



UCL INSTITUTE OF HEALTH EQUITY

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

Across the world, people's health is shaped by the conditions in which they are born, grow, live, work and age – and the inequities in power, money and resources that give rise to these conditions [1]. These 'social determinants of health' influence the length and quality of peoples' lives, and create clear inequalities in health outcomes between countries as well as within countries. Most of the systematic differences in health and life expectancy between populations across the world arise as a result of differences in the conditions in which people are born, grow, live work and age. These levels of health inequality are unnecessary and avoidable and reducing them is a matter of social justice.

Health is profoundly shaped by factors outside the health care sector and reducing health inequality requires the involvement of sectors outside healthcare is essential. But there are also significant and important actions that health professionals can take to help improve the conditions in which people live.

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

The report explicitly sets out a strategy for WMA and NMAs and provides practical approaches for medical professionals and their associations to incorporate the social determinants of health in 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, and political will.

This report takes the same view as the WHO European Review of Social Determinants of Health: 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 some existing policies, this review shows how 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.

Following the introduction, the report is structured to follow the areas for action:

1. [Education and Training](#)
2. [Building the evidence: monitoring and evaluation](#)
3. [The clinical setting: working with individuals and communities](#)

4. [Health system roles: as employers, managers and commissioners](#)
5. [partnerships: within the health sector and beyond](#)
6. [Advocating for change: for the patient, community and health system](#)

THE DRAFT

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THE DRAFT

INTRODUCTION

GLOBAL HEALTH INEQUITIES

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. In 2013 life expectancy was 68 years for men and 73 years for women (world health statistics). These gains were seen across countries in different income groups, and are 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.

The gaps 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 socio-economic position the higher the risk of poor health and greater the likelihood of premature death. To illustrate this we have looked at life expectancy or mortality rates, between and within countries.

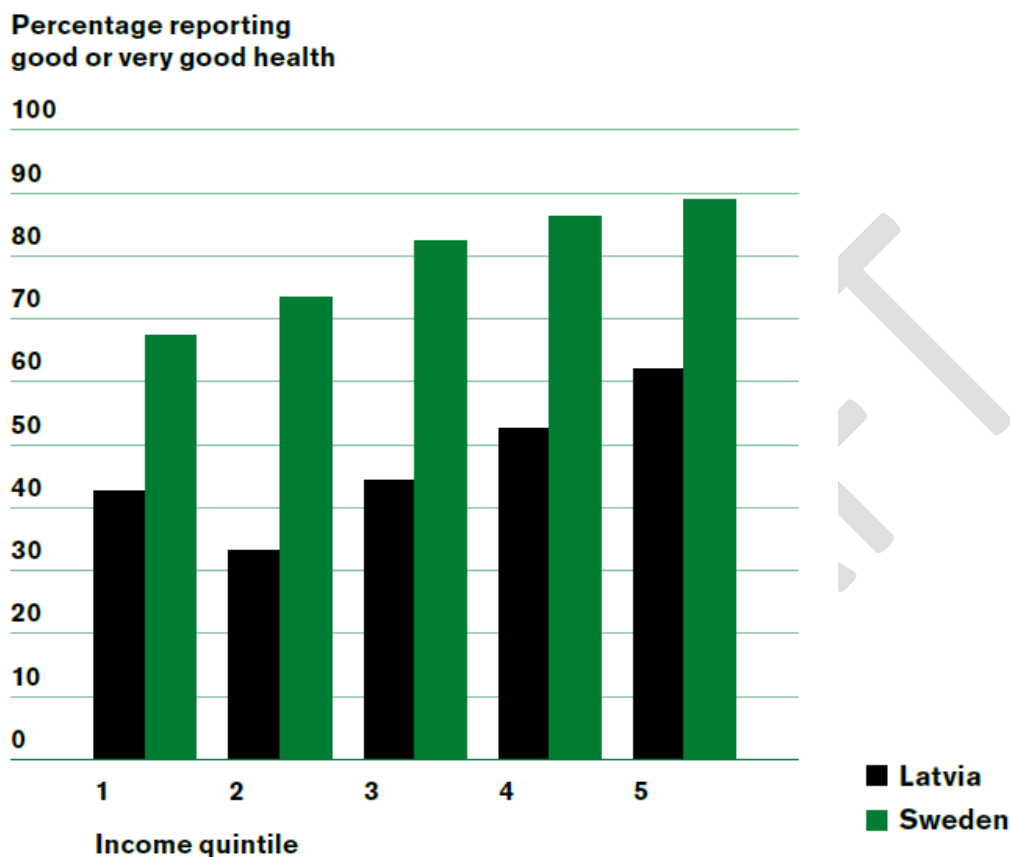
REGIONAL DIFFERENCES

In 2013, the region of the Americas had the highest life expectancy at 77, the European Region, and Western Pacific Region followed with a life expectancy of 76, followed by Eastern Mediterranean Region and South-East Asia Region 68. Africa has an average life expectancy of 58 with many countries within Africa having life expectancies in the 50s. [2]

WITHIN COUNTRY INEQUITIES

For all countries for which data exist 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] Fig. 3 illustrates this by comparing 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, United Kingdom, personal communication, 2012 (from European Review).

For England as a whole, the average life expectancy at birth in 2011-13 was 79.4 for males and 83.1 for females. This average, however, can hide vast differences in life expectancy between individuals, as shown in figures 2 and 3. When neighbourhood deprivation is looked at the median level of inequality 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 examined. In 2011-13 healthy life expectancy for males in Blackpool, the most deprived area based on the 2015 classification, was 54.9 while it was 71.4 in Wokingham (classified as the least deprived) – a 16.5 year difference. For females the respective figures were 58.3 and 69.9 – an 11.6 year difference. In England, people from more deprived areas do not only die sooner, but they spend longer of their shorter lives with disabilities. [4]

