner (or domestic) violence, and parental stress. It is available in a number of languages.
- Intervention: Ideally, a behavioural or mental health specialist is available to help, initially assess and briefly address problems and facilitate referrals to community resources. The health professional mostly has a triage role and ideally a mental health professional and/or social worker is available to more fully assess and address the problems. Parent handouts have also been developed to provide basic information and list organisations with resources to assist parents.

Two randomised control trials have been conducted using the SEEK model in low and middle income communities. The trials have shown a number of positive effects, including those below.

- There is a statistically significant reduction in child maltreatment, measured in a number of ways (for example, fewer Child Protection Services reports), and fewer instances of medical neglect (fewer cases of 'non-compliance' with medical services and fewer delayed immunisations).
- Health professionals demonstrate improved attitudes, knowledge, comfort, competence and practice behaviour related to psychosocial risk factors (they are more likely to screen and assess for these). Parents also have more favourable views of healthcare professionals.
- Parents report fewer cases of 'psychological aggression' and 'minor physical assault'.
- Most health professionals did not need to spend additional time with patients to address psychosocial problems.
- Cost-benefit analysis revealed that applying SEEK to 100,000 families could save up to US\$37 million in paediatric primary care, medical, mental health and social service costs.

DOCTORS AND THE COMMUNITY

Evidence demonstrates that community- and neighbourhood-level interventions can improve health outcomes generally, but particularly for disadvantaged groups. [112] Interventions can include active travel arrangements (for example providing safe bicycle lanes), provision of good quality green spaces, decent housing, accessible services and social/community centres, good quality early-years provision, and local policies to ensure good quality air.

Behforouz recommends that doctors visit the neighbourhoods where the majority of their patients live, as it can enhance their social perspective and help them understand their patients' lived experience. [93] Healthcare professionals have the potential to occupy a unique space in the community and the health service, as they are often seen as leaders in both fields and can be highly effective advocates for healthy places. Burt described the potential of this role as that of a 'boundary crosser' who can operate as an opinion leader and can bridge the community and healthcare system. [113] It is important that doctors are able to work with early years staff, schools, planners, housing providers, transport, environmental health and other agencies. The importance of developing these partnerships is discussed in Section 5.

WORKING WITH INDIGENOUS COMMUNITIES TO IMPROVE HEALTH OUTCOMES

Indigenous, or Aboriginal, populations are recognised as being among the world's most vulnerable, disadvantaged and marginalised people. Indigenous/Aboriginal communities are spread across the world in around 90 countries, numbering approximately 370 million.

[114] The UN Declaration on the Rights of Indigenous Peoples, approved by the UN General Assembly in 2007, identifies numerous areas in which national governments could work to improve their situation, giving prominence to collective rights. Indigenous peoples in many countries have secured more control over community-based health services, in the hope of improving access and responsiveness. [114]

WORKING WITH ABORIGINAL COMMUNITIES IN CANADA

Aboriginal peoples in Canada include First Nations, Dene, Metis and Inuit peoples, and estimates suggest they will make up 4.1% of the Canadian population by 2017. [115] Aboriginal status has been highlighted as a social determinant of health in Canada [116] and researchers have emphasised that Aboriginal Canadians continue to experience adverse health effects related to Canada's colonial legacy. [117] They have a lower life expectancy than the total population, for example, projections suggest that in 2017 an Inuit man can expect to live to 64 years, 15 years fewer than the average Canadian life expectancy of 79 years. [115] Illicit and prescription

drug use disorders are two to four times more prevalent among Aboriginal peoples in Canada than the general population. [118] However, a growing pool of evidence is demonstrating that Aboriginal communities and cultures are important means of protecting and promoting Aboriginal health. For example, a study of illicit drug taking by Aboriginal peoples in a mid-sized city found that Aboriginal enculturation was a protective factor associated with reduced risk of illicit and prescription drug problems among Aboriginal adults. [118] Community-based health services have been promoted as a means of reducing health inequity, and as of March 2008, 83% of eligible First Nations communities were involved in managing their own community-based health services, to varying degrees. [119] Researchers sought to document the relationship between local access to primary care, measures of community control, and the rates of hospitalisations for First Nations on-reserve populations in Canada. [120] The study found that the longer community health services have been under community control, the lower the hospitalisation rate in the area. A community owned health service and an urban strategy for off-reserve Aboriginal people are outlined in case studies 25 and 26.

CASE STUDY 25: KAHNAWAKE, MOHAWK NATION, QUEBEC, CANADA [121]

Kahnawake is a Mohawk Nation community of about 8,000 people, which manages its health system through the Kahnawake Health and Social Services Commission. Health is seen as integrally connected to nation building and self-determination of the community and its people. The health system includes a community health unit offering public health services, a hospital with an extensive range of health professionals for both inpatient and outpatient care, a medical centre offering speciality services, a dental clinic and a diabetes education programme. A community service centre provides a comprehensive range of mental health and social services including alcohol and drug abuse treatment. The community has also constructed a 20-bed Elders lodge, a residential home for elderly members of the community. The directors of the various health and social programmes meet regularly to create long-term global community plans, reduce duplication and share resources. There is a shared community vision of an Aboriginal health system with holistic practices. In the future the commission would like all institutions and health professionals working in the community to be internally regulated and licensed to provide a direct line of accountability to the community.

CASE STUDY 26: ABORIGINAL HEALING AND WELLNESS STRATEGY (AHWS), HEALTH CENTRES, ONTARIO, CANADA [122]

The AHWS is a collaboration of four Ontario government ministries and funds a number of health streams such as community workers and health outreach; shelters, healing lodges and treatment centres; health centres; maternal and child centre; and translator and advocate services. The health centres are located off-reserve but many serve on-reserve populations too. They provide primary care and incorporate Aboriginal culture and beliefs. The centres comprise a physician and a nurse, often a nurse practitioner as well as a mix of other primary health professionals such as a nutritionist, psychologist, traditional coordinator, diabetes educator or exercise therapist. A six-year longitudinal evaluation of the centres identified the core components of effective service delivery to be:

- interventions that integrate traditional and Western approaches to care, including cultural teachings and spiritual development, combined with seeking a balance in the physical, mental, spiritual, and emotional aspects of a person
- supportive environments
- community development and empowerment through the use of centres as community resources.

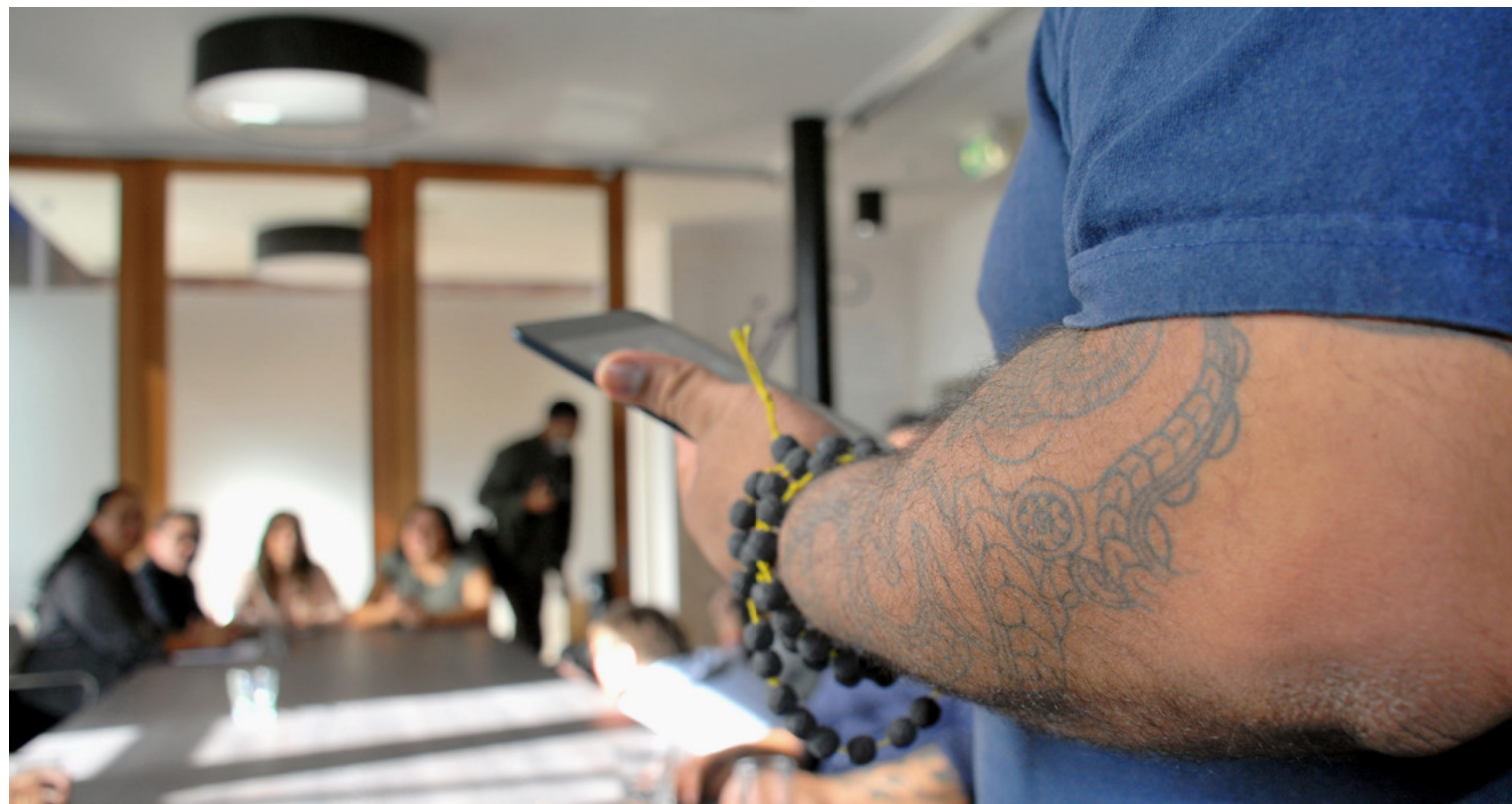
The health centres involve the community in service delivery, for example videos or plays are produced and performed by community members depicting personal experiences with HIV/AIDS, or cultural teachings are used to frame healthy lifestyle choices.

WORKING WITH ABORIGINAL COMMUNITIES IN NEW ZEALAND

Māori New Zealanders, the country's Aboriginal people, are more likely than the non-Aboriginal majority to live in deprived communities, and they have the worst health outcomes in New Zealand. The avoidable mortality rate for Māori is 2.3 times the rate for other New Zealanders. [123] Even when income is accounted for, wealthier Māori have worse health outcomes than wealthier non-Māori. [124] In response, the New Zealand government has created the Māori Health Strategy, He Korowai Oranga, guidelines which highlight the importance of community empowerment and providing effective health services that are tailored to the community. Māori cultural processes are used as a basis for developing and delivering health services that support self-sufficiency and Māori control. From a Māori perspective, health has four cornerstones: te taha wairua (a spiritual dimension), te taha hinengaro (a psychological dimension), te taha tinana (a bodily dimension) and te taha whanau (a family dimension). [125] Incorporating this understanding has been identified as crucial to the success of these provider organisations. [126] The New Zealand Ministry of Health highlights successful examples of these principles being incorporated at the clinical level, and two examples of this are highlighted in case studies 27 and 28. Recently the health inequity gap has begun to close, and many cite the importance of 'By Māori for Māori' participation as a key reason for this. [127]

CASE STUDY 27: NGATI HINE TRUST, NEW ZEALAND [128]

The Ngati Hine Trust is the largest Māori health provider in the Te Tai Tokerau region. Services are focused on the family (whanau) and the Trust's aim is to promote the social and economic advancement of family, clans and tribes (whānau, hapū and iwi). A number of services are provided such as GP services, oral health, primary nursing, disability support, home support services, health promotion and education/training, Family Start programme, restorative justice programmes, mental health programmes, and a radio station, Ngati Hine FM. The Trust is in the process of developing an Integrated Family Health Centre to enable families to access all the key primary care services they need from a single facility. The Trust has also developed an early childhood centre, with the understanding that education is a pre-determinant for good health. People enrolling their children in the centre are signed up to a GP service and nurse. Depending on their needs they are also offered enrolment in quit smoking services (Aukati KaiPaipa), oral health and other services.



CASE STUDY 28: HEALTHCARE IN OTANGAREI: TE HAU AWHIOWHIO O OTANGAREI WHĀNAU ORA COLLECTIVE, NEW ZEALAND [129]

In Otangarei the healthcare team noticed that the clinic, which serves 98% Māori people, was treating similar conditions regularly, including dog bites, infectious skin infections and cuts underfoot. The team suspected that the reason might be that many children did not wear shoes and that almost every household had a dog or cat. Their solution was to hold a pet outreach clinic once every two weeks on the lawn of the clinic. This clinic became very popular and in the first six months an obvious decline was seen not only in skin infections and dog bites but also in the number of dogs loose on the streets. This also provided the clinic with an opportunity to provide community outreach especially to people not engaging in the health system. They could tap people on the shoulder while they were waiting and invite them to have a cervical smear test or immunisation there and then, or confirm appointments for another day. By understanding a community need that was not directly health-related, the clinic positively impacted on the overall health of the community.