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

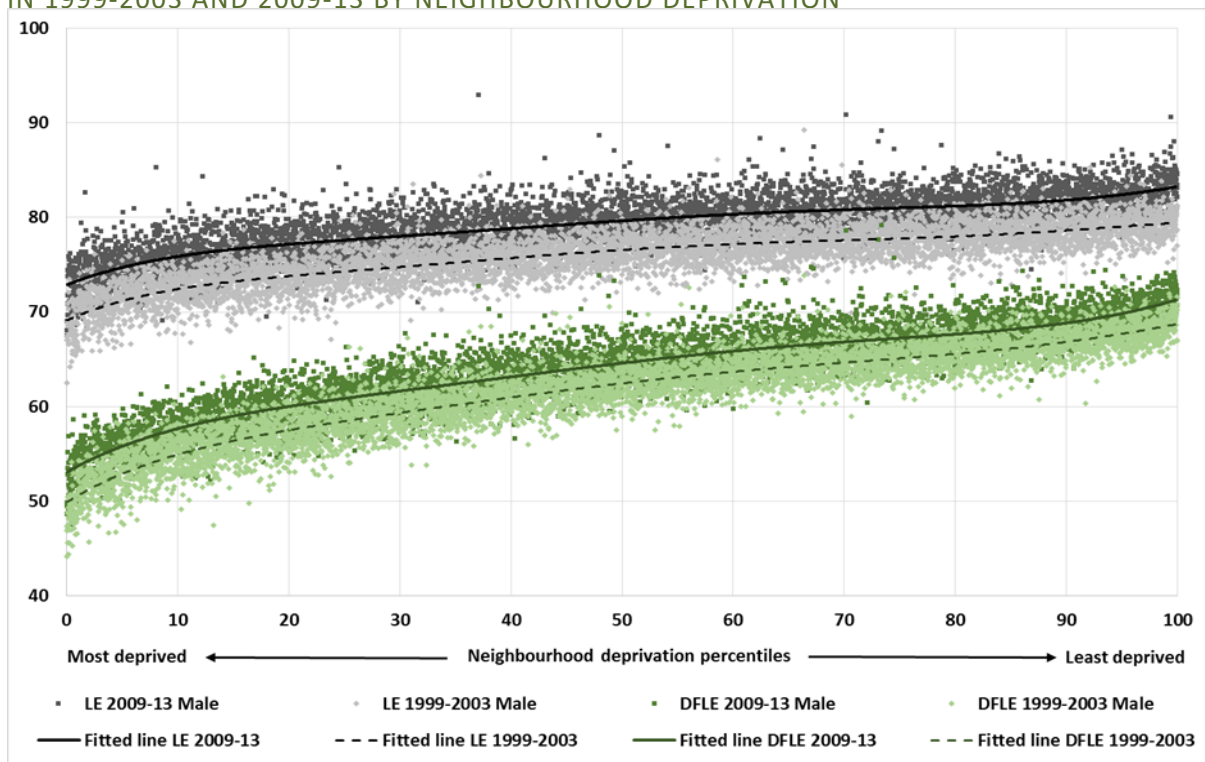
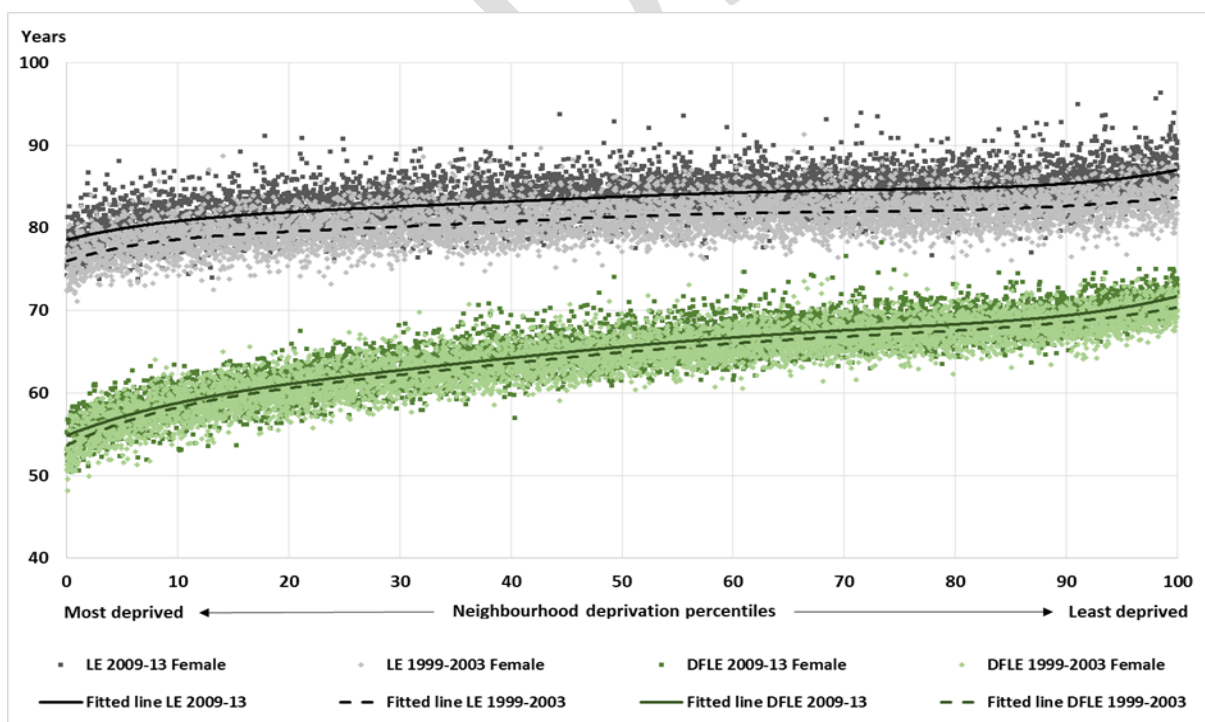


FIGURE 3: FEMALE LIFE EXPECTANCY AND DISABILITY FREE LIFE EXPECTANCY (DFLE) AT BIRTH IN 1999-2003 AND 2009-13 BY NEIGHBOURHOOD DEPRIVATION



Source: Marmot Indicators 2015 [4]

Life expectancy by socioeconomic status is not regularly measured for all countries; however, data on the social gradient in under-five mortality can be found. In low and middle-income countries a clear gradient can be seen in under-five mortality, as shown in the figure 3 below.

FIGURE 3: UNDER FIVE MORTALITY BY WEALTH QUINTILE IN UGANDA, INDIA, TURKMENISTAN, BANGLADESH AND PERU AT VARIOUS DATES



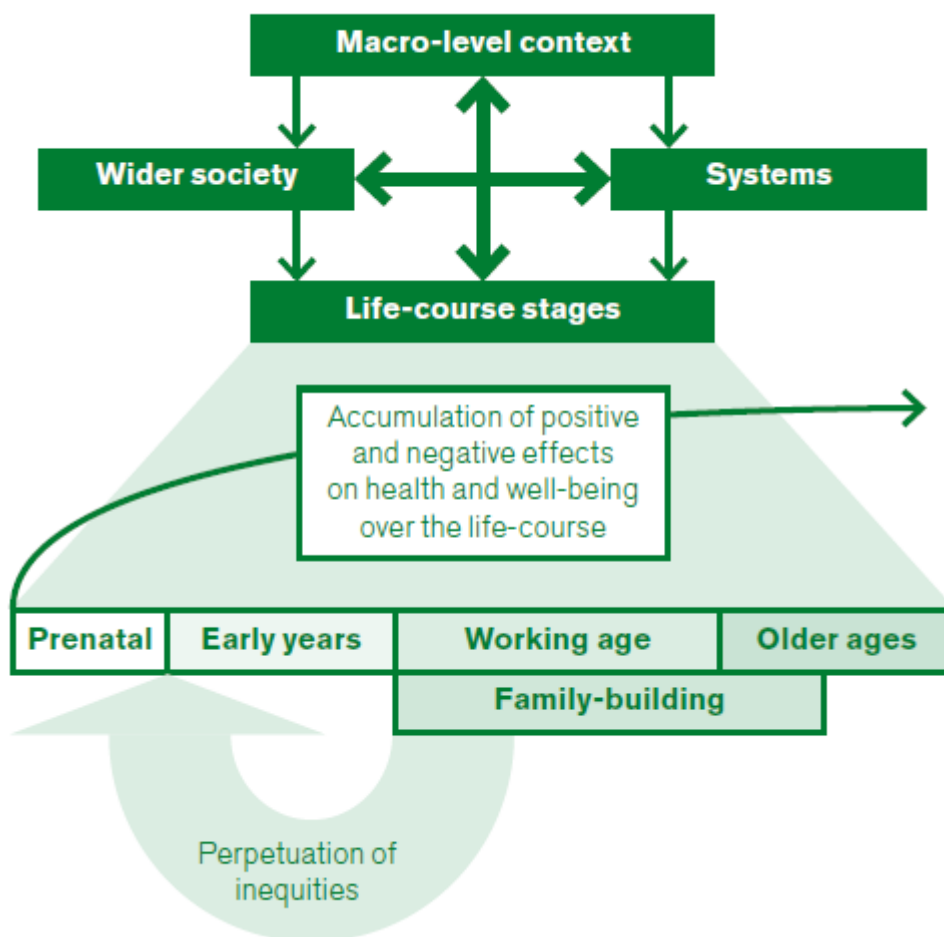
Source: DHS [5]

THE SOCIAL DETERMINANTS OF HEALTH

Health inequalities are caused by 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 health care system, education and judicial system. [6] Exposure to these health-damaging (and health-promoting) effects are determined by an individual's social positions such as their education, occupation, income, and influenced by other characteristics such as gender and ethnicity. For example, in New York City, USA the rate of premature death (under 70) is 50% higher among black men than among white men. [7] Figure 4 below outlines the broad mechanisms that impact on individual's health.

FIGURE 4: CONCEPTUAL FRAMEWORK FOR THE SOCIAL DETERMINANTS OF HEALTH, BASED ON THE HEALTH DIVIDE

Broad themes



Source: WHO European Review of Social Determinants of Health [8]

The WHO Commission on the social determinants of health highlighted the following key areas to tackling the SDH:

- early child development;
- education;
- work and living conditions; and
- the structural causes of these living and working conditions.

The three principles of action highlighted to tackle the SDH were:

- improve the conditions of daily life;

- tackle the inequitable distribution of power and
- 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 average health of the population and to reduce health inequities. To do this effectively it is essential to bring the health of less-advantaged people closer towards the level of the most-advantaged by tackling the root causes of inequalities. The social determinants of health approach looks beyond provision of health care 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, health care 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 health care system, a growing body of evidence suggests that health professionals, and the health care system have the levers and influence to improve health for the whole population. 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, [8] as outlined in figure 4 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. [9] 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 – 'intergenerational transmission' of inequalities. The life-course perspective should be used to understand the context of patients' lives and emerges as an effective way to plan partnerships and action on social determinants of health 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. [8]

Cultural and societal norms can affect health by influencing trust and cooperation in society, the levels of trust and support in society, or 'social capital' is associated with health inequalities as it is associated with total mortality and mortality related to coronary heart disease. [10] 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 face powerful social, economic, political and cultural exclusionary processes, including prejudice and discrimination, which adversely affects their human rights and self-determination. [11] The influence of wider society points for the need for joint action at every level as

well as the need to advocate for vulnerable groups who face exclusion. The large effect of wider society on an individual patient's health, points to the need for the health system to work closely with communities, organisations and charities that can influence this.

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 individuals' exposure to health damaging (and health-promoting) conditions. They affect individuals' and communities' vulnerabilities (and resilience). Factors affecting health and health inequality are often the very same factors determining for example environmental quality. 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 health care system. There is a need to integrate health with other social and environmental policies. Health inequality should be integrated with other societal and environmental policies. This points to the need for doctors and medical associations to be aware of this macro-level context and to be empowered to advocate on behalf of communities and individuals whose health is negatively affected by this. For example, the negative health effects of climate change on individuals in poorer countries. [12]

SYSTEMS

The health system and health professionals deal with many health outcomes which are the result of actions in other sectors including national governments; multinational organisations; foundations; civil society and nongovernmental organisations; academic institutions and corporations. Coherence of action is needed across these sectors to effectively tackle the social determinants of health and reduce the distributions of health inequities. This has led some countries such as Finland to adopt a Health in all Policies Approach (HiAP), [13] which is supported by the WHO. [14] This strategy should include a strong focus on health equity, and many have suggested that Health Equity in All Policies should be adopted. [15]

These systems themselves should be designed and governed to reduce the social gradient in health inequality 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, show that health inequities affect everyone to some degree, except those at the very top. So efforts to improve health equity need to focus on lifting and flattening the gradient. This requires effort proportionate to need across the whole social class gradient. Effort needs to be universal, for the whole population, but proportionate to need. For doctors and health systems, this suggests that health services should be designed around the concept of proportionate universalism.

SOCIAL DETERMINANTS OF HEALTH AND THE WMA

Despite the fact that health professionals are witnesses to inequalities and see the outcomes on a daily basis, their potential impact and that of the health care system, to reduce health 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 all over the world. As the only organisation representing the voice of the medical profession globally, it plays a key role in setting standards and advocating for doctors, medical students and for a healthy society in general. 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. [16] At the WMA General Assembly in Delhi, 2009, the WMA formally recognised the importance of SDH [17] and made the following recommendations:

- Recognise the importance of health inequality 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 to plan clinical activities (diagnostic and treatment) to counter their consequences.
- Advocate for the abolishment of financial barriers to obtaining needed medical care.
- Advocate for equal access for all to health care services irrespective of geographic, social, age, gender, religious, ethnic and economic differences or sexual orientation.
- Require the inclusion of health inequality 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. [18] The role of doctors as informed participants in the debate and advocates for action were stated. The WMA defined its role:

- Understand what the emerging evidence shows and what works, in different circumstances.
- To help doctors to lobby more effectively within their countries and across international borders, and ensure that medical knowledge and skills are shared.
- Gather data of examples that are working, and 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 the appropriate steps to try to minimise these root causes of premature ill health.
- The WMA should gather examples of good practice from its members and promote further work in this area.

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 general support by General Medical Assembly in Moscow in 2015 [19]. This report aims to use the best evidence to develop this agenda and support the 2015 declaration. A number of NMAs around the world are enthusiastic about

working on SDH and this report provides evidence and examples of what doctors can do to effectively tackling the SDH.

CURRENT GUIDELINES FOR HEALTH PROFESSIONALS ON THE SOCIAL DETERMINANTS OF HEALTH

While the primary focus for addressing the social determinants of health by the WMA has been on fostering and supporting national policy changes by government policies and society, there is growing recognition of the need to also target the *"lived experience of inequalities"* p967)[20] in healthcare settings. [21]

For example, a child with asthma that is living in a damp home requires remedial action on the causes of the poor health - the damp home. Doctors may advocate for that patient and request that the 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 the child's education, wellbeing and activity levels.