SYSTEMS WHICH SUPPORT DOCTORS TO TAKE ACTION ON SOCIAL DETERMINANTS OF HEALTH

System-wide factors that improve an individual physician's ability to work collaboratively with individuals and communities to tackle the SDH include:

- **System commitment:** A system-wide leadership and commitment to tackle the wider determinants of health gives clinicians both a supported means to reduce health inequity and also a mandate to do it.
- **Community engagement/facilitator role:** many communities have a number of services and facilities. It is not always possible for doctors to act as 'boundary crossers', and it can be hard for busy healthcare professionals to make informed referrals in their local community. A signposting or facilitator role that can act as a bridge between healthcare professionals and social activities, community services and organisations is very important. This role can be performed by paid members of the local community; nurses, pharmacists or other health practitioners with additional training; volunteers or peers; receptionists or administration staff; or new types of professional roles created for particular services. Evidence shows that when this facilitator is embedded in clinics, healthcare professionals can get to know much more about local community assets, which assists them in social prescribing. [130]
- **Capacity of the community to engage:** The level at which a community can engage and partner with health services is related to the community's resources and social capacity. These resources include financial assets, physical infrastructure (facilities and equipment), individual knowledge and skills, relations among people and organisations, relationships between local people and organisations and the community's external environment, access to services, and community attitudes. [131] Tools have been developed to assess community capacity, for example Version C 2007. [132] By measuring a community's capacity, community interventions can identify community strengths and needs, and assist in developing capacity, including for engagement and partnership with health services.

However, even without these factors, healthcare professionals can make some steps to engage more with individuals and the community through, for example, education on motivational interviewing, recording more extensive patient social histories, and visiting the community and advocating on behalf of individuals and communities (as discussed in other sections).

WHAT THE WMA CAN DO

- Provide education-skills training in effective actions to address the social determinants of health for patients, including taking social histories, care planning and social prescriptions
- Recognise and promote the importance of developing and delivering education about social determinants of health for all health professionals working in traditional and non-traditional health settings
- Collect evidence of effective individual and community interventions on social determinants at the international level to develop an evidence base to be disseminated
- Support physicians in providing care that is empowering to the patient and utilises the strengths of the community
- Encourage the development of a system-wide commitment to support health professionals to address the social determinants of health

WHAT NATIONAL MEDICAL ASSOCIATIONS CAN DO

- Provide education-skills training in effective actions to address the social determinants of health for patients, including taking social histories, care planning and social prescriptions
- Share evidence of what works to reduce health inequalities and take action on the social determinants
- Advocate to government and other agencies to ensure support for the provision and uptake of education and skills in social determinants
- Support physicians in providing care that is empowering to the patient and utilises the strengths of the community
- Understand the issues faced by marginalised communities, and work with governments to ensure better inclusion of all patient groups, including traditionally hard-to-reach groups
- Encourage the development of a system-wide commitment to support health professionals to address the social determinants of health

WHAT DOCTORS CAN DO

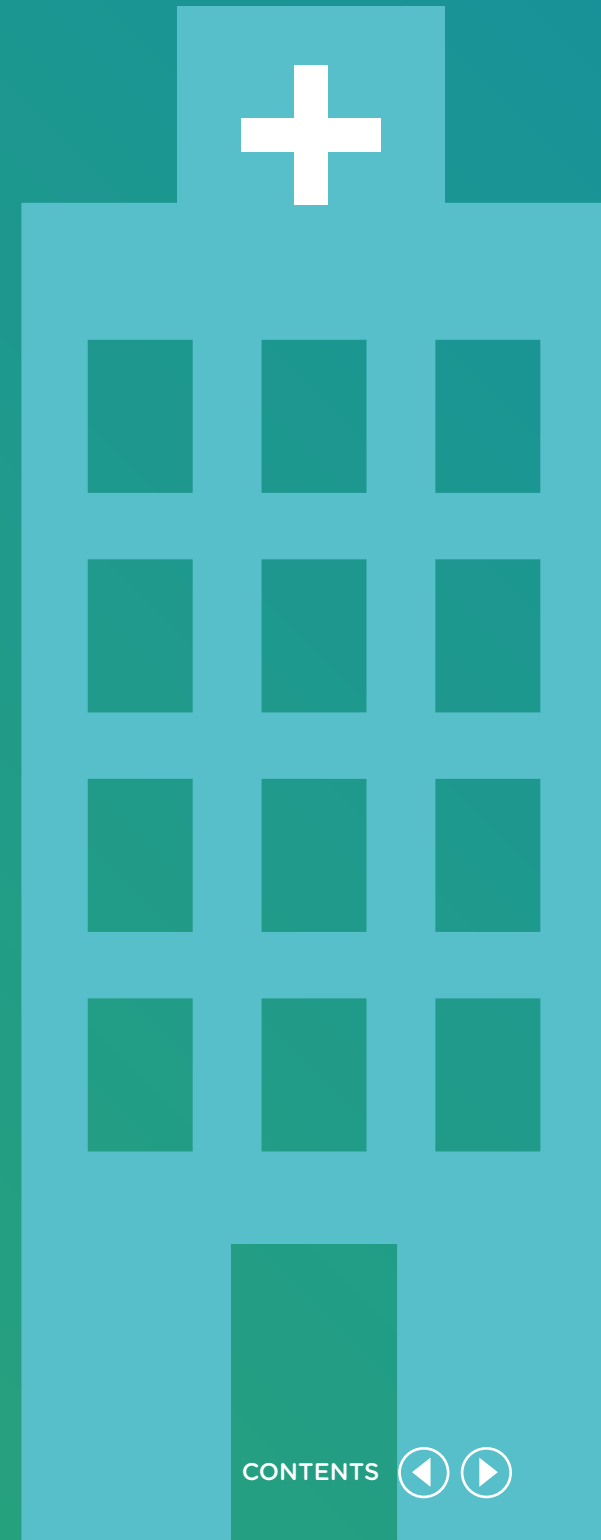
INDIVIDUAL RELATIONSHIP WITH PATIENTS

- 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 discussions 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 for 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

4 Healthcare organisations as employers, managers and commissioners



While the health service impacts on health and inequity through direct interactions with patients and communities, it also has a highly significant role as an employer, manager and commissioner of services.

The healthcare system employs a large number of people in many communities – including those employed directly in healthcare organisations and indirectly through the supply chain, including unskilled or semi-skilled employees. This gives the healthcare industry an important opportunity and responsibility to reduce health inequalities by providing good quality work and good employment terms and conditions, and ensuring safe working conditions, as well as working to increase employment opportunities for people from disadvantaged backgrounds. The healthcare system can thus have a positive impact by boosting economic activity in deprived communities.

Healthcare workers are exposed to a number of risks – such as musculoskeletal disorders and sharp injuries – the nature of their work, which for some includes shift work, also has health impacts. There is a concerning increase in attacks on healthcare facilities and healthcare staff working in conflict and crisis settings. In late December 2014, the UN General Assembly passed a resolution calling for concerted and specific actions by states to protect health workers from violence and to assure patients access to healthcare in situations of conflict and insecurity. [133] In Bahrain and Turkey human rights and international humanitarian law were violated when healthcare workers treating government protestors were arrested; in February 2015 the WMA demanded that all charges be dropped against Turkish doctors. [134]

Health and social work is also a high risk sector for adverse psychosocial conditions that are related to increases in



stress. [135, 136] These conditions include conflicts within the workplace, lack of autonomy and control, low pay and insufficient hours, temporary work, job insecurity and the risk of redundancy. [137] Studies have shown that these adverse psychosocial conditions are associated with an increased risk of coronary heart disease. [138]

Doctors have an important role to play in reducing these risks: many are leaders in the health system, as commissioners, as managers and employers. It is therefore important that their role is understood in terms of the social determinants of health. This includes doctors ensuring safe work practices, demanding safe and health-enhancing working conditions for staff through procurement, and employing and training local staff when possible.

THE HEALTH SERVICE AND THE SOCIAL DETERMINANTS OF HEALTH

AS EMPLOYERS

According to the International Labour Organization (ILO), there will be a decrease in manufacturing and routine level jobs and an increase in jobs requiring face-to-face interaction (for example health and personal services) between 2015 and 2020, signalling the emergence of a large 'care economy'. Public services in healthcare, education and administration will continue to be a major source of employment, representing 15% of total employment globally. [139]

More effort should be made to ensure that everyone has an opportunity to access these jobs, particularly people from disadvantaged communities.

This requires active outreach to communities, as has been seen in the multiagency partnership to transition the long-term unemployed into allied health careers in the USA, and in the recruitment of local populations as community health workers in Zambia (see case studies 29 and 30). There is a need for this work to be of a good quality, as discussed in the next section.

CASE STUDY 29: TRANSITIONING THE LONG-TERM UNEMPLOYED INTO ALLIED HEALTH CAREERS, NORTH CAROLINA, USA [140]

In 2011, a multiagency partnership was set up in North Carolina, USA, to address the relatively high long-term unemployment rate of 9%, half of whom were unable to secure a job within six months of being registered unemployed. While the job market was relatively stagnant generally, with a small growth rate of 3%, healthcare jobs increased by 46%, presenting an opportunity to reduce unemployment.

To identify the challenges that the long-term unemployed in rural communities may experience as they navigate the career pathway of allied health professionals, a range of stakeholders were interviewed. These stakeholders included healthcare employers, community colleges, workforce development boards, social services, funders and the long-term unemployed that live in rural communities. The challenges identified centred around four key areas: career guidance, limited resources, individual support and employer collaboration or 'buy in'.

As of March 2015, over 205 unemployed people were assessed, enrolled into training and supported to continue training. Services include career counselling, academic/training vouchers, books, uniforms, immunisations, transportation and professional development. Projections suggest that 25% or more will gain employment upon successful workforce training. Human Resource Development departments at community colleges have the ability to sustain the recruitment and implementation beyond the funding cycle of the project.

CASE STUDY 30: RECRUITING QUALITY COMMUNITY HEALTH WORKERS, ZAMBIA

In 2010, the Government of the Republic of Zambia launched a programme to create a new civil service position, the Community Health Assistant (CHA), in an attempt to formalise and professionalise the community-based lay health workers that are common in Zambia and to address staff shortages in rural areas. The aim is to train 5,000 new CHAs by 2017. CHAs undergo a year of formal training, and then return to their rural home communities to work. The CHAs' main task is to visit households to conduct environmental inspections (safe water practices, household waste management, sanitation, hygiene and ventilation), advise on women and children's health, and refer them to the health post (the first-level health facility in rural Zambia) as needed (for example, for routine checks for children and pregnant women, or for giving birth). They also spend one day a week in the community health post and organise community health education meetings at the health post and in schools. The Ministry requires CHAs to work for two years before applying for promotion.

Researchers tested how individual incentives (opportunities for promotion and further professional development) affect the skills and motivation of applicants for this role and how, in turn, this self-selection affects job performance. [141] Half of the districts had recruitment posters emphasising the social benefits of becoming a CHA, such as serving and being a leader in one's community. In the other half, recruitment materials emphasised the career development benefits. Once deployed, actual benefits were identical between the two treatment groups; as a result, any difference in performance was attributed to the selection effect of the incentives.

The outcome was that career-focused incentives attracted CHAs that were more qualified and had the same level of pro-social preferences as CHAs recruited through the social-focused incentives. The CHAs in the former category consequently performed their job better. CHAs in both groups led to increased use of health services by rural communities, but this increase was higher in communities with CHAs recruited by focusing on the career incentives (for example, a 31% increase in women giving birth at the health centre). Applicants recruited through the career-centred approach were more ambitious regarding their career advancement: a larger portion aspired to hold a higher-ranking government position such as a Clinical Officer, Nurse or Environmental Health Technologist in the next 5-10 years. Promoting high-performing CHAs to nursing and other higher-level cadres is likely to be a benefit to the Zambian health service.

Providing good quality skilled work at an entry level in the health sector to the local community has the potential to reduce health inequity in three ways. Firstly, it leads to better health provision for rural communities and better uptake of health services by the community. Secondly, it provides paid, secure jobs to the rural community, where currently in Zambia the agriculture sector is the largest employer, which often does not pay for work (61% of women and 39% of men are not paid at all for their work, whereas 85% of women and 91% of men in the non-agricultural sector are paid in cash). [142] Thirdly, by recruiting in local rural areas for entry-level positions that include the possibility of progression in the health service, Zambia's government is increasing the likelihood of having a more diverse workforce, representative of the local population, which as stated in Section 1, has been shown to lead to a more culturally competent workforce.



AS MANAGERS

As discussed, those employed by the health and social sectors are at an increased risk of adverse physical and psychosocial working conditions. Improving the quality of the working environment – both the physical and organisational setting – can greatly contribute to the elimination of the risks of associated with these sectors. The importance of doing so is increasingly recognised, with focus on the elimination or mitigation of the causes of work-related stress and other adverse working conditions by creating ‘good work’. [136]

While there is no universally accepted definition of what constitutes ‘good work’, many of the definitions available share common features. For example, the International Labour Organization, the Trades Union Congress (UK), and the international Employment Conditions Knowledge Network all highlight the following conditions to be associated with good work: work that both sustains the worker financially, providing security, but also enriches the worker’s life through a good work-life balance, and work that promotes good physical and mental health. [143] [144] [145]

Many hospitals are managed directly by doctors and some research suggests that hospitals perform better when this is the case. [146] When physicians are in a position to manage staff, they should make an effort to ensure that good physical and psychosocial work is provided to all staff, as case study 31 demonstrates.

CASE STUDY 31: HEALTHWISE: IMPROVING SAFETY AND WORK PRACTICES IN HEALTHCARE

The ILO and WHO have developed HealthWISE, a practical manual and guide that encourages managers and staff to work together to promote safe and healthy workplaces and to improve work practices. [147] It includes modules on topics such as controlling occupational hazards and improving workplace safety; biological hazards and infection control; tackling discrimination, harassment and violence in the workplace; and promoting more eco-friendly and healthier workplaces.

In Senegal, a pilot project has been implemented, where the new approach led to better information and practices on working conditions and sensitisation of hospital health workers about HIV. Health workers benefited from training sessions to increase their knowledge of HIV infection and of safer work practices. In the future a network of local trainers and practitioners will be developed to promote practical approaches to strengthen health systems in their own countries.