However, clear guidance on how doctors can influence and improve the social determinants has been minimal. A forthcoming review of recommendations internationally for doctors to tackle the SDH [22] demonstrated that only 13% of all recommendations were 'downstream', or 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, namely 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 [23] which included commitments to action from a number 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 in the UK participated in the report including midwives, paramedics, dieticians, physiotherapists and speech and language therapists. Each organisation provided statements about actions that health professionals could take in their practitioner role, and provided 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 published the report the Future Hospital Commission, [24] 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, they are supporting more joined-up ways of working across the local health and social care economy, including doctors working out in the community. They are also developing an e-learning module on the role of physicians in tackling health inequality, which they

aim to have accredited for continuous professional development (CPD) (*REF-tool when online*). The Royal College of GPs produced the Social Inclusion Commissioning Guide with the University of Birmingham.[25] They are 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 tackling health inequalities perspective. They have published a clinical handbook on working with vulnerable patients for those undergoing GP training.

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 set out a strategy for the WMA, NMAs and medical professionals to better incorporate the social determinants of health into their work. These strategies are categorised according to the following sections.

1. [Education and Training](#)
2. [Building the evidence: monitoring and evaluation](#)
3. [The clinical setting: working with individuals and communities](#)
4. [Health system roles: as employers, managers and commissioners partnerships: Within the health sector and beyond](#)
5. [Advocating for change: for the patient, community and health system](#)

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

In many countries the education of health professionals does not include a focus on the social determinants of health – the real drivers of poor health and inequity. Whilst professionals are comfortable with interventions around individual level factors that affect health, training in broader community and social levels are generally lacking, leading to professionals feeling less comfortable with this level of intervention. [26] This has led some national medical associations (NMAs) to call for this to be included in the curriculum for health professionals. For example, the Australian MA encourages medical colleges and professional societies to increase their members' awareness of health inequities in general, and of potential bias in medical treatment decisions. [27] 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, should be to enhance the performance of health systems to meet the needs of people and populations in an efficient and equitable manner. 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. The Commission on the Education of Health Professionals categorised the challenges to health professional education according to the four Cs [28, 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:* 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 e.g. lectures, small student learning groups, team-based education, early patient or population exposure, different worksite training bases, longitudinal relationship 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. *“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 [28]

CRITERIA FOR ADMISSION

As discussed, access to the medical profession by minorities and people from lower socio-economic 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, [30] and 20% of secondary schools provide 80% of applicants to medicine. [31] 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. [32] Only 4% of U.S. doctors are black, compared with 13% of the population, and the number of black medical school graduates has not increased noticeably in the past decade. [33]

Improving access to the medical profession can impact on social determinants of health by increasing employment opportunities for people from lower socioeconomic groups, as described in section 4. There is also evidence that people from more deprived areas are more likely to work in deprived areas [34] and it creates a more culturally competent workforce capable of treating a diverse society [35].

The Australian MA 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. [27] 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, [31] 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 and;
- the use of more 'contextualised' admission processes.

A number of universities are working towards implementing this, such as the University of Glasgow, as outlined below.

CASE STUDY: WIDENING OPPORTUNITIES FOR ALL TO STUDY MEDICINE UNIVERSITY OF GLASGOW [36]

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 19.6 students between 2012 and 2014. This was achieved through a number of activities:

- 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 this stage,
- applying a broad definition of work experience to allow for all applicants to be considered, irrespective of ability to obtain direct experience in the health sector,
- considering applicants flexibly under 'extenuating circumstances' and accepts 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 preconception from 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.

Given the shortages of health care professionals in lower and middle income countries (LMICs), as discussed in Section 4, many LMIC countries are developing education programmes to train health professionals. 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. [37] 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 LMIC countries, discussed below.

CASE STUDY: CUBA: ESCUELA LATINOAMERICANA DE MEDICINA (ELAM) (LATIN AMERICAN SCHOOL OF MEDICINE) [38]

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 Organization. While initially only students from Latin America and the Caribbean could enrol, it is now open to candidates from low income or medically underserved areas in Africa, Asia and the United States¹.

Preference is given to applicants who are from lower socio-economic 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. [39] 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.

Today, Cuba sends 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. [40]

COMPETENCIES

‘Competencies’ refers to the development of practical skills. For the education of health professionals to address health inequality, 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 inequality 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 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 have 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. [23] Examples of how this can be done are outlined below.

UNDERGRADUATE AND POSTGRADUATE

Education on the social determinants of health should be a mandatory core element of all undergraduate courses. [23] 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 workers; third sector workers and childcare specialists. [41] Maryon-Davis (2011) suggests that rotations in community-based specialties, such as general practice, community paediatrics and public health should be considered and that shared learning programmes and placements between clinical specialties and public health could be productive. [42] 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, 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 stated a perception of learning more about this topic in the HSP than in their formal medical training and often a long-term desire to serve vulnerable communities as a result. [43] O'Brien and colleagues point to the need to develop and monitor community level outcomes. 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 below.

CASE STUDY: UCL MEDICAL SCHOOL SOCIAL DETERMINANTS OF HEALTH MODULE [44]

The Social Determinants of Health Module in UCL 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 of 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, screening 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 Electives Global health 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 STUDIES: UNIVERSITIES INCORPORATING THE SOCIAL DETERMINANTS OF HEALTH IN MEDICAL TRAINING:

Leeds School of Medicine; in the UK have incorporated the social determinants of health and health inequalities into their teaching. [45] This includes:

- Emphasises 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 for students on poverty and the social determinants of health

Centre on Social Disparities in Health at the University of California, San Francisco, School of Medicine (UCSF) [46]

- 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.

University of Pennsylvania Perelman School of Medicine [46]

- 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
- Pilot projects are hosted on an ongoing basis 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.

University of New Mexico Health Sciences Centre and New Mexico State have developed the Health Extension Rural Offices (HEROs) program, [46] which

- Has 12 health extension agents to 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.
- Established a pipeline programme for medical students to tribal areas
- Health extension agents trained community health workers which are now in one-third of New Mexico counties, and HEROs plans to train more.

Culturally Competent in Medical Education (C2ME) project includes 11 medical schools in the European Union. The C2ME project has defined a set of knowledge and skills (e.g., basic knowledge of ethnic and social determinants of health; skills to teach in a non-judgmental way; and skills to engage, motivate, and encourage participation of all students) that all teachers need in order to incorporate cultural competence topics into their teaching [47]

CONTINUAL PROFESSIONAL DEVELOPMENT

Continual Professional Development (CPD) should be “*flexible, practice based and work based*”. (p. 56 [23]). It should be free, universally available and have incentives for professionals to take part. The provision should be a broad assessment of social and economic conditions that affect health, and on strategies and successful practices within the profession to 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 HI and SDH.

E-LEARNING ON THE SOCIAL DETERMINANTS OF HEALTH: ROYAL COLLEGE OF PHYSICIANS, AND THE ROYAL COLLEGE OF MIDWIVES, UK: (REF WHEN AVAILABLE)

The Institute of Health Equity is working with both the RCP and the RCM 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 in an equitable way 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, longitudinal relationship with patients and communities, reflective learning and online courses. Experiential training is important and placements with community groups, charities and social care networks allow students to see how a variety of social situations affect the health of the people living within them, enabling students to develop a sense of social responsibility. [48] [49] The University of Hong Kong is piloting a ‘service learning’ programme in partnership with local NGOs with targeting populations that are socially disadvantaged. Students will work on site in both medical-related and non-medical work. [50] Using the SDH approach can

inform how these channels can be utilized to effectively tackle health inequality. Two such examples are outlined below.

CASE STUDY: KATHMANDU MEDICAL COLLEGE, NEPAL: COMMUNITY DIAGNOSIS PROGRAMME [51]

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 with an increased awareness of health-related matters and evidence of behavioural changes towards healthier lifestyles.

CASE STUDY: WHO E-BOOK [52]

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

It aims to draw together the best global resources on social determinants of health illustrates with cases studies drawn from around the world and is designed to be used on multiple platforms

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, teamwork, have a strong foundation in ethics and be centred on the interests of patients and populations. [28] A rights based approach to health has been promoted as a means of educating professionals on equitable policies and programmes. [53]

Medical students often enter the medical profession with a passion to tackle the SDH and mobilise to tackle health inequality, such as the International Federation Of Medical Students Associations (IFMSA) 'white coat die ins' around the USA to protest health inequality of Black people in the United States[54]. More generally, IFMSA have developed a Global Health Equity Initiative, see the case study below. This interest is not driven or developed by their 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 NMAs should work with student groups that are mobilised to tackle the social determinants of health. Some of these initiatives are outlined below.

THE INTERNATIONAL FEDERATION OF MEDICAL STUDENTS ASSOCIATIONS (IFMSA) GLOBAL HEALTH EQUITY INITIATIVE[55]

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

AUSTRALIAN MEDICAL STUDENTS ASSOCIATION CAMPAIGN TO INFLUENCE AUSTRALIAN MEDICAL SCHOOLS:[56]

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.

WHAT THE WMA CAN DO

The WMA has no direct influence on the education of medical professionals at any level (undergraduate, 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.

- issue a declaration on the need for mandatory core elements of SDH in education
- promote that declaration internationally and to its membership
- work with student groups and educational bodies to issue a statement on core knowledge and skills that should be taught around the social determinants of health,
- learn from low and middle-income countries, and from students and junior doctors who have a huge wealth of experience about what needs to be done.
- develop e-learning materials, this will be part of a blended learning approach that involves meetings and workshops and will be developed over time. We are also developing a MOOC to bring the online discussion to wider audience, conduct workshops (potentially regional clusters) for all NMAs to send candidates.

WHAT NMAS CAN DO

NMAs' power to influence the undergraduate and postgraduate curriculum is also limited, but they could still influence education at a number of levels. For example, they could:

- Review the existing arrangements that medical schools have on the SDH and work nationally to influence the curricula by:
 - 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
 - ensure that education providers are competent and capable in educating on the SDH
 - advocating that specific skills training to work with individuals and communities is incorporated into education, including cultural sensitivity training
- Work with student groups and young professionals to empower them to advocate for the teaching of the social determinants of health 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 specific skills such as cultural competencies; taking social histories; motivational interviewing
- Health Profession: 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 [57]

Health inequality monitoring is the process of tracking the health of a population according to key socioeconomic variables and is an important tool to provide information for policies, programmes and practices to reduce health inequality. 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 social determinants 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 likely impact of policies and programmes on the social determinants possible. 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 NMAs 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 inequality [58], 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, NMA 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 WMA, NMAs 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 [59] 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 well-being across sectors (e.g. 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 inequality. 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, working with individuals, where we discuss the Ontario College of Family Physicians’ Primary Care Interventions in Poverty. [60] This provides a tool for physicians to monitor for poverty but importantly this was linked with the action of signposting patients to appropriate services and ensuring that 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 social level data that are known to impact on health e.g. housing situation, employment, education, ethnicity, social protection. These national level data can help practitioners to prioritise action where need is greatest and to evaluate the success of their strategies.

SDH INDICATORS IN ENGLAND

In England, the UCL Institute of Health Equity produce SDH indicators in England for every local 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 identifies good practice, outliers and changes over time. [61] The Public Health Outcomes Framework has also been developed by Public Health England, and it 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. [62] These could be utilised by health professionals for advocacy purposes.

In countries where access to health services are high, such services provide an ideal place to monitor health determinants in a country, as can be seen in the example below of a GP survey in the Netherlands.

DUTCH NATIONAL SURVEY OF GENERAL PRACTICE (DNSGP) [63]

The Dutch Ministry of Health have 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 health care system almost all Dutch residents are registered with a GP, which 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 both 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 programmes included in this review had not been subject to any formal means of assessment. [64] There are many advantages to setting up SDH based interventions with methods of evaluation in place from the beginning, to compare baseline measure. However, there is no universal evaluation methodology that should be applied as the extent of this evaluation should depend 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 below

WELL LONDON: A CLUSTER-RANDOMISED-TRIAL AND LONGITUDINAL QUALITATIVE EVALUATION [65, 66]

Well London is a multicomponent community-engagement programme promoting healthy eating, physical activity and mental well-being in deprived neighbourhoods in 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 several levels: individual 'participant' level, project level, programme level, community level and whole population wide level. In the first phase of the programme included 14 interrelated projects in 20 neighbourhoods using a coproduction approach. The programmes focused on physical activity, healthy eating, mental wellbeing, local environments, and arts and culture, aimed 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 well-being. These were measured by individuals eating five portions of fruit/vegetables a day, physical activity was measured by individuals doing five 30-minute moderate-level physical activities a week and mental wellbeing was measured using the GHQ-12 and 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 4000. Qualitative interviews and an environmental audit were also conducted to capture neighbourhood characteristics and qualitative information.

While there was no statistical 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 that may have compromised impact.

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 is also exploring how these interventions can be scaled up to a system wide healthcare intervention.

At the hospital level, data collection of social determinants of health, enables hospitals to focus resources where they are needed, as outlined in the case study below.

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

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

- Race and ethnicity
- Income and education (i.e., socioeconomic status)
- Age
- Gender
- Other personal characteristics (e.g., 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 vs. non-white
- Ethnicity: Hispanic vs. non-Hispanic
- SES (socioeconomic status) proxy: commercially-insured vs. self-pay/Medicaid

OHE identifies and tracks these variations by producing an annual “BHCS Health Equity Performance Analysis” (HEPA) that reports data on:

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)
- 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 improvement momentum. 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 inequality in diabetes care was found in the percentage of non-Hispanic and Hispanic patients with superior diabetes control (HgbA1c levels 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<7%). Based on this, the project was scaled up to a further four experiencing low diabetes care management performance among Hispanic patients.