AS COMMISSIONERS

Healthcare providers often commission and procure services from third parties, indirectly affecting the pay and conditions of many workers and, consequently, health outcomes. It is important that healthcare commissioners consider local employment conditions when allocating resources. In England, research has shown that by allocating additional investment and resources to areas with higher levels of socioeconomic deprivation, the health service has likely reduced inequalities in population ill health. [148]

In England, by law, the social value of NHS commissioning must be taken into consideration. [149] The Institute of Health Equity has written about how the social determinants of health approach could shape procurement and commissioning practices, so that procurement directly improves conditions in the social determinants and reduces health inequalities. Figure 6 is adapted from this. [150]

FIGURE 6. HOW THE SOCIAL DETERMINANTS OF HEALTH APPROACH COULD INFORM PROCUREMENT AND COMMISSIONING PRACTICES [150]



In 2012, Blackburn with Darwen Care Trust Plus established and developed a Social Value Self-Assessment tool to ensure transparency and accountability in the social value of their procurement decisions, as outlined below. [151] A push for this can come inside the profession, as the case study on the Fair Medical Trade campaign organised through the British Medical Association demonstrates.

CASE STUDY 32: USING SOCIAL DETERMINANTS OF HEALTH IN COMMISSIONING OF PRODUCTS AND SERVICES, BLACKBURN WITH DARWEN, UK [150]

In 2012, Blackburn with Darwen (BwD) Care Trust Plus (an integrated adult social care/Primary Care Trust commissioning body) developed a local stakeholder group for social value development. BwD is currently doing three things to generate social value from its local spend:

- Developing a local social value self-assessment tool and piloting it within specific public health contracts
- Analysing and maximising local public sector spend with local businesses
- Investing in local social enterprises as part of its public services reform

The approach has been led by the council, with the involvement of local NHS bodies, providers and the community. An example of social value in procurement includes the support for a local social enterprise in Darwen – Café Hub – which provides a drug- and alcohol-free venue for people in recovery from substance misuse. The council has also moved to an e-procurement system ('the chest') that provides greater access to local, registered suppliers and thus increases opportunities for local spend. A total of 120 council officers have been trained on this e-procurement system and 600 local suppliers have registered to be notified of opportunities. In 2012/13 48% of the council's total spend was with Lancashire-based suppliers; in 2014/15 this increased to 55%.

CASE STUDY 33: BRITISH MEDICAL ASSOCIATION: FAIR MEDICAL TRADE, UK [152]

The National Health Service in the UK spends over £40 billion per annum on procuring goods and services. This is a global supply chain with millions of employees around the world. However, in some cases, the basic employment rights of people in this chain are infringed, affecting their health due to unsafe working conditions and unfair wages. The BMA has campaigned for fair and ethical trade in medical supplies since 2007, and encourages its members to do the same by:

- Educating them about the issue. The BMA provides an online learning course and created a campaign film, The Human Cost of Healthcare [153]
- Raising awareness among colleagues
- Campaigning for their NHS organisation to purchase medical supplies ethically
- Asking healthcare suppliers where they produce their goods

Because of this campaign, many Clinical Commissioning Groups (which are led by physicians) are adopting sustainable procurement and commissioning policies. For example, the City and Hackney Clinical Commissioning Group now includes a commitment in its Constitution to only commission services from providers who can demonstrate a commitment to their social responsibilities and to sustainability principles.

The BMA has campaigned for fair and ethical trade in medical supplies since 2007, and encourages its members to do the same

WHAT THE WMA CAN DO

- Devise an action plan of what can be done to improve access to health professional training and employment for the health professions. This is especially important to the physicians, but should be considered at every level of the healthcare system including auxiliary and support staff
- Provide support for member associations seeking to ensure access for all populations to the healthcare profession
- Protect and advocate for good quality working conditions, health and wellbeing of physicians and other staff working in the health system, including non-professional staff
- Provide support for member associations seeking to ensure good quality work for members and other health professions
- Advocate that all staff working within the healthcare sector are treated with respect and enabled to live with dignity, including being able to feed and house themselves
- Campaign for the rights of workers in the global procurement chain of medical supplies

WHAT NATIONAL MEDICAL ASSOCIATIONS CAN DO

- Prioritise promoting access to the health profession by people from lower socioeconomic positions and marginalised groups
- Promote a safe working environment for all healthcare works, enabling them to protect and assist their patients and communities
- Protect and advocate for the working conditions, health and wellbeing of physicians and other health professionals and others working in the health system
- Support local employment
- Support healthcare systems to consider the welfare of those providing resources, and to ensure no workers are exploited unfairly
- Promote the use of social value assessment in the decision making at every level of commissioning and employment

WHAT DOCTORS CAN DO

- 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 or community-based services
- Support staff: Advocate for good quality work within the profession and where possible advocate for the working conditions of lower skilled, 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



5 Working in partnership: within the health sector and beyond



As described, the most significant influences on population health lie outside the healthcare sector. Adopting the SDH approach means that health professionals form alliances and partnerships with those working in other sectors in order to improve health. Improving conditions in the social determinants of health is a multi-sector endeavour – it involves collaborative action in early years, education, employment and housing, for instance. Action to improve health inequity must therefore be based on partnerships with all these sectors.

Healthcare professionals should partly view their work as being a partner with stakeholders to improve a wide range of social and economic factors that will affect people's health. Doctors need to be trained to develop skills to be effective champions of the SDH approach and to form collaborations and partnerships with other sectors. Adopting the SDH approach requires a nuanced understanding of leadership, facilitation and partnership between the healthcare sectors, other government sectors (such as social protection, early years, transport, education, housing and urban planning), community and third sector organisations and the private sector – which have responsibilities as employers. [154]



PARTNERSHIPS OUTSIDE THE HEALTH SECTOR

Partnerships between the health sector and those outside the health sector can have a significant impact on health inequity, but are often under-utilised. Any action with health services will be strengthened if wider policies in other areas are also being implemented.

The WHO Commission on Social Determinants of Health stated that tackling health inequalities should be a priority across a wide range of areas. [3] These partnerships should go beyond information-sharing to facilitate joint planning, commissioning and delivery. [22] Partners could include other sectors including local government, police and fire services, charities, the private sector, places of work and schools. [155] The social determinants of health can inform these partnerships through taking a life-course approach, highlighting the need for proportionate universalism (as mentioned in the introduction). Case studies 34 and 35 highlight the lasting benefits to local communities and a reduced pressure on the healthcare system when these strategies are taken into consideration.

CASE STUDY 34: BROMLEY BY BOW CENTRE, LONDON [156] [157]

East London's Bromley by Bow Centre is a healthy living centre that has been providing services to the community, available to all, for 30 years. There is a GP surgery along with services ranging from accredited educational and learning courses including English for Speakers of Other Languages (ESOL), to numeracy and literacy courses and access to family learning, employment services with bespoke programmes, a children's centre, artists' studios, outreach programmes and a range of advice services. These services are integrated and cooperative in nature. This approach enables GPs to refer patients to services, including welfare, employment, housing and debt advice services, which help to tackle the social determinants of ill health. The services are tailored to the needs of the whole community, and enable focused interventions for specific groups – families, young people, vulnerable adults and older people. As well as the high levels of chronic physical illnesses there are also significantly high level of mental health problems, which often route back to the social circumstances within which people are living, which the centre aims to address. This model is 73% social (employment, enterprise, arts, skills, welfare and so on) and just 27% clinical.

The centre aims to support people across a range of projects and services in four main ways:

- to overcome chronic illness and unhealthy lifestyles
- to learn new skills
- to become less grant-dependent and to find work
- to use the tools provided to create an enterprising community.





It is feasible and effective to integrate social and emotional development interventions into primary care services with benefits to children's development and mothers' child-rearing knowledge and practices.

CASE STUDY 35: MALNOURISHED CHILDREN'S PROGRAMME, JAMAICA [158]

Health services are often the only government sector routinely making contact with children aged under 3 years in Jamaica, and in many low and middle income countries. Therefore, integrating early-years interventions into healthcare services is a relatively cost-effective way to promote health equity and improve conditions in the early years.

The Tropical Metabolism Research Unit of the University Hospital of the West Indies established the Malnourished Children's Programme in Jamaica in 1994 after hospital personnel noted that many children admitted with malnourishment who recovered and were sent home had to be readmitted for the same condition after a short time. A number of interventions such as nutritional supplements, psychosocial stimulation, and mother and family support have been evaluated in isolation and in combination since then. The results demonstrate that biomedical interventions such as nutritional supplements were far more effective when combined with broader psychosocial interventions and family support. This points for the need to integrate a broader focus on early years than the traditional biomedical focus of health services.

Home visits are organised after the child is discharged from the hospital with the aim of identifying specific and interconnected social determinants of children's health and that of their family. Paraprofessional health staff (health aides) deliver the intervention in addition to their usual duties. Staff focus on stimulation, environmental factors and nutritional status of children.

They also work to increase the economic stability of families. Parents are enrolled in a weekly parental education programme and social welfare project. They are supported to develop income-generating skills, find jobs and shelter. They make job referrals and sponsor parents to take advantage of skills training opportunities. Food packages, bedding and clothing for needy, unemployed parents are provided. A community outreach programme has been developed in three locations in poor areas with high prevalence of malnutrition. The programme includes psychosocial stimulation of children up to age 3, and a mobile toy-library.

Evaluations of interventions revealed a number of important findings. Interventions that included nutritional rehabilitation alone were shown to be insufficient to reduce malnourished children's developmental deficit, demonstrating that medical and nutritional care are not sufficient to reduce the long-term effects of this health inequity. When this was combined with home visits that included a play programme with the aim of promoting mother-child interaction and self-esteem, over a three-year period, malnourished children were shown to catch up to the nourished group after 24 months. While this dipped once the intervention finished, it remained substantially above the malnourished control group. Mothers in the intervention group had improved knowledge of child-rearing and reductions in depressive symptoms. A 22-year follow-up study demonstrated benefits through to adulthood in areas such as cognition, educational attainment, mental health and reduced violent behaviour. [159] The group's research has also demonstrated that it is feasible and effective to integrate social and emotional development interventions into primary care services with benefits to children's development and mothers' child-rearing knowledge and practices. [160]

WORKING WITH COMMUNITIES

As discussed in Section 3, there is a clear need to work with the communities in which patients live, to understand and intervene on the social determinants of health. Many countries have created a role in the health service with a specific focus of engaging with the local community and creating a link between communities and the health service. Community health workers can be effective in tackling SDH and support health professionals more generally to take action on SDH. Provision of community health workers has been shown to be an effective way for healthcare systems to support marginalised communities which have unequal access to healthcare, especially when recruited from the populations they serve. [161] [162] A review of 100 studies demonstrated that the critical factors which influence the overall performance of community health workers include the nature of employment, career prospects and incentives and training. [162] A further review found evidence that community health workers and community participation were most effective when they were large in scale, and integrated throughout the health services and other sectors and services outside healthcare. [163] An example of doctors, nurses and community health workers working in partnership with communities to tackle health inequity can be found in Brazil, as outlined in case study 36.

CASE STUDY 36: THE ROLE OF COMMUNITY HEALTH WORKERS IN PRIMARY CARE, BRAZIL

Primary care teams, composed of a doctor, nurse and at least four community health workers are a key part of the Brazilian government's Sistema Único de Saúde (SUS), or Unified Health System, providing universal care free at the point of delivery. SUS attempts to access the hard-to-reach by employing health workers from the local community. As well as a method for the health service to target people in remote communities, it is also a source of local employment and community empowerment. [164] The method has been demonstrated to be cost-effective and has high levels of user satisfaction. [165] Community health workers are trained for up to three months and carry out a range of activities including basic triage, chronic disease management, breastfeeding support, immunisations, household data collection and health education. Their role also includes a more specific mandate to work with the local community by identifying household determinants of ill health and acting as a liaison between the health service and community leaders, as well as acting as community leaders themselves. [166] Each community health worker visits every household in their micro-area (approximately 100 to 150 households) every month.

Community health workers have been working in Brazil for over 20 years and as of 2013, there were 257,265 lay community health workers in the country, serving 54% of the population. Since their implementation, Brazil has seen significant health improvements and a reduction in health inequity, [167] which researchers have attributed to the programme. [166] Improvements include a reduction in infant mortality and in hospitalisations, particularly hospitalisations due to conditions that are sensitive to effective primary care interventions. There have been improvements in the uptake of screening, breast-feeding, antenatal care and immunisations, and reductions in mental health problems. [166]

Since their (Community Health Workers) implementation, Brazil has seen significant health improvements and a reduction in health inequity, [167] which researchers have attributed to the programme. [166]

CASE STUDY 37: SELF-EMPLOYED WOMEN'S ASSOCIATION (SEWA) HEALTH SERVICES, GUJARAT, INDIA [168] [169]

SEWA is a trade union of self-employed women from the informal sector in India. It has been registered since 1972 and has over 900,000 members. [169] Informal sector workers are not entitled to welfare benefits and often do not have a regular salary. However, the informal sector is by far the largest source of employment in India. [170] SEWA's main goals are to organise women workers for full employment – with job, income, food and social security.

SEWA members are at an increased risk of developing illness, disability and premature death, and SEWA has been engaged in many different forms of preventative and primary healthcare with its members and the local community – particularly those not served by other health providers. Initially this included health education and provision of maternity benefits. It also works to build the capacity of local women (especially local midwives, called dais). Today, SEWA Health works with primary healthcare professionals in stationary health centres and mobile clinics, and provides health education and training, local capacity-building, and occupational and mental health facilities. The mobile camps are led by a physician. They provide reproductive health provision and education, tuberculosis detection and treatment.

A study of the primary users of SEWA Health services found that in Ahmedabad City, services were used disproportionately by the poor, while users did not vary significantly in other areas (particularly rural areas). Qualitative analysis found that success in reaching the poor in this area was achieved through the following elements:

- Providing poor people with respect
- Providing services that are generally free or low cost
- Offering consultations at convenient times
- Locating services in the community
- Generating trust and security through provision by a women-led grassroots organisation

These findings highlight how delivery of services through a grassroots organisation can facilitate equitable delivery of services.