USING TECHNOLOGY

The current landscape on data collection is changing due to technological advances and this is growing in LMICs. There are 5.3 billion phone subscribers worldwide, and more than 330 million subscribers

live in sub-Saharan Africa alone. [67] Although it is not fully understood how this will impact on health, it has the potential to help collect information and data, which can help shape policies and interventions to improve the SDH and monitor the likely impact of policies on social 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. [67] 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 below.

CASE STUDY: AN APP FOR ASTHMA RESEARCH [68]

The Icahn School of Medicine at Mount Sinai have 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, promotes 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 inequality 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 wider conditions which lead to or worsen asthma can 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.

WHAT THE WMA CAN DO

- provide training in monitoring and evaluation
- publish examples of training programmes
- connect people designing and delivering training, enabling the sharing of resources

WHAT NMAS CAN DO

- support physicians on the ground to monitor and evaluate SDH interventions
- campaign for social determinants data to be collected through census and household surveys nationally
- promote recognition of the importance of monitoring and evaluation, including to national regional and local government and other agencies

WHAT DOCTORS CAN DO

- expand social histories, this can be as simple as asking patients if they had trouble making ends meet in the last month, or could include a detailed social history taking (annually) that could be done by the doctor, support staff, or through IT systems. Where appropriate, assessments should be followed by interventions (e.g. 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 health care 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's journey 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 is a natural part of doctor's role, and many patients have very good relationships with their doctors. The OECD captured patient's perspective of their healthcare in up to 14 high-income countries. [69] It found that 87.1% of patients report that their regular doctor spends enough time with them in the consultation, 89.3% believes that doctors gave them the opportunity to ask questions; 91.1% say their doctor provided easy-to-understand explanations and 86.1% believe that the doctor involved them in the decisions about their care and treatment. This report will outline aspects of these successful relationships, and outline 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 a number of factors, such as the 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 and to empower healthier lifestyle choices and collectively exploring the wider social determinants of health. [70] This has meant that in many countries, the traditional paternalistic approach, where patients are seen as passive recipients of medical information, is being replaced with other models that view the PPR as more equal. Recently, research looks 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. Wilson & Childs reviewed available literature and determined that doctors with longer average consultation lengths prescribed less, incorporated lifestyle activities and preventative activities, dealt with more problems at once and exchanged more information. They suggested that this may explain why some studies found longer consultation times were related to lower consultation rates, as the wider determinants of the patients' health are being dealt with [71]. Howie et al. compared consultation length 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 recognized and were relevant to the patient's care; dealing with more of the long term health problems which had been recognized as relevant; and carrying out more health promotion in the consultation [72]. In a study in the UK, 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 recording of health promotion activities by general practitioners [73].

Many high income countries have mean consultation times far above 10 minutes, for example Sweden (21 minutes) Switzerland (15.6 minutes); Belgium (15 minutes). [74] However, as discussed in section 4, LMIC countries have fewer doctors and are often working in high-pressure environments and therefore are often characterised by a shorter mean consultation time and lower consultation rates as can be seen in the Asia/ Pacific region. [75] Within countries, increasing socioeconomic deprivation is associated with shorter consultations. [76] 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. [77] In the Netherlands, patients with higher education had on average longer consultations than those less well educated, and both patient and GP talk more with patients being more involved in the decision making process [78]

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 [79]. While changes to the structure of consultations, and use of technology are interesting ways that health inequality can be tackled, 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 inequality.

Recently, research is demonstrating 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 [79]:

- valuing patient experience and new professional and non-professional roles as sources of expertise;
- having 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 and
- social prescription incorporating nonmedical provision.

In Bromley-by-Bow Centre, 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 without the healthcare system.

INTERVENTIONS

SOCIAL HISTORY

For a physician to be able to assist a patient with the social and economic factors of their life 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 recommend a more extensive social history than is commonly used, that incorporates more detailed questions in six categories: individual characteristics, life circumstances, emotional health, perceptions of health care, health related behaviours [80]. 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 explored, as unexplored prejudices will influence a doctor's ability to obtain or act on important information. Moscrop & MacPherson suggest that recording patients income is a useful addition to medical histories[81]. Bloch and colleagues have developed a simple tool to allow physicians to screen for poverty and importantly to intervene to reduce poverty, Doctors of the World take detailed social histories of patients when they work with marginalised individuals who are not accessing health services in a number of countries in Europe, as outlined below.

CASE STUDY: POVERTY TOOL: A CLINICAL TOOL FOR PRIMARY CARE, ONTARIO CANADA[60]

In Ontario, Canada a Poverty Intervention Toolkit has been developed, and work is under way to develop it further. It provides three simple steps to tackle health inequality:

- Screen for poverty,
- Adjust risk and
- 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). [82] 85% 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 considering 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. They suggest, for instance, if an otherwise healthy 35 year old comes to your office, without risk factors for diabetes other than living in poverty, you 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 to relevant information and organisations that can help them apply for relevant benefits and support.

ST. MICHAELS HOSPITAL, ONTARIO CANADA

When patients enter the hospital, there is a computer that collects socio-demographic information about them, namely:

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

The hospital employs a number of staff that support patients who are flagged as needing support:

- Income Security Health Promoter (provides individual income interventions, education and advocacy)
- Medical-legal Partnership (Individual legal services, health provider training, patient rights education and systematic advocacy)

Community Engagement Specialist (Bringing in the community voice, and out the health team voice, and works as an advocate)

CASE STUDY: CONSULTATIONS WITH PATIENTS:

MEDECINS DU MONDE (MDM) (DOCTORS OF THE WORLD) EUROPE: [83]

In 25 European cities MdM provide free consultations with vulnerable groups such as migrants (regardless of their legal status), homeless people and sex workers. The aim is to provide medical and social welfare advice for people who have fallen through the gaps and reintegrate them into the mainstream healthcare system. A key part of this is to provide patients with information about their rights and helping them to exercise these rights. For example, in Mytilene, Greece, medical, psychological and legal assistance is offered to migrants arriving on the island by boat and requiring international protection. In the United Kingdom, 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. 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 in 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 (e.g. had lived in a country of war, violence by police or armed forces, sexual assault and rape). 55.3% of the pregnant women who attended consultations were living in an unstable housing situation, and 30.3% of pregnant women said they had a poor level of moral support. Asking patients these questions is routine to all consultations and allows the team to acquire a full social history of the patient, and allows them to signpost patients to appropriate services. This requires that a large amount of time is 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, e.g. immigration advice, peer support etc. [84]

WORKING WITH PATIENTS

Many of the key health behaviours significant to the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity and unhealthy nutrition. Prevention requires interventions from a range of actors and should include partnership between the health service, the voluntary sector, local government, communities and individuals (as discussed in section 5). Supporting patients to change behaviours should therefore be understood in the broader context of their lives. Patients with chronic conditions that fail to follow treatments cite lack of capacity, skills and knowledge as the main reasons for non-adherence. [85] Research demonstrates that when patients' psychological needs for autonomy, competence and understanding is 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 a key skill for physicians during their education or CPD. In the UK for example, the 'making every contact count' includes a competence framework to train health professionals on individual behaviour change. [70] These techniques have been shown to be more effective than traditional information sharing. [23]

CARE PLANNING

Care planning can help to provide a framework for a different type of consultation that is more equal. 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 identify and compile their health and wellbeing goals; set achievable targets for progress towards these and puts in place the support and resources to get there which often involve support in the community. These resources could involve social prescribing, as discussed later, peer support, and advocacy. Often this process is done in collaboration with the patient, however in some circumstances, such as in the case study below, this is done privately by the patient first, before being discussed with health professionals.