COMMUNITY LEADERS/FAITH LEADERS

Partnering with community leaders can be an effective way to engage hard-to-reach populations and create a culture that encourages health behaviour change. The example below demonstrates how faith-based and community leaders helped to facilitate cardiovascular disease (CVD) checks for South Asian populations in the UK and to create a 'community spirit' for lifestyle changes.

CASE STUDY 38: CVD CHECKS IN FAITH AND COMMUNITY-BASED ORGANISATIONS FOR SOUTH ASIAN POPULATION, LONDON [171]

In the UK people of South Asian ethnic origin on average experience CVDs such as myocardial infarction rates at an earlier age than Caucasian populations. This is true for both the migrant population in the UK (and other high income host countries) and for populations resident in South Asia. Hindu temples, a Mosque and a Bangladeshi community centre were used to conduct health checks targeting this population in London. The team included GPs (family doctors), health check team members, temple community leaders and a Bangladeshi community leader. All attendees of the check were positive about it, and mentioned the convenience and motivating attitude of staff. By working in religious and community venues, there was a high recruitment of the target population including individuals who had not registered with a doctor, an opportunity to educate whole families, and a feeling of mutual support in the community. Some attendees noted that the community centre learnt itself to a patient-centred rather than 'GP-centred' consultation. However, there were some disadvantages, such as privacy being sub-optimal and a need to better ensure data transfer to health services for follow-up so that high-risk patients can be channelled back into mainstream services.

Many of the community and religious leaders added to the programme in a number of ways. The healthcare team highlighted the importance of community volunteers and 'champions', who assisted with the administration of the programme and inspired community participation. In the temple communities, prior to the visit, health education programmes were used to 'prime' the target population. They also organised health promotion activities (for example, healthy cooking classes), which created a community spirit and motivation to enact and maintain lifestyle changes afterwards.

PARTNERSHIPS WITH VOLUNTARY, AND CHARITABLE ORGANISATIONS

The voluntary and charitable sector often has a strong community focus and can be a key place in which to help shape the wider social determinants of health. Doctors should therefore consider their role in referring patients to charity and support services as well as their role as an advocate for these services. For example, the hospital based charity partnership to tackle homelessness described below demonstrates how this can be effective.

CASE STUDY 39: PATHWAY, A CHARITY SECTOR PARTNERSHIP TO TACKLE HOMELESSNESS, UK [172]

Homelessness is an independent risk factor for premature mortality [4] and is associated with extremes of deprivation and multi-morbidity. The annual cost of providing unscheduled care for homeless patients is eight times that of the housed population [1] and homeless patients are over-represented among frequent attenders in hospital Accident and Emergency departments. The average age at death for homeless people in the UK is just 47 years (compared with an average age at death of 86 for men and 89 for women in 2011–2013). [173] Four acute hospitals, with a high proportion of homeless people who are frequent attenders, and which have high admissions and number of bed days, have partnered with the charity Pathway to provide more targeted care that addresses the wider determinants of people's health.

The charity has developed a service that includes a GP, nurse and 'care navigator' (people with experience of homelessness who provide peer support on the ward and for a time after discharge) that are hired on honorary hospital contracts. The nurse interviews all patients in the hospital who have no fixed address or are using a hostel address to discuss the patients' medical and social history and to ask the patient what they would like to gain from the admission. The GP reviews the goals and care plans, and plans the patient's discharge with the patient. One of Pathway's key recommendations following from reviews is the need for multiagency meetings to coordinate care. It found that attendance was improved by having the backing of a senior hospital staff member. These meetings are attended by ward staff, local housing options managers, social workers, drug and alcohol workers, psychiatrists, street outreach workers, hostel key workers and members of the Pathway homelessness team. From these, an 'ideal' multiagency plan is sketched for the homelessness team to develop.

A review of the programme found a decrease in the average length of hospital stay for this group, and a downward trend in bed occupancy. [174]

NATIONAL PARTNERSHIPS

The need to address the wider determinants of health, to reduce health inequity has led a number of governments to develop Health in All Policy (HiAP) approaches. This approach assesses the likely impact of cross sector national, local and international policies on the health of the population and health equity (international, national, regional and local). The HiAP approach also aims to improve accountability of policymakers in all sectors for health and health equity. Among other places the HiAP approach has been adopted in South Australia, [175] Finland [12] and in Wales in the UK [176]. In Norway, the Public Health Act of 2012 has similarities with a HiAP approaches as it places responsibility for public health work as a whole-of-government and a whole-of-municipality responsibility rather than a responsibility for the health sector alone. [177] Doctors can play a leading role in developing and supporting a HiAP approach and in assessing the likely impact of other policies on health and particularly health equity. The Finnish government has adopted this principle to ensure that health professionals are seen as partners in decision-making, as outlined in case study 40.

Municipalities have a legislative duty to reduce health inequity, to promote health and wellbeing and to report annually on this.

CASE STUDY 40: HEALTH IN ALL POLICIES, FINLAND

Finland is a world leader in public health and tackling health inequalities has been high on the agenda since the 1980s, leading to the development of an inter-sectoral health policy, the National Health for All programme in 1987. [178] This process was revised when Finland entered the European Union in 1995 but remains high on the government agenda and the strategy was renewed with the Government resolution on Health 2015. Internationally, the Finnish government promoted the Health in All Policies agenda when it held the EU president role in 2006. Municipalities have a legislative duty to reduce health inequity, to promote health and wellbeing and to report annually on this. There are clearly defined responsibilities and cooperation between administrative sectors, private enterprise and other local actors. The healthcare sector contributes expertise around health. [178]

For example, an unhealthy diet was common in the 1980s in Finland, especially for people in lower socioeconomic groups, which increased the risk of coronary heart disease (CHD). In response, the Finnish government developed a health-based policy around nutrition. This was developed by a number of ministries including the Ministry of Agriculture and Forestry, Ministry of Finance, Ministry of Education and Ministry of Trade and Industry. Although food safety is not the health sector's responsibility, there was collaboration with the health sector to develop and advise on this programme. The health and education sectors have collaborated to develop policies in areas such as health-enhancing physical activity and healthy nutrition. In addition, free food catering in comprehensive schools, as well as subsidised meals for students and workers, were introduced to reduce health inequalities associated with diet and nutrition. While differences in the incidence of CHD between populations is still significant, this collaboration and focus on health inequity are considered as having contributed to the Finnish diet becoming healthier and the gap in diets between socioeconomic groups being reduced. [179]

At a global symposium on the role of physicians and national medical associations in addressing the social determinants of health in 2015, Taru Koivisto, Finland's Director of Ministry of Social Affairs and Health, highlighted the importance of involving the health sector in planning and delivery of cross sector services. This requires that people within the health sector have time, resources and sufficient knowledge of policies in other sectors to engage with a dialogue. There is a need for the health sector to be aware of its own health priorities and how these fit with the priorities of other sectors for mutual benefit. [65]



CASE STUDY 41: CROSS-SECTIONAL PLANNING AND COLLABORATION TO TRAIN HEALTH PROFESSIONALS AND DELIVER A COMPREHENSIVE CERVICAL CANCER PROGRAMME, RWANDA

In 1994 77.8% of the Rwandan population lived below the poverty line. [180] The 1994 genocide decimated an already weak health system and much of the health workforce had fled or been killed. Infectious diseases and child mortality increased rapidly, with 25% of children dying before reaching the age of five. [181] However, years of intensive rebuilding has led to improvements: by 2011 life expectancy had increased to 63 years; the percentage of the population living below the poverty line had reduced to 44.9% in 2012, and under-5 child mortality reduced by 70.4% between 2000 and 2011. According to the most recent available data (2014-15), Rwanda is now on target to achieve each of the health targets set in the Millennium Development Goals- reducing child mortality and improving maternal health. [182] [183] [184] Strategic partnerships between doctors, Rwanda's Ministry of Health, researchers, universities and development partners has led to a strengthened health system capable of delivering the government vision laid out in Vision 2020, [185] a strategy for social and economic development in Rwanda that incorporates health inequity.

Rwanda is the first African country to develop and implement a national strategic plan for cervical cancer vaccination, screening, treatment and care. Cervical cancer is one of the most common cancers affecting women around the world [186] and it disproportionately affects the poorest populations with 77% of new cases and 88% of deaths attributed to cervical cancer occurring in the developing world. [187] To effectively

deliver the vaccine throughout the country, the national government partnered with private companies, community leaders and the community to deliver the HPV vaccine, along with other health prevention initiatives. In 2009 the Rwandan Ministry of Health formed a partnership with a pharmaceutical company of a HPV vaccine for a national rollout. Teachers and village leaders were enlisted in sensitisation efforts and community health workers were mobilised to trace out-of-school girls, who are more likely to be living in poverty. This enabled the principle of proportionate universalism to be applied: a universal programme was combined with targeted efforts to reach those at risk of not receiving the service. Since 2011 three 'health days' are organised each year to vaccinate girls in Grade 6 of primary school. These days also include the dissemination of adolescent health messages and the deworming of 3.8 million children. In 2012 the health days were planned to coincide with Rwanda's annual Maternal and Child Health Week, which involves sensitisation about hand hygiene and reproductive health, delivery of mebendazole (worming treatment), iron and folic acid to pregnant women, and the provision of vitamin A supplementation to children and breastfeeding women. This has led to 93.2% coverage for all three doses of the HPV vaccine among eligible girls in 2011. [188] The success of the school-based HPV vaccination programme shows the effectiveness of health authorities partnering with Ministries of Education, Gender, and local government as well as international development partners, religious organisations and community members.

The key lessons from this initiative include the value of cross-sectoral collaboration and planning, which includes health professionals, conducting sustained campaigns of communication and social mobilisation by using locally employed community health workers, and partnering with local leaders to ensure that universal services are delivered with effort proportionate to the needs of different groups.

INTERNATIONAL PARTNERSHIPS

Partnership is a key part of the WMA's role; the WMA has an official relationship with the WHO and other UN organisations and agencies as well as partnerships with international health professional organisations, patient and student organisations. Professional bodies can also partner with the WMA to make joint statements, which adds extra authority. The WMA has successfully worked with other world associations. For example, in 2008, the WMA and the International Council of Nurses (ICN) submitted a joint statement to the Human Rights Council with a view to embedding the autonomy and freedom from reprisal of health professionals within the existing mandate of the UN Special Rapporteur on the Right to Health and to including surveillance and action on human rights violations related to health professionals. [189] The WMA is also a member of the World Health Professions Alliance (WHPA), which includes the International Council of Nurses, the International Pharmaceutical Federation, the World Confederation for Physical Therapy, the World Dental Federation and the World Medical Association. [190] In 2013, the WHPA issued a statement outlining the importance of inter-professional collaboration; of health system infrastructure, governance, educational programmes, use of evidence and monitoring; and of person-centred practice. [191] Other international bodies are also vitally important for health such as the ILO, UNICEF, and UNDP (United Nations Development Programme). It is imperative for the WMA to partner with a broad range of international organisations to effectively champion the SDH.

WHAT THE WMA CAN DO

- Develop and support better inter-professional understanding and thus partnership working and ideas for collaborative work for action on the social determinants
- Support development of HiAP approaches, with a particular focus on equity
- Work with other health professional representative groups, and other agencies and professions, to prepare guidance and policies to promote inter-professional and cross-professional working, as well as community integration
- Create or develop online regional discussions between national medical associations, such as the African Forum on the Social Determinants of Health, which was developed by past president Dr. Margaret Mungherera for NMAs in the African Region
- Promote the need to work within and with local communities to ensure that healthcare is designed around the needs of the community

WHAT NATIONAL MEDICAL ASSOCIATIONS CAN DO

- Disseminate the message that physicians should be working in partnership with local governments, community leaders and the voluntary and charitable sector
- Produce guidance for physicians on cross-sectoral partnerships in their country's context
- Create networks of physicians to share good practice and develop best practice on social determinant action
- support the development of HiAP approaches, with a focus on equity
- Create working groups to develop action plans to tackle health inequity that include allied health professionals, and if possible, public health, primary and secondary providers. The involvement of the local community is also important
- Support physicians in providing care that is empowering to the patient and utilises the strengths of the community
- Involve the community in partnerships with the healthcare sector to design and deliver healthcare action on the SDH

WHAT DOCTORS CAN DO

- 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



6 Health professionals as advocates



A doctor's important role as an advocate for health is stated in various professional charters and standards around the world. [192] However, how this is conceptualised in everyday practice is less clear and has led to a debate within the profession. Traditionally, advocacy has focused on increasing access to services and drugs. While this is a vitally important role for doctors, the SDH model, which frames health within the broader context of people's lives, means that advocacy needs to have a broader remit if it is to effectively reduce health inequity and improve health. Doctors routinely use their knowledge and skills to advocate for healthcare and healthcare systems improvement; it is essential that they also advocate for broader changes that will reduce health inequities by tackling the social determinants of health. Based on their skills and experiences as well as their trusted role within society, doctors have substantial contributions to make in advocating for the social determinants of health.

As outlined in previous sections, doctors have a role in advocating for SDH to be incorporated into medical education, for individual patients, their local community, and those employed within the health sector. The WMA has committed to taking action on the social determinants of health in its Declaration of Oslo (2015), and through this report and other work seeks to help physicians and national medical associations to advocate to reduce health inequities. This involves advocating both nationally and internationally. There are inspiring examples from around the world of individual doctors, groups of doctors and medical associations advocating for individual patients and the communities that they serve, for the health system and staff, and the broader policy level (national and international), which will impact on the health of individuals and reduce health inequality.



ADVOCATING FOR INDIVIDUALS AND COMMUNITIES

Being advocates for patients is an appropriate role for doctors and other health professionals to have. This often includes advocacy outside the healthcare system. For example, a doctor could write to the providing organisation or owner on behalf of a child with asthma living in a damp home, highlighting the need for refurbishment or rehousing. If a detailed social history is taken of patients, as outlined in Section 3, a clearer understanding of the needs of patients can be gathered, and therefore more effective advocacy would be possible.

Doctors have also been involved in advocating for the needs of specific communities. Recently the Australian Medical Association has updated its Position Statement on the Health Care of Asylum Seekers to highlight asylum seekers' rights particularly around their right to adequate accommodation. They call for an end to the prolonged and open ended detention of asylum seekers, especially of children, in detention centres that are not suitable for their health and wellbeing. For example point 17 states that "Doctors have a duty to speak out when health care services or the environment within an immigration detention centre is inadequate or poses a threat to health." [193] A campaign organised by doctors on behalf of migrants in Spain following the Royal Decree-Law, is outlined in case study 42.



CASE STUDY 42: MEDICAL ORGANISATIONS ADVOCATING FOR POLICY CHANGE IN SPAIN

Sociedad Española de Medicina de Familia y Comunitaria – semFYC (the Spanish Society for Family and Community Medicine) and Médicos del Mundo – MdM (Doctors of the World, Spain). On 20 April 2012 the Royal Decree-Law 16/2012 was passed in Spain, which led to the exclusion of undocumented migrants from access to healthcare; tied healthcare coverage to employment status; and increased out-of-pocket charges for medication. The only remaining point of entry for many people was through hospital accident and emergency services, which meant that, increasingly, people with diseases and those who were victims of violence were not identified and given the necessary care and treatment. Excluding vulnerable groups from access to healthcare will increase health inequity and have an effect on the whole of the population. Some experts have already predicted that, as a result of denial of access to healthcare and medications for about 2% of the population in Spain, there will be an increase of communicable diseases such as HIV and tuberculosis in the population as a whole. Other experts warned of the probability of an increase in mental health problems, including cases of suicide. Many human rights groups, including Amnesty International, have said that the law breaks many existing international acts.

In 2012 the Derecho a Curar (Right to Care) campaign was launched by the Spanish Society for Family and Community Medicine, Médicos del Mundo and other organisations involved in primary and specialist health services, as well as a range of social sector organisations and European networks engaged in defending migrants' rights. Various promotional materials were made available online to provide publicity for the campaign, disseminate information and enable health professionals and the general public to support the campaign. These included posters, videos, car stickers and widgets (an application to embed third party sites onto your webpage or social media account). A number of campaign videos were made and had

been viewed by over 253,000 people in a few months. When the protest campaign against the law was relaunched in the social media in summer 2013, with the video series using the hashtag #leyesquematan (laws that kill), it became a trending topic on Twitter. In 2013, the Nadie Desechado campaign revealed how the healthcare reform, announced as affecting 'only' migrants, also excludes all of society's most vulnerable groups from the healthcare system, in particular people with chronic health conditions. Tens of thousands of signatures in support of the campaign were collected.

MdM has promoted the establishment of 'observatories' to document as accurately as possible cases encountered and barriers to accessing healthcare and so far has recorded more than 1,000 cases of violation of the right to healthcare. Its reports have been submitted to the Health Commission of the Congress of Deputies and to the Ombudsman.

MdM and semFYC urge health workers to resist and to object to the law on grounds of conscience, and to continue to treat all people in need of healthcare, regardless of their administrative status. During the first phase of the campaign, more than 2,000 health professionals formally declared their refusal to implement the exclusions required under law. In addition, 19,000 signatures were collected in support of a letter submitted to the Minister of Health at the beginning of January 2014. A number of regions, such as Andalusia and Catalonia, kept providing healthcare to illegal immigrants.

In March 2015, just before a general election, Spain's government overturned the law. [194] The Prime Minister Rajoy cited rationale from the campaign when explaining the change in policy: "It seems more sensible and more reasonable for primary healthcare to be carried out in health centres so that, among other things, emergency centres are not overwhelmed." [195]

ADVOCATING FOR THE WORKING CONDITIONS OF DOCTORS AND OTHER HEALTH STAFF

Adverse working conditions of healthcare staff (and students) will not only have a negative effect on individuals' health and wellbeing, but can also lead to reduced quality of care for patients, including safety. [196] Burnout is a long-term stress reaction often seen in human service professions. Burnout can be defined as a “psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment”. [197]

Changes in medical practice across the world over the last 20 years may have contributed to a decline in autonomy, diminished status of physicians and increased work pressure, which have led to increased incidence of burnout in the profession, with examples seen in Europe and the USA. [198] Services to support the health and wellbeing of health professionals are inconsistent and often lacking. There is also inequity in who has access to these services where they are present. For example, in the UK an audit revealed that staff working in NHS services who are not directly contracted by NHS organisations do not have the same access to support as colleagues who are directly employed by NHS organisations. [196] Self-care and advocating for the health and wellbeing of all staff and students in the health system may support a workforce which is more ready to tackle the social determinants of health. The WMA supports the human rights of doctors and often intervenes on behalf of doctors who have been persecuted or imprisoned for exercising their human rights.

INTERNATIONAL ADVOCACY

As the only organisation representing the voice of the medical profession globally, the WMA considers advocacy one of its key priorities. The Association has a long history of advocacy in a range of areas. In the field of ethics, it is celebrating the fiftieth anniversary of the Declaration of Helsinki, one of the WMA's best known policy statements, on the ethical principles for medical research involving human subjects, including research on identifiable human material and data. [199] This was originally a response to the systematised abuse of medical research in the 1930s and 1940s, but has developed to reflect the development of a more sophisticated understanding of patients' rights, including autonomy, and the involvement of patients and community members in monitoring the quality of healthcare research. [200] It has been hugely influential the world over.

The WMA has advocated for the development of coordinated public health policies in order to prevent disease, prolong life and improve the health status of all, in areas such as tobacco control, [201] violence against women, [202] and the social determinants of health. [17] The WMA also has a role in encouraging and educating doctors in becoming leaders and advocates, and has done this through methods such as the WMA Caring Physicians of the World Initiative, described in case study 42



CASE STUDY 43: WMA CARING PHYSICIANS OF THE WORLD INITIATIVE [203]

The WMA advocates for the development of comprehensive, sustainable, fully functioning healthcare systems (including medical education). Past President of WMA Yank D. Coble Jr. MD introduced the Caring Physicians of the World Initiative in 2004. Its purpose was to celebrate and inspire doctors around the world and to encourage them to become advocates and leaders. The initiative included the development of a book and a training course that ran over a number of years to develop physicians' leadership skills.

The Declaration of Oslo, on the social determinants of health, was formally adopted by the WMA Council meeting in 2015. [18] The current president of the WMA, Professor Sir Michael Marmot, will be building on this Declaration and utilising its influence and role as an advocate to push this agenda forward. The WMA should also support medical associations to create country-specific social determinants of health action plans and help doctors to lobby more effectively within their countries and across international borders.

NATIONAL ADVOCACY

Many medical associations consider advocacy one of their core aims, particularly influencing public policy to promote best practice in healthcare, guaranteed to citizens and ensuring that public policies are designed to promote public health and reduce inequality. For example, the Bangladesh Medical Association states one of its aims as being to: “consider and express its views on all the laws promulgated in Bangladesh in connection with medical profession, medical practice or medical education, and to keep a keen eye over legislation in Bangladesh which concerns public health, medical profession or medical education and take such steps and adopt such measures from time to time as may be deemed expedient”. [204] The Finnish Medical Association states that it believes “the expertise of doctors has a lot to add to public health policy”. [205] The Irish Medical Organisation launched a campaign to ensure healthcare was centre stage during the 2016 general election. They released a policy document outlining the key pressures on the health service, and suggested areas that should be focused on, including health in all policies. [206] This advocacy role needs to be harnessed for national medical associations to address the social determinants of health in their own countries, including advocating for health and equitable public policies and for SDH to be included in medical education. These associations should work together to increase their power as advocates.

DOCTORS AS ADVOCATES FOR POLICY CHANGE

As outlined in previous sections, doctors have a role in advocating for SDH to be incorporated and developed in medical education, advocating for individual patients, their local community, and those employed within the health sector. Their role as advocates should be supported by national medical associations and the WMA, and encouraged through educational training, where skills and leadership training should be provided. Although it should not be compulsory, doctors can also have a role in informing public debate and encouraging policies which improve health, as case study 44 demonstrates. This role is part of many charters on professional responsibility, such as the American Medical Association’s Declaration of Professional Responsibility: Medicine’s Contract with Humanity, which states that doctors should “advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being”. [207]

CASE STUDY 44: A BASIC INCOME GUARANTEE, ONTARIO, CANADA [208] [209]

In August 2015, 194 physicians in Ontario, Canada signed a letter to the Minister of Health and Long-Term Care asking for leadership in introducing a trial for a Basic Income Guarantee (BIG).

They define a BIG as a guarantee that “ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status”; and a BIG for all as one that “ensures that everyone can meet their needs, participate in society and live with dignity. It reduces steep income inequalities and contributes to better health and fewer societal problems, opening the door to long-term savings in healthcare and other public services. It enables people to manage transitions and setbacks, supports creativity and entrepreneurship, and keeps money moving and producing in our economy.” [210] A long-term aim of this policy would be to reduce health inequity.

This, along with advocacy and campaigning from a number of organisations has led the provincial government of Ontario to include budget funds for a basic income pilot project, and the federal government of Canada is considering similar plans. [211]

STUDENTS AS ADVOCATES

As demonstrated in the example highlighted by case study 45, student doctors are often very committed advocates for improving health equity. However, during the education process this passion often dissipates. A longitudinal study of empathy scores in the USA found that the empathy of medical students' scores diminish throughout their education, most notably in their third year, when they begin to interact with patients. [212] This matches other studies, which found a similar decline in empathy, compassion and humanitarian attitudes by many students as they progress through their medical education. [213] [214] Efforts have been made to understand why this occurs. Qualitative analysis suggests that factors such as lack of adequate role models, a demanding curriculum, time pressure, sleep deprivation, dominance of the biomedical model in education which promotes clinical neutrality and emotional detachment, lack of appreciation and a fear of making mistakes were all outlined as contributing to this marked decline in empathy, or 'socialised amnesia'. [215] While doctors are taught that they should be empathetic in order to provide more patient-centred care and to act as advocates for patients, a number of factors create barriers for this to happen. The WMA, national medical associations, doctors and students should advocate that the social determinants of health is more engrained into the education of health professionals.

CASE STUDY 45: STUDENTS ADVOCATING FOR THE SOCIAL DETERMINANTS OF HEALTH: IFMSA [216]

In 2011, the International Federation of Medical Students' Associations (IFMSA), which represents 1.2 million medical students worldwide, made health inequities and action on social determinants of health a key policy focus. It proposed that civil society groups, for example groups concerned with HIV/AIDS, maternal and child health, non-communicable diseases, and climate change, bring their agendas together under the banner of the social determinants of health to turn current disease-orientated silos into a global coalition for health equity. It recommended that globally agreed indicators of health inequity were established and used for countries to measure progress. IFMSA proposed that students from disciplines beyond the health sector, such as law, economics, business, politics, and environment, also receive training in the social determinants of health.

WHAT THE WMA CAN DO

- Build on the Declaration of Oslo by gathering evidence and case studies of what works and working with national medical associations to promote the SDH
- Promote SDH in all its publications, policies and speeches
- Advocate at an international level for action on SDH and health inequity
- Work with others, including the WHPA, to develop an inter-professional understanding of SDH
- Advocate for the SDH to be incorporated into the education of all health professionals

WHAT NATIONAL MEDICAL ASSOCIATIONS CAN DO

- Advocate for change to the education system to include the SDH
- Advocate for policy changes at the local and national level to support action on the SDH
- Advocate on behalf of their workforce and health care professions to ensure good quality work for those in the health service.
- Advocate at national, regional and local level for policies which recognise the importance of an SDH-based/life-course approach including consideration of the Health in All Policies (HiAP) approach
- Undertake advocacy on behalf of their membership, involving those members who feel able to work as advocates
- Advocate for individuals and communities across sectors and to improve conditions of daily life.

WHAT DOCTORS CAN DO

- 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 health 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 instance.

WHAT STUDENTS CAN DO

- Produce a written statement asking for the social determinants of health to be included in the education curriculum
- Work with trained colleagues to provide convincing arguments for reshaping curricula to incorporate SDH.

Conclusion

The World Medical Association has prioritised addressing the social determinants of health as central to health improvement and tackling health inequity, through the declaration of Oslo 2015. [18] This is in response to a growing body of evidence demonstrating that doctors working at all levels can make significant impact on health inequity through action on the social determinants.

Whether its social prescribing [71] designing services to meet the needs of marginalised communities [121], partnering with community leaders and organisations [168] working to ensure that the health service provides good quality work [147] advocating for a basic income [208] or working with governments to ensure health equity is at the heart of all policy decision. [178] It is clear that doctors, national medical associations and the WMA have a key role to play in tackling health inequity internationally, at a national level, at the local level, and for communities, individuals and their families.

In producing this report we have been inspired by the wide range of areas in which doctors are addressing the social determinants of health—from students advocating for marginalised communities to senior doctors designing programmes to improve community conditions to working with government to create more equitable health policies. This report has highlighted these examples and focused on the key areas through which doctors can influence and reduce health inequity. This 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 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.

The priority for action will depend on the local context and available resources, and many national medical associations and doctors will be constrained by limited resources. However, this does not mean that action is not possible. Effective action ranges from very small changes in what doctors regularly do, to systematic changes at the national level, as illustrated in the case studies throughout.