TE AWA – A SELF-ASSESSMENT TOOL FOR ABORIGINAL PEOPLES IN NEW ZEALAND [86]

The tool, Te Awa, is a self-assessment or analysis tool that is given to aboriginal 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 prioritise areas they would like to change or develop. These items encompass all the elements of wellbeing and health identified by Maori people, and recognise the interconnectedness of health, education, housing, justice, welfare, employment, and lifestyle as elements of whanau (family) wellbeing. It allows 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 allows 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 is an area of concern for a large percentage of the community, wider scale interventions can be designed. Te Awa has been adopted by a number of agencies throughout the country over the past several years.

Integrating referrals, or social prescribing, with a care planning process gives clinicians an explicit mandate to refer to services outside the health service a process known as social prescribing.

SOCIAL PRESCRIBING

Social prescribing describes the process of 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 [87]. 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 Referral'; 'Social Enterprise Schemes' and 'Time Banks'. [64] They can also directly impact on financial support for example, the poverty intervention tool demonstrated that referring people in debt, to debt counselling services or various other support services. To work effectively it 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 health care settings. Branding and House highlighted that patients with the following characteristics are most likely to be referred by physicians:

- a history of mental health problems
- frequent attenders of primary care services
- two or more long-term conditions
- socially isolated

- untreatable or poorly understood long-term conditions such as irritable bowel syndrome and chronic fatigue syndrome
- not benefiting from clinical medicine and drug treatment.

Evidence suggests that social prescribing increases people's confidence, provides opportunities to build social networks, increases self-efficacy and can increase people's engagement with weight loss and exercise programmes. [79] Programmes are more successful when they involve organisations from beyond the health service such as social enterprises and voluntary organisations. [79] 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.

ROTHERHAM SOCIAL PRESCRIBING, SHEFFIELD HALLAM UNIVERSITY, UK [88] [89]

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 Rotherham. GPs lead case management teams and are responsible for identifying patients who are eligible for the scheme. This model includes a 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. Initial analysis of this data shows that patients are making positive progress: 78 per cent made progress on at least one outcome after six months. The most common types of services that have been accessed are: community based activity; information and advice; befriending and community transport. Six months after the referral system was initiated Accident and Emergency attendances reduced by 21 per cent; hospital admissions reduced by nine per cent; outpatient appointments reduced by 29 per cent. Although it is not possible to directly attribute this change to the social prescribing intervention

TRAINING HEALTHCARE STAFF ON INTIMATE PARTNER VIOLENCE IN THE DOMINICAN REPUBLIC, THE ROLE OF REFERRALS [90]

In the Resolution on Violence against Women and Girls, the WMA defines violence against women as a health determinant that doctors, NMs and the WMA should be tackling as health services are well placed for identifying women and offering them referral or support services when possible. [91] 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 for IPV by a physician using a form, with questions ranging from emotional violence to childhood sexual abuse. About one in seven women respond positively to at least one of the screening questions, they are then informed that support is available, but they are not pressured to take action. Fewer than half accept a referral for action. 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 with information on services offered, the population served, and hours of operation and means of contact that is available to physicians. A two part referral form is used where the physician

fills in the first part with information on the client's needs, the client takes the form to the provider, who describes the visit and the follow up plan which can be returned to the clinic.

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

DOCTORS AND THE COMMUNITY

A body of evidence demonstrates that community and neighbourhood level interventions can improve health outcomes generally, and particularly for disadvantaged groups [92]. Interventions can include active travel arrangements, provision of good quality green spaces, decent housing, accessible services and social/community centres, good quality early years provision, local policies to ensure good quality air. Behforouz [80] recommend 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' "health homes." 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 [93] described the potential of this role as a 'boundary crosser', who can operate as opinion leaders and can bridge the community and healthcare system. It is important that doctors are able to work with early year's staff, schools, planners, housing providers, transport, environmental health etc. The importance of developing these partnerships is discussed in a later section.

WORKING WITH INDIGENOUS COMMUNITIES TO IMPROVE HEALTH OUTCOMES

Indigenous peoples are recognised as being among the world's most vulnerable, disadvantaged and marginalised peoples. They are spread across the world, in around 90 countries, numbering around 370 million. [94]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 the situation of Aboriginal peoples, 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. [94]

WORKING WITH ABORIGINAL COMMUNITIES IN CANADA

Aboriginal peoples in Canada include First Nations, Dene, Metis, and Inuit, and estimates suggest they will make up 4.1% of the Canadian population by 2017. [95] Aboriginal status has been highlighted as a social determinant of health in Canada [96] and researchers have emphasized that Aboriginal Canadians continue to experience health effects related to Canada's colonial legacy. [97] They have a lower life expectancy than the total population (e.g. in 2017, an Inuit man can expect to live to 64 years, 15 years less than the total population at 79 years). [95] Illicit and prescription drug use disorders are two to four times more prevalent among Aboriginal peoples in North America than the general population. [98] However, a growing pool of evidence is demonstrating that Aboriginal

communities and culture are important means of protecting and promoting Aboriginal health. For example a study of illicit drug taking of 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[98]. Community based health services have been promoted as a means of reducing health inequality, and as of March 2008, 83% of eligible First Nation communities are involved in managing their own community-based health services, to varying degrees. [99] 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. [100] The study found that the longer community health services have been under community control, the lower the hospitalization rate in the area. A community owned health service and an urban strategy for off-reserve aboriginals are outlined below.

Working with Māori New Zealanders

Māori New Zealanders are more likely to live in deprived communities and have the worst health outcomes in New Zealand. The avoidable mortality rate for Maori is 2.3 times the rate of other New Zealanders [101]. Even when income is accounted for, wealthier Māori still have worse health outcomes than wealthier non-Māori. [102] The New Zealand government have created the Māori Health Strategy, He Korowai Oranga to tackle this disparity for Māori people. These guidelines highlight the importance of community empowerment and providing effective health services that are tailored for 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 Maori 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) [103]. Incorporating this understanding has been identified as crucial to the success of these provider organisations. [104] The New Zealand Ministry of Health highlight successful examples of these principles being incorporated at the clinical level, and two examples of this are highlighted below. Recently the health inequality gap has begun to close, and many cite the importance of 'By Maori for Maori' participation as a key reason for this. [105]

KAHNAWAKE, MOHAWK NATION IN QUEBEC, CANADA [106]

Kahnawake is a Mohawk Nation community of about 8,000 people that manage 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 complement of health professionals for both inpatient and outpatient care, a medical centre offering specialty services, a dental clinic, and a diabetes education program. 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. The directors of the various health and social programs meet regularly to create long-term global community planning, 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.