This report is just the first step in a larger body of work to better integrate the social determinants of health into the work of doctors globally. The WMA plans to be at the forefront of this shift in focus and to harness the potential of doctors to reduce health inequity. It is clear that while much is being done, there is a need for doctors to do something, do more, do better.[10]



REFERENCES

- 1 Marmot, M., *Fair society, healthy lives: the Marmot review ; strategic review of health inequalities in England post-2010*. 2010: [S.l.]: The Marmot Review.
- 2 World Health Organization, *World health statistics 2015*, World Health Organization, Editor. 2015: Luxembourg
- 3 WHO Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health: Commission on Social Determinants of Health Final Report*. 2008: World Health Organization.
- 4 Roberts, J., *Marmot Indicators 2015: A preliminary summary with graphs*. 2015, UCL Institute of Health Equity.
- 5 Demographic and Health Survey. *STATcompiler*. [cited 2015 09/10/2015]; Available from: <http://beta.statcompiler.com/>.
- 6 Bassett, M.T., #BlackLivesMatter — A Challenge to the Medical and Public Health Communities. New England Journal of Medicine, 2015. **372**(12): p.1085-1087.
- 7 Marmot, M.G., *Review of social determinants and the health divide in the WHO European Region: final report*. 2013: World Health Organization, Regional Office for Europe.
- 8 Giele, J.Z. and G.H. Elder, *Methods of life course research: Qualitative and quantitative approaches*. 1998: Sage Publications.
- 9 Kawachi, I., et al., *Social capital, income inequality, and mortality*. *American journal of public health*, 1997. **87**(9): p.1491-1498.
- 10 World Health Organization Regional Office for Europe, *Review of social determinants and the health divide in the WHO European Region: final report*. 2014, World Health Organization Regional Office for Europe: Brussels,.
- 11 Mendelsohn, R., A. Dinar, and L. Williams, *The distributional impact of climate change on rich and poor countries*. *Environment and Development Economics*, 2006. **11**(02): p.159-178.
- 12 Stahl, T., et al., *Health in All Policies: Prospects and potentials*. 2006, Ministry of Social Affairs and Health: Finland.
- 13 World Health Organization, *Health in all policies: training manual*, V. Stone, Editor. 2015: Italy.
- 14 Public Health England, *Health Equity in All Policies Masterclass: Executive summary*, L. Toleikyte, Editor. 2015: London.
- 15 World Medical Association and on behalf of the World Health Professions Alliance, *Statement on the Social Determinants of Health, in World Health Assembly*. 2009: Geneva.
- 16 World Medical Association, *WMA Statement on Inequalities in Health, in WMA General Assembly*. 2009: New Delhi, India.
- 17 World Medical Association, *WMA Statement on Social Determinants of Health, in WMA General Assembly*. 2011: Montevideo, Uruguay.
- 18 World Medical Association. *WMA Declaration of Oslo on Social Determinants of Health*. 2015 [cited 2015 17/12]; Available from: <http://www.wma.net/en/30publications/10policies/s2/>.
- 19 Popay, J., et al., *Social problems, primary care and pathways to help and support: addressing health inequalities at the individual level. Part I: the GP perspective*. *Journal of Epidemiology and Community Health*, 2007. **61**: p.966-971.
- 20 Franks, P. and K. Fiscella, *Reducing Disparities Downstream: Prospects and Challenges*. *Journal of General Internal Medicine*, 2008. **23**(5): p.672-677.
- 21 Clarke, E., L. Fitzgerald, and A. Mutch, *The role of primary care in addressing the social determinants of health: A systematic review of recommendations for general practice*. [Forthcoming].
- 22 Allen, M., et al., *Working for health equity: the role of health professionals*. 2013, UCL Institute of Health Equity: London.
- 23 The Future Hospital Commission, *Future hospital: caring for medical patients*. 2013, Royal College of Physicians: London.
- 24 UCL Institute of Health Equity. *Working for Health Equity: The Role of Health Professionals*. 2016 [cited 2016 17/05]; Available from: <http://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals>.
- 25 Royal College of General Practitioners, *Improving access to health care for Gypsies and Travellers, homeless people and sex workers: An evidence-based commissioning guide for Clinical Commissioning Groups and Health & Wellbeing Boards*. 2013, Royal College of General Practitioners: London.
- 26 Baird, A. and e. al., *Working with Vulnerable Groups: A Clinical Handbook for GPs*, ed. P. Gill, N. Wright, and I. Brew. 2014: Royal College of General Practitioners
- 27 Taylor, J., D. Wilkinson, and B. Cheers, *Working with communities in health and human services*. 2008: Oxford University Press.
- 28 Australian Medical Association. *Social Determinants of Health and the Prevention of Health Inequities*. 2007 [cited 2015 09/10/2015]; Available from: <https://ama.com.au/position-statement/social-determinants-health-and-prevention-health-inequities-2007>.
- 29 Frenk, J., et al., *Health professionals for a new century: transforming education to strengthen health systems in an interdependent world*. *The lancet*, 2010. **376**(9756): p.1923-1958.
- 30 China Medical Board. *Health Professionals for the 21st Century*. [cited 2015 01/04]; Available from: http://www.chinamedicalboard.org/health_professionals_21st_century.
- 31 General Medical Council, *National training survey 2013: socioeconomic status questions*. 2013, General Medical Council: London.
- 32 Medical Schools Council, *A Journey to Medicine: Student Success Guidance* 2014: London.
- 33 BMA Equal Opportunities Committee, *Equality and diversity in UK medical schools*. 2009, British Medical Association: London.
- 34 Rao, V. and G. Flores, *Why aren't there more African-American physicians? A qualitative study and exploratory inquiry of African-American students' perspectives on careers in medicine*. *Journal of the National Medical Association*, 2007. **99**(9): p.986.
- 35 Kington, R., D. Tisnado, and D.M. Carlisle, *Increasing racial and ethnic diversity among physicians: an intervention to address health disparities*. *The right thing to do, the smart thing to do: Enhancing diversity in the health professions*, 2001: p.57-75.



- 36 Furler, J.S., et al., *The inverse care law revisited: impact of disadvantaged location on accessing longer GP consultation times*. The Medical Journal of Australia, 2002. **177**(2): p.80-83.
- 37 Harris, B., et al., *Inequities in access to health care in South Africa*. Journal of public health policy, 2011: p. S102-S123.
- 38 Cohen, J.J., B.A. Gabriel, and C. Terrell, *The case for diversity in the health care workforce*. Health Affairs, 2002. **21**(5): p.90-102.
- 39 University of Glasgow. *Widening opportunities for all to study medicine*. 2014 [cited 2015 09/10]; Available from: http://www.gla.ac.uk/news/archiveofnews/2014/december/headline_383033_en.html.
- 40 Republic of Rwanda, *Human Resources for Health Program. Strategic plan 2011-2016*, M.o. Health, Editor. 2011.
- 41 Huish, R. and J.M. Kirk, *Cuban Medical Internationalism and the Development of the Latin American School of Medicine*. Latin American Perspectives, 2007. **34**(6): p.77-92.
- 42 Souers, J. *CUBA LEADS THE WORLD IN LOWEST PATIENT PER DOCTOR RATIO; HOW DO THEY DO IT?* 2015 [cited 2015 09/10]; Available from: <http://www.socialmedicine.org/2012/07/30/about/cuba-leads-the-world-in-lowest-patient-per-doctor-ratio-how-do-they-do-it/>.
- 43 Porter, C., *Cuba-trained doctors making difference around the world*, in The Star. 2012: Toronto.
- 44 Policy Team, *Tackling the social determinants of health through culture change, advocacy and education*. 2010, Royal College of Physicians,.
- 45 Maryon-Davis, A., *How can we better embed the social determinants of health into postgraduate medical training?* Clinical Medicine, 2011. **11**(1): p.61-63.
- 46 O'Brien, M.J., et al., *Training medical students in the social determinants of health: the Health Scholars Program at Puentes de Salud*. Adv Med Educ Pract, 2014. **5**: p.307-14.
- 47 Berlin, A., *UCL Medical School Social Determinants of Health module* S. Thomas, Editor. 2015.
- 48 Leeds School of Medicine. *Working in Partnership with patients, carers and their families*. [cited 2015 09/10]; Available from: http://medhealth.leeds.ac.uk/info/256/patients_and_carers/.
- 49 Gabriel, B.A., *Beyond Hospital Walls: Teaching Students About Social Determinants of Health*. 2012, AAMC Reporter: Association of American Colleges.
- 50 Suurmond, J.L., P. Hudelson, and N. Dogra, *Culture and health*. The Lancet, 2015. **385**(9968): p.602.
- 51 Rother, H.-A., *CASE STUDY: UNIVERSITY OF CAPE TOWN, SOUTH AFRICA*, WMA Secretariat, Editor. 2016.
- 52 Kreisberg, J., *Preventive Medicine: Taking an Environmental History*. Integrative Medicine. **8**(5).
- 53 Rother, H.-A., *Improving poisoning diagnosis and surveillance of street pesticides*. SAMJ: South African Medical Journal, 2012. **102**(6): p.485-488.
- 54 Faulkner, L.R. and R.L. McCurdy, *Teaching medical students social responsibility: the right thing to do*. Academic Medicine, 2000. **75**(4): p.346-350.
- 55 Dharamsi, S., et al., *The physician as health advocate: translating the quest for social responsibility into medical education and practice*. Academic Medicine, 2011. **86**(9): p.1108-1113.
- 56 Wong, W., *SDH in curriculum for primary care Hong Kong*, J. Allen, Editor. 2015.
- 57 Vaidya, A., et al., *Acquaintance with the actuality: community diagnosis programme of Kathmandu Medical College at Gundu village, Bhaktapur, Nepal*. 2008.
- 58 World Health Organization, *WHO eBook on integrating a Social Determinants of Health Approach into Health Workforce Education and Training, in First Meeting of the Steering Group*. 2014, WHO: Geneva.
- 59 WHO. *Transformative Education for Health Professionals*. [cited 2016 06/07]; Available from: <http://whoeducationguidelines.org/case-studies>.
- 60 Hunt, P., *Report on progress and obstacles to the health and human rights movement 2007*, Office of the United Nations High Commissioner for Human Rights: Geneva.
- 61 Flowers, M. *Nationwide Medical Students' Die-In, #WhiteCoats4BlackLives*. 2014 [cited 2015 01/04]; Available from: <https://www.popularresistance.org/nationwide-medical-students-die-in-whitecoats4blacklives/>.
- 62 International Federation of Medical Students' Associations. *The IFMSA Global Health Equity Initiative*. [cited 2015 01/04]; Available from: <http://www.ifmsa.org/Activities/Initiatives/The-IFMSA-Global-Health-Equity-Initiative>.
- 63 Australian Medical Students' Association, *Health Inequities and Their Social Determinants*. 2011.
- 64 Jong-wook, L., *Address to WHO staff*. 2003, WHO: Geneva.
- 65 Buckley, J., *REPORT OF THE GLOBAL SYMPOSIUM: , in The role of physicians and national medical associations in addressing the social determinants of health and health equity*. 2015, Canadian Medical Association: BMA House, London.
- 66 Plough, A., *Developing New Systems of Data to Advance a Culture of Health*. eGEMs, 2014. **2**(4).
- 67 Bloch, G., *Poverty: A clinical tool for primary care in Ontario*, S.M.s. Hospital, Editor. 2013, Ontario College of Family Physicians: Toronto.
- 68 UCL Institute of Health Equity. *Marmot Indicators* 2014. 2014 10/11/2014]; Available from: <http://www.instituteofhealthequity.org/projects/marmot-indicators-2014>.
- 69 Public Health England. *Public Health Outcomes Framework*. 2014 16/05/2014]; Available from: <http://www.phoutcomes.info/>.
- 70 Westert, G., et al., *Monitoring health inequalities through general practice: the Second Dutch National Survey of General Practice*. The European journal of public health, 2005. **15**(1): p.59-65.
- 71 Thomson, L.J., P.M. Camic, and H.J. Chatterjee, *Social Prescribing: A review of community referral schemes*. 2015, University College London: London.
- 72 Phillips, G., et al., *Well London Phase-1: results among adults of a cluster-randomised trial of a community engagement approach to improving health behaviours and mental well-being in deprived inner-city neighbourhoods*. Journal of epidemiology and community health, 2014: p. jech-2013-202505.
- 73 Derges, J., et al., *'Well London' and the benefits of participation: results of a qualitative study nested in a cluster randomised trial*. BMJ open, 2014. **4**(4): p. e003596.
- 74 Millenium Villages Project. *Sector Strategy*. 2013 [cited 2015 09/10]; Available from: <http://millenniumvillages.org/about/sector-strategy/>.
- 75 Sinai, I.S.o.M.a.M. *Asthma Mobile Health Study*. 2015 [cited 2015 09/10]; Available from: <http://apps.icahn.mssm.edu/asthma/>.
- 76 Setel, P.W., et al., *A scandal of invisibility: making everyone count by counting everyone*. The Lancet, 2007. **370**(9598): p.1569-1577.

- 77 National Bureau of Statistics (NBS) [Tanzania] and ICF Macro, *Tanzania Demographic and Health Survey 2010*. 2011, NBS and ICF Macro: Dar es Salaam, Tanzania.
- 78 *Tanzania rolls out birth registration by mobile phone*, in Al Jazeera. 2015.
- 79 UNICEF, *The Government of Tanzania launches a new national birth registration system set to massively accelerate the number of children under 5 with birth certificates*. 2013.
- 80 Bisin, S., *In the United Republic of Tanzania, a new solution for birth registration*. 2014, UNICEF.
- 81 Garratt, A., E. Solheim, and K. Danielsen, *National and cross-national surveys of patient experiences: a structured review*. 2008, Norwegian Knowledge Centre for the Health Services (Kunnskapsenteret): Oslo.
- 82 NHS Yorkshire and The Humber, *Prevention and Lifestyle Behaviour Change: A Competence Framework*. 2010.
- 83 Wilson, A. and S. Childs, *The relationship between consultation length, process and outcomes in general practice: a systematic review*. British Journal of General Practice, 2002. 52(485): p.1012-1020.
- 84 Howie, J., et al., *Long to short consultation ratio: a proxy measure of quality of care for general practice*. British Journal of General Practice, 1991. 41(343): p. 48-54.
- 85 Wilson, A., et al., *Health promotion in the general practice consultation: a minute makes a difference*. Bmj, 1992. 304(6821): p.227-230.
- 86 Deveugele, M., et al., *Consultation length in general practice: cross sectional study in six European countries*. Bmj, 2002. 325(7362): p.472.
- 87 OECD/WHO, *Consultations with doctors, in Health at a Glance*. 2012: OECD Publishing.
- 88 Stirling, A.M., P. Wilson, and A. McConnachie, *Deprivation, psychological distress, and consultation length in general practice*. British Journal of General Practice, 2001. 51(467): p.456-460.
- 89 Mercer, S.W., et al., *Multimorbidity and the inverse care law in primary care*. Vol. 344. 2012.
- 90 Westert, G.P., L. Jabaaij, and F.G. Schellevis, *Morbidity, performance and quality in primary care: Dutch general practice on stage*. 2006: Radcliffe Publishing.
- 91 Hampson, M., K. Langford, and P. Baeck, *Redefining Consultations: changing relationships at the heart of health*, J. Temperley, Editor. 2013, NESTA: London.
- 92 Heap, M., *CASE STUDY: PROFESSIONAL SIGN LANGUAGE INTERPRETERS ENSURING EQUITABLE ACCESS TO HEALTH CARE FOR SIGNING DEAF PEOPLE. A CASE STUDY IN CAPE TOWN WMA Secretariat*, Editor. 2016.
- 93 Behforouz, H.L., P.K. Drain, and J.J. Rhatigan, *Rethinking the Social History*. New England Journal of Medicine, 2014. 371(14): p.1277-1279.
- 94 Moscrop, A. and P. MacPherson, *Should doctors record their patients' income?* British Journal of General Practice, 2014. 64(627): p. e672-e674.
- 95 Chauvin, P., et al., *Access to healthcare for people facing multiple health vulnerabilities in health*. 2015, Doctors of the World: Paris.
- 96 Brcic, V., C. Eberdt, and J. Kaczorowski, *Development of a tool to identify poverty in a family practice setting: a pilot study*. International journal of family medicine, 2011. 2011.
- 97 Pinto, A.D., et al., *Building a Foundation to Reduce Health Inequities: Routine Collection of Sociodemographic Data in Primary Care*. The Journal of the American Board of Family Medicine, 2016. 29(3): p.348-355.
- 98 de Leeuw, S., *Physician activism and prescribing against poverty*. Canadian Family Physician, 2016. 62(4): p.332-335.
- 99 Jones, E., *Consultations with patients*, S. Thomas, Editor. 2015.
- 100 Barber, N., et al., *Patients' problems with new medication for chronic conditions*. Quality and Safety in health care, 2004. 13(3): p.172-175.
- 101 Miller, W.R. and S. Rollnick, *Motivational interviewing: Helping people change*. 2012: Guilford press.
- 102 Rollnick, S. and W.R. Miller, *What is motivational interviewing?* Behavioural and cognitive Psychotherapy, 1995. 23(04): p.325-334.
- 103 National Hauora Coalition, *Māori Health Innovation Programme: Sharing knowledge, innovation and successful practises*. 2012, National Hauora Coalition.: Auckland.
- 104 Swift, J., *An Investigation into GPs and Social Prescribing. A Pilot Study*. 2007, Glasgow Centre for Population Health: Glasgow.
- 105 Brandling, J. and W. House, *Social prescribing in general practice: adding meaning to medicine*. Br J Gen Pract, 2009. 59(563): p.454-456.
- 106 Voluntary Action Rotherham. *Social Prescribing Service*. [cited 2015 09/10]; Available from: <http://www.varotherham.org.uk/social-prescribing-service/>.
- 107 Dayson, C., N. Bashir, and S. Pearson, *From dependence to independence: emerging lessons from the Rotherham Social Prescribing Pilot*. 2013, Sheffield Hallam University: Sheffield.
- 108 MacKeith, J., *The development of the Outcomes Star: A participatory approach to assessment and outcome measurement*. Housing, Care and Support, 2011. 14(3): p.98-106.
- 109 Population Council, *Living Up to Their Name: Profamilia Takes on Gender-based Violence*, D. Rogow, Editor. 2006, Population Council: New York.
- 110 World Medical Association, *WMA Resolution on Violence against Women and Girls, in 61st WMA General Assembly*,. 2010: Vancouver, Canada.
- 111 Dubowitz, H., *The Safe Environment for Every Kid Model: Promotion of Children's Health, Development, and Safety, and Prevention of Child Neglect*. Pediatric annals, 2014. 43(11): p. e271-e277.
- 112 Hunter, D.J. and A. Killoran, *Tackling health inequalities: turning policy into practice*. 2004, NHS Health Development Agency: London.
- 113 Burt, R.S., *The Social Capital of Opinion Leaders*. Annals of the American Academy of Political and Social Science, 1999. 566: p.37-54.
- 114 Gargett, A., *The United Nations Declaration on the Rights of Indigenous Peoples: A Manual for National Human Rights Institutions*. 2013, Asia Pacific Forum of National Human Rights Institutions and the Office of the United Nations High Commissioner for Human Rights: Geneva.
- 115 Statistics Canada, *Projections of the Aboriginal Populations, Canada, Provinces and Territories, 2001 to 2017*. 2010.
- 116 Mikkonen, J. and D. Raphael, *Social Determinants of Health: The Canadian Facts*. 2010, York University School of Health Policy and Management: Toronto.
- 117 Richmond, C.A.M. and N.A. Ross, *The determinants of First Nation and Inuit health: A critical population health approach*. Health & Place, 2009. 15(2): p.403-411.
- 118 Currie, C.L., et al., *Illicit and prescription drug problems among urban Aboriginal adults in Canada: The role of traditional culture in protection and resilience*. Social Science & Medicine, 2013. 88: p.1-9.

- 119 Health Canada, *First Nations and Inuit Health Strategic Plan: A shared path to improved health*. 2012, Health Canada: Ottawa.
- 120 Lavoie, J.G., et al., *Have investments in on-reserve health services and initiatives promoting community control improved First Nations' health in Manitoba?* Social Science & Medicine, 2010. **71**(4): p.717-724.
- 121 Mohawk Council of Kahnawake, *Kahnawake Community Health Plan 2012-2022*. 2013.
- 122 Ontario Ministry of Community and Social Services. *Supporting Aboriginal people*. 2012 [cited 2015; Available from: <http://www.mcscs.gov.on.ca/en/mcscs/programs/community/programsforaboriginalpeople.aspx>].
- 123 Hefford, M., P. Crampton, and J. Foley, *Reducing health disparities through primary care reform: the New Zealand experiment*. Health Policy, 2005. **72**(1): p.9-23.
- 124 Sporle, A., N. Pearce, and P. Davis, *Social class mortality differences in Maori and non-Maori men aged 15-64 during the last two decades*. N Z Med J, 2002. **115**(1150): p. 127-31.
- 125 Durie, M.H., *A Maori perspective of health*. Social Science & Medicine, 1985. **20**(5): p.483-486.
- 126 Crengle, S., *The development of Maori primary care services*. Pacific Health Dialog, 2000. **7**(1): p. 48-53.
- 127 Ratima, M.M., et al., *Strengthening Maori participation in the New Zealand health and disability workforce*. Medical Journal of Australia, 2007. **186**(10): p.541.
- 128 New Zealand Ministry of Health, *Nga Koero Mai i Te Kete Hauora*. 2014.
- 129 Roberts, A. *Improving community health one pet at a time*. 2015 [cited 2015 09/10]; Available from: <http://www.health.govt.nz/our-work/populations/maori-health/maori-health-case-studies/improving-community-health-one-pet-time>.
- 130 Langford, K., P. Baek, and M. Hampson, *More than Medicine: new services for People Powered Health*, J. Temperley, Editor. 2013, NESTA: London.
- 131 Kilpatrick, S., et al., *Boundary crossers, communities, and health: Exploring the role of rural health professionals*. Health & Place, 2009. **15**(1): p.284-290.
- 132 Keele, H., *The Community Capacity Assessment (CCA) Tool*. 2007, Adelaide: PIRSA.
- 133 Lancet, T., *Don't forget health when you talk about human rights*. The Lancet, 2015. **385**(9967): p.481.
- 134 World Medical Association, *Turkish Government Urged to Restore Basic Health Care to Cities in Conflict*. 2015.
- 135 Health and Safety Executive, *Stress and psychological disorders in Great Britain 2013*. 2013.
- 136 Di Martino, V., *Relationship of work stress and workplace violence in the health sector*. 2003: Citeseer.
- 137 Durcan, D., *Promoting good quality jobs to reduce health inequalities*. 2015, UCL Institute of Health Equity: London.
- 138 Kuper, H. and M. Marmot, *Job strain, job demands, decision latitude, and risk of coronary heart disease within the Whitehall II study*. Journal of Epidemiology and Community Health, 2003. **57**(2): p.147-153.
- 139 International Labour Office, *World employment and social outlook 2015: The changing nature of jobs*. 2015, ILO: Geneva.
- 140 Institute for Emerging Issues, *Transitioning the Long-Term Unemployed in Rural North Carolina into Allied Health Careers: A Demonstration Model & Suggestions for Implementation*. 2012, North Carolina State University.
- 141 Ashraf, N., O. Bandiera, and S.S. Lee, *Do-gooders and go-getters: career incentives, selection, and performance in public service delivery*. 2014, Suntory and Toyota International Centres for Economics and Related Disciplines, LSE.
- 142 Central Statistical Office (CSO) [Zambia], M.o.H.M.Z., ICF International. , *Zambia Demographic and Health Survey 2013-14*. 2014, Central Statistical Office, Ministry of Health, and ICF International: Rockville, Maryland, USA.
- 143 International Labour Organisation. *Decent Work*. 24/10/14; Available from: <http://www.ilo.org/global/topics/decent-work/lang--it/index.htm>.
- 144 Touch Stone Extras, *In Sickness and in Health? Good work - and how to achieve it*. 2010. p.3.
- 145 Benach J, Muntaner C, and Santana V, *Employment Conditions Knowledge Network (EMCONET) Final Report*. 2007.
- 146 Goodall, A.H., *Physician-leaders and hospital performance: Is there an association?* Social Science & Medicine, 2011. **73**(4): p.535-539.
- 147 International Labour Organisation and World Health Organisation. *HealthWISE - Work Improvement in Health Services - Action Manual*. 2014 [cited 2015 01/04]; Available from: http://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---sector/documents/instructionalmaterial/wcms_237276.pdf.
- 148 Barr, B., C. Bambra, and M. Whitehead, *The impact of NHS resource allocation policy on health inequalities in England 2001-11: longitudinal ecological study*. BMJ, 2014. **348**.
- 149 Social Enterprise UK, *Public Services (Social Value Act): A brief guide*. 2012, Social Enterprise UK: London.
- 150 Allen, M. and J. Allen, *Using the Social Value Act to reduce health inequalities in England through action on the social determinants of health*. 2015, PHE publications: London.
- 151 Gilroy, R. and M. Tewdwr-Jones, *Joining the dots - making healthcare work better for the local economy*. 2015, The Smith Institute: London.
- 152 British Medical Association. *Fair Medical Trade: Take action - Healthcare professionals*. [cited 2015 09/10]; Available from: <http://bma.org.uk/working-for-change/international-affairs/fair-medical-trade/take-action/take-action-health-professional>.
- 153 BMAtv. *The Human Cost of Healthcare*. 2012 [cited 2015 09/10]; Available from: The Human Cost of Healthcare.
- 154 Marmot, M., *Fair society, healthy lives*. Inequalities in Health: Concepts, Measures, and Ethics, 2013: p.282.
- 155 Marmot, M., et al., *Fair society, healthy lives: Strategic review of health inequalities in England post-2010*. 2010.
- 156 UCL Institute of Health Equity. *Bromley By Bow Centre*. 2012 [cited 2015 09/10]; Available from: <http://www.instituteofhealthequity.org/projects/bromley-by-bow-centre>.
- 157 centre, B.b.b. *Our Impact*. 2015 [cited 2015 09/10]; Available from: <http://www.bbhc.org.uk/our-impact>.
- 158 Young, M., *From Early Child Development to Human Development: Investing in Our Children's Future*. 2002, Washington: World Bank.
- 159 Walker, S., et al., *Building human capacity through early childhood intervention: the Child Development Research Programme at the Tropical Medicine Research Institute, the University of the West Indies, Kingston, Jamaica*. The West Indian medical journal, 2012. **61**(4): p.316-322.
- 160 Powell, C., et al., *Feasibility of integrating early stimulation into primary care for undernourished Jamaican children: cluster randomised controlled trial*. BMJ, 2004. **329**(7457): p.89.
- 161 Labonté, R., et al., *Implementation, effectiveness and political context of comprehensive primary health care: preliminary findings of a global literature review*. Australian Journal of Primary Health, 2008. **14**(3): p.58-67.

- 162 Prasad, B.M. and V. Muraleedharan, *Community health workers: a review of concepts, practice and policy concerns*. A review as part of ongoing research of International Consortium for Research on Equitable Health Systems (CREHS), 2007.
- 163 Lehmann, U. and D. Sanders, *Community health workers: What do we know about them? The state of the evidence on programmes, activities, costs and impact on health outcomes of using community health workers*. World Health Organization, 2007. **2**: p.1-42.
- 164 Harris, M., *Integrating primary care and public health-learning from the Brazilian way*. London Journal of Primary Care, 2012. **4**: p.126-32.
- 165 Lewin, S., et al., *Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases*. Cochrane Database of Systematic Reviews, 2010(3): p. Cd004015.
- 166 Johnson, C.D., et al., *Learning from the Brazilian community health worker model in North Wales*. Globalization and health, 2013. **9**(25): p. 10.1186.
- 167 Macinko, J. and M. Lima-Costa, *Horizontal equity in health care utilization in Brazil, 1998-2008*. International Journal for Equity in Health, 2012. **11**(1): p.33.
- 168 Ranson, M.K., et al., *India: assessing the reach of three SEWA health services among the poor*. Reaching the Poor with Health, Nutrition, and Population Services, 2005: p. 163-87.
- 169 Association, S.E.W.s. *About Us*. n.d. [cited 2016 04/01]; Available from: http://www.sewa.org/About_Us.asp.
- 170 Sastry, N., *Estimating informal employment & poverty in India*. 2004: Human Development Resource Centre.
- 171 Eastwood, S.V., et al., *Cardiovascular risk assessment of South Asian populations in religious and community settings: a qualitative study*. Family Practice, 2013. **30**(4): p.466-472.
- 172 Pathway. *Transforming health services for homeless people*. 2015 [cited 2015 09/10]; Available from: <http://www.pathway.org.uk/>.
- 173 Office for National Statistics, *Statistical bulletin: National Life Tables, United Kingdom, 2011-2013*. 2014.
- 174 Hewett, N., A. Halligan, and T. Boyce, *A general practitioner and nurse led approach to improving hospital care for homeless people*. BMJ, 2012. **345**.
- 175 World Health Organization and G.o.S. Australia, *Adelaide Statement on Health in All Policies moving towards a shared governance for health and well-being*. 2010, World Health Organization, Government of South Australia: Adelaide, South Australia.
- 176 Health Improvement Division, *Fairer Health Outcomes For All: Reducing Inequities in Health Strategic Action Plan* 2011, Welsh Assembly Government Cardiff, Wales.
- 177 Ministry of Health and Care Services (MHCS) Norway, *The Norwegian Public Health Act (ACT 2011-06-24 no. 29) – for international audience*, Ministry of Health and Care Services (MHCS) Norway, Editor. 2012.
- 178 Melkas, T., *Health in all policies as a priority in Finnish health policy: a case study on national health policy development*. Scandinavian Journal of Public Health, 2013. **41**(11 suppl): p.3-28.
- 179 Raulio, S., E. Roos, and R. Prättälä, *School and workplace meals-Do they promote healthy food habits in the population?* Publ Health Nutr, 2010. **33**: p.987-92.
- 180 Farmer, P., et al., *Reduced premature mortality in Rwanda: lessons from success*. Bmj, 2013. **346**.
- 181 United Nations Children's Fund, et al., *Levels and trends in child mortality*.
- 182 MDG Monitor. *Fact sheet on current MDG progress of Rwanda (Africa)*. 2015 [cited 2016 16/05]; Available from: <http://www.mdgmonitor.org/mdg-progress-rwanda-africa/>.
- 183 National Institute of Statistics of Rwanda (NISR) [Rwanda], Ministry of Health (MOH) [Rwanda], and and ICF International, *Rwanda Demographic and Health Survey 2014-15*. 2015: Rockville, Maryland, USA.
- 184 Binagwaho, A., et al., *The Human Resources for Health Program in Rwanda – A New Partnership*. New England Journal of Medicine, 2013. **369**(21): p. 2054-2059.
- 185 Republic of Rwanda, *RWANDA VISION 2020, MINISTRY OF FINANCE AND ECONOMIC PLANNING*, Editor. 2000.
- 186 Ferlay, J., et al., *Estimates of worldwide burden of cancer in 2008: GLOBOCAN 2008*. Int J Cancer, 2010. **127**(12): p.2893-917.
- 187 Forouzanfar, M.H., et al., *Breast and cervical cancer in 187 countries between 1980 and 2010: a systematic analysis*. The Lancet. **378**(9801): p.1461-1484.
- 188 Binagwaho, A., et al., *Achieving high coverage in Rwanda's national human papillomavirus vaccination programme*. Bulletin of the World Health Organization, 2012. **90**(8): p.623-628.
- 189 International Council of Nurses and World Medical Association. *Extension of the mandate of UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health in order to include health professionals' autonomy and freedom from reprisal*. 2008 [cited 2015 02/04]; Available from: http://www.wma.net/en/20activities/20humanrights/10health/0102_Human_rights-rev-att2.pdf.
- 190 World Health Professional Alliance. *What is the WHPA?* n.d. [cited 2015 16/12]; Available from: <http://www.whpa.org/whpa.htm>.
- 191 World Health Professions Alliance, *WHPA Statement on Interprofessional Collaborative Practice*. 2013.
- 192 Medicine, A.F.A.B.o.I., *Medical professionalism in the new millennium: a physician charter*. Annals of Internal Medicine, 2002. **136**(3): p.243.
- 193 Australian Medical Association, *Health Care of Asylum Seekers and Refugees - 2011*. Revised 2015., in Position Statement. 2015.
- 194 Rodriguez, B. and S. Morris, *Spain to reinstate primary healthcare for illegal immigrants, in Reuters*. 2015: Online.
- 195 Frankham, S., *Illegal immigrants to regain rights to healthcare in Spain, in EuroWeekly News*. 2015: Online.
- 196 Royal College of Physicians, *Work and wellbeing in the NHS: why staff health matters to patient care*. 2015, Royal College of Physicians, : London.
- 197 Van Dierendonck, D., W.B. Schaufeli, and H.J. Sixma, *Burnout among General Practitioners: A Perspective from Equity Theory*. Journal of Social and Clinical Psychology, 1994. **13**(1): p.86-100.
- 198 Linzer, M., et al., *Predicting and preventing physician burnout: results from the United States and the Netherlands*. The American Journal of Medicine, 2001. **111**(2): p.170-175.
- 199 World Medical Association, *WMA Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects*. 1964: Helsinki, Finland.

- 200 Carlson, R., K. Boyd, and D. Webb, *The revision of the Declaration of Helsinki: past, present and future*. British journal of clinical pharmacology, 2004. **57**(6): p.695-713.
- 201 World Medical Association. *WMA Statement on Health Hazards of Tobacco Products and Tobacco-Derived Products*. 1988 [cited 2016 05/01]; Available from: <http://www.wma.net/en/30publications/10policies/h4/>.
- 202 World Medical Association. *WMA Resolution on Violence against Women and Girls*. 2010 [cited 2016 05/01]; Available from: <http://www.wma.net/en/30publications/10policies/v3/>.
- 203 Duncan, N., *Caring Physicians of the World*. New York: Pfizer Medical Human Initiatives, 2005.
- 204 Bangladesh Medical Association. *BMA Activities*. 2014 [cited 2016 05/01]; Available from: http://bma.org.bd/index.php?option=com_content&view=article&id=1262:bma-activities&catid=106:sports-news.
- 205 Finnish Medical Association. *The Finnish Medical Association Health actor*. 2014 [cited 2015 09/10]; Available from: <http://www.laakariliitto.fi/liitto/terveyspoliittinen/>.
- 206 Irish Medical Organisation, *2020 Vision for Health*. 2014, IMO: Dublin, Ireland.
- 207 American Medical Association. *H-140.900 A Declaration of Professional Responsibility*. 2015 [cited 2015 17/12]; Available from: <https://www.ama-assn.org/ssl3/ecommerce/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/H-140.900.HTM>.
- 208 Upstream. *A basic income guarantee may be the best medicine*. 2015 [cited 2015 09/10]; Available from: http://www.thinkupstream.net/big_medicine.
- 209 Berger, P. and On behalf of the 194 physician signatories, *Ontario Physicians letter to Minister of Health and Long-Term Care, Hon. Dr. Eric Hoskins*. 2015: Health Providers Against Poverty.
- 210 Basic Income Canada. *A basic income guarantee is an idea that works*. [cited 2015 09/10]; Available from: <http://www.basicincomecanada.org/>.
- 211 Anderson, L. and D. Martin, *Let's get the basic income experiment right*, in *The Star*. 2016: Online.
- 212 Hojat, M., et al., *The devil is in the third year: a longitudinal study of erosion of empathy in medical school*. Academic Medicine, 2009. **84**(9): p.1182-1191.
- 213 Chen, D., et al., *A cross-sectional measurement of medical student empathy*. Journal of General Internal Medicine, 2007. **22**(10): p.1434-1438.
- 214 Woloschuk, W., P. Harasym, and W. Temple, *Attitude change during medical school: a cohort study*. Medical education, 2004. **38**(5): p.522-534.
- 215 Hafferty, F.W., *Into the valley: Death and socialization of medical students*. 1991: Yale University Press.
- 216 International Federation of Medical Students' Associations. *IFMSA Policy Statement: Health Equity and the Social Determinants of Health*. 2011 [cited 2016 05/01].



CASE STUDY INDEX

CASE STUDY 1: Widening Opportunities For All To Study Medicine, University Of Glasgow, Scotland [39]	17
CASE STUDY 2: Escuela Latinoamericana De Medicina (ELAM) (Latin American School Of Medicine), Cuba [41]	19
CASE STUDY 3: UCL Medical School Social Determinants Of Health Module [47]	20
CASE STUDY 4: Universities Incorporating The Social Determinants Of Health In Medical Training	21
CASE STUDY 5: E-Learning On The Social Determinants Of Health: Royal College Of Physicians And The Royal College Of Midwives, Uk [24]	22
CASE STUDY 6: Incorporating Environmental Determinants Of Health Into Medical Training And Linking Research To Training And Practice, Univeristy Of Cape Town, South Africa [51]	22
CASE STUDY 7: Community Diagnosis Programme, Kathmandu Medical College, Nepal [57]	23
CASE STUDY 8: WHO Ebook [58]	23
CASE STUDY 9: The International Federation Of Medical Students Associations (Ifmsa) Global Health Equity Initiative [62]	24
CASE STUDY 10: Australian Medical Students Association Campaign To Influence Australian Medical Schools [63]	24
CASE STUDY 11: Production Of Sdh Indicators, England	28
CASE STUDY 12: Dutch National Survey Of General Practice (Dnsgp), Netherlands [70]	28
CASE STUDY 13: Well London – A Cluster Randomised Trial And Longitudinal Qualitative Evaluation, Uk [72, 73]	29
CASE STUDY 14: Baylor Health Care System, Dallas, Texas, Usa	30
CASE STUDY 15: An App For Asthma Research, Icahn School Of Medicine, New York, Usa [75]	32
CASE STUDY 16: Birth Registration By Text Message In Tanzania	33
CASE STUDY 17: Professional Sign Language Interpreters Ensuring Equitable Access To Healthcare For Signing Deaf People, Cape Town, South Africa [92]	38
CASE STUDY 18: Poverty Tool: A Clinical Tool For Primary Care, Ontario, Canada [67]	39
CASE STUDY 19: St. Michael's Hospital, Ontario, Canada [97] [98]	40
CASE STUDY 20: Consultations With Patients – Medecins Du Monde (Doctors Of The World), Europe [95]	40
CASE STUDY 21: Te Awa – A Self-Assessment Tool For Aboriginal Peoples In New Zealand [103]	41
CASE STUDY 22: Rotherham Social Prescribing, Uk [106] [107]	43
CASE STUDY 23: Training Healthcare Staff On Intimate Partner Violence In The Dominican Republic: The Role Of Referrals [109]	43
CASE STUDY 24: Safe Environment For Every Kid (Seek) Project, University Of Maryland School Of Medicine, Usa [111]	44
CASE STUDY 25: Kahnawake, Mohawk Nation, Quebec, Canada [121]	46



CASE STUDY 26: Aboriginal Healing And Wellness Strategy (Ahws), Health Centres, Ontario, Canada [122]	46
CASE STUDY 27: Ngati Hine Trust, New Zealand [128]	47
CASE STUDY 28: Healthcare In Otangarei: Te Hau Awhiowhio O Otangarei Wh Nau Ora Collective, New Zealand [129]	47
CASE STUDY 29: Transitioning The Long-Term Unemployed Into Allied Health Careers, North Carolina, Usa [140]	52
CASE STUDY 30: Recruiting Quality Community Health Workers, Zambia	53
CASE STUDY 31: Healthwise: Improving Safety And Work Practices In Healthcare	55
CASE STUDY 32: Using Social Determinants Of Health In Commissioning Of Products And Services, Blackburn With Darwen, Uk [150]	57
CASE STUDY 33: British Medical Association: Fair Medical Trade, Uk [152]	57
CASE STUDY 34: Bromley By Bow Centre, London [156] [157]	61
CASE STUDY 35: Malnourished Children's Programme, Jamaica [158]	62
CASE STUDY 36: The Role Of Community Health Workers In Primary Care, Brazil	63
CASE STUDY 37: Self-Employed Women's Association (Sewa) Health Services, Gujarat, India [168] [169]	64
CASE STUDY 38: CVD Checks In Faith And Community-Based Organisations For South Asian Population, London [171]	65
CASE STUDY 39: Pathway, A Charity Sector Partnership To Tackle Homelessness, Uk [172]	65
CASE STUDY 40: Health In All Policies, Finland	66
CASE STUDY 41: Crosssectional Planning And Collaboration To Train Health Professionals And Deliver A Comprehensive Cervical Cancer Programme, Rwanda	67
CASE STUDY 42: Medical Organisations Advocating For Policy Change In Spain	72
CASE STUDY 43: WMA Caring Physicians Of The World Initiative [203]	74
CASE STUDY 44: A basic income guarantee, ontario, canada [208] [209]	75
CASE STUDY 45: Students Advocating For The Social Determinants Of Health: Ifmsa [216]	76