ABORIGINAL HEALING AND WELLNESS STRATEGY (AHWS), HEALTH CENTRES, ONTARIO, CANADA [107]

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. They comprise of 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 co-ordinator, diabetes educator, or exercise therapist. A six year longitudinal evaluation of the centres identified core components of an effective service delivery:

- integrated interventions that combine 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 incorporate community into service delivery for example videos or plays are produced and performed by community members depicting personal experiences with HIV/AIDS or cultural teachings used to frame healthy lifestyle choices.

NGATI HINE TRUST- NEW ZEALAND [108]

The Ngati Hine Trust is the largest Māori health provider in the Te Tai Tokerau. Services are whānau (family) focused and its aim is to promote the social and economic advancement of whānau, hapū and iwi (family, clans and tribes). 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/addiction programmes; Radio Ngati Hine FM. The Trust is in the process of developing an Integrated Family Health Centre (IFHC) to allow 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 Aukati KaiPaipa (quit smoking services), oral health and other services.

HEALTH CARE IN OTANGAREI: TE HAU AWHIOWHIO O OTANGAREI WHĀNAU ORA COLLECTIVE-NEW ZEALAND [109]

After noticing that the clinic, which serves 98% Māori, were treating similar conditions regularly including dog bites, infectious skin infections, and cuts under foot. The team suspected that the reason might be that many children didn't 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 6 months of the clinics, 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 inviting them to pop in for their smears or immunisations, or confirming appointments for another day. By understanding a community need that wasn't directly health related, they positively impacted on the overall health of the community.

SYSTEMS WHICH SUPPORT DOCTORS TO TAKE ACTION ON SDH

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

- **System Commitment:** A system wide commitment to tackling the wider determinants of health gives clinicians both a supported means to tackle health inequality, but also a mandate to do it.
- **Community engagement/facilitator role:** With all of the available community options, 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 is so important. This can be performed by a variety of people, they may be 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 and trust them and understand their role better which assists them in social prescribing. [110]
- **Capacity of the community to engage:** The level at which a community can engage and partner with health services is determined by the community's resources and social capacity. These resources include financial assets, physical infrastructure (facilities and equipment), individual knowledge and skills, relations amongst people and organisations, relationships between local people and organisations and the community's external environment, access to services, and community attitudes etc. [111] Tools have been developed to assess community capacity, for example Version C 2007 [112] which measures 17 capacities in each of the eight social fields. By measuring a community's capacity, community interventions can identify community strengths and needs, and assist in prioritizing these needs.

However, even without these factors, healthcare professionals can make some small steps to engage more with individuals and the community, for example, education on motivational interviewing, carrying out more extensive social histories, 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
- recognise and promote the importance of developing and delivering education for all health professionals
- collaborate with other health professional organisations
- collect evidence of effective individual and community interventions 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

WHAT NMAS CAN DO

- provide education-skills training
- collect evidence of effective individual and community interventions at the national level
- share evidence of what works
- advocate to government and other agencies to ensure support for the provision and uptake of education-skills
- support physicians in providing care that is empowering to the patient and utilises the strengths of the community
- work with governments to ensure better inclusion of all patient groups, including traditionally hard to reach groups, in patient centred care

WHAT DOCTORS CAN DO

INDIVIDUAL RELATIONSHIP WITH PATIENTS

At the clinical level there is a significant amount that can be done to tackle health inequality and tackle the social determinants and provide culturally appropriate care is key: ensure that staff are recruited with this in mind and ensure adequate training is provided.

- patient-doctor Relationship: Creating a supportive environment, Motivational interviewing training; Integrate care planning into consultations
- clinic around patient, not patient around clinic: where possible, provide care that is culturally appropriate, safe, in the right location, at the right time e.g. non-traditional office hours, office location convenient for community;
- individual advocacy: write letters to housing, schools etc. on behalf of patients and their families
- reflective practice to examine the doctors own prejudices as these might impact on his/her assumptions about patients

RELATIONSHIP WITH COMMUNITIES

Make better use of local opportunities that could benefit patients and which might benefit the local community

- working with Community: Social prescribing to local services when appropriate, link patients to supportive community programmes. If this is not available, advocate for community assessments in local area and for support staff
- make tackling health inequalities a component of their role as a local community employer. Employing members of the community is mutually beneficial. For the health system, local staff have a wealth of knowledge about the community, know culturally appropriate ways to engage. It also brings employment to the community.
- community advocacy: Use position of power and trust to speak to improve the social and economic conditions of their community and reduce health inequalities in their local area
- community engagement beyond the role of a clinician, demonstrating that they see themselves as a part of the community

THE DRAFT

4. AS AN EMPLOYER, MANAGER AND COMMISSIONER

While the health service impacts on health and inequality through direct interactions with patients and communities it also has a highly significant role as an employer, manager and commissioner. The healthcare system is a significant employer in many communities– including those employed directly in health care organisations and those employed indirectly through the supply chain. These include occupations that are unskilled or semi-skilled and do not require a professional qualification. This gives the healthcare industry an important opportunity and responsibility to reduce health inequalities by providing good quality work and conditions, and ensuring safe working conditions, as well as working to increase employment opportunities for people from disadvantaged backgrounds. *The health care system can thus have a positive impact by boosting economic activity in deprived communities. That is, as well as helping individuals it can help communities*

Healthcare workers are exposed to a number of risks due to the nature of their work including shift work, musculoskeletal disorders and sharp injuries. This is coupled with a concerning growth in attacks on health-care facilities and health workers in conflict and crisis setting. 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 health care in situations of conflict and insecurity. [113] In Bahrain and Turkey human rights and international humanitarian law were violated when health care workers treating government protestors were arrested, in February 2015 the WMA demanded that all charges be dropped against Turkish doctors. [114]

The health and social work sector is also a high risk sector for adverse psychosocial conditions that are related to increases in stress.[115, 116] These include conflicts within the workplace, lack of autonomy and control, low pay and insufficient hours, temporary work, insecurity and the risk of redundancy [117] Studies have shown that these adverse psychosocial conditions are associated with an increased risk of coronary heart disease [118]. Many doctors are leaders in the health system, sitting on commissioning boards, as managers and as employers. It is therefore important that this role is understood in terms of the social determinants of health. This includes ensuring safe work practices, demanding safe and health enhancing working conditions for staff through procurement, and working towards the employment and training of local staff.

THE HEALTH CARE WORKFORCE AND THE SOCIAL DETERMINANTS OF HEALTH

AS EMPLOYERS

According to the ILO, over the next five years public services in health care, education and administration will continue to be a major source of employment representing 15% of total employment in the world, signalling the emergence of a large ‘care economy’. [119] More effort should be made to ensure that everyone has an opportunity to access these jobs, including the medical profession, and particularly people from disadvantaged communities. This requires active outreach to communities, such the multiagency partnership to transition the long-term unemployed into allied health careers in the USA, and recruiting local populations as community health workers in Zambia, as outlined in the case studies below. There is a need for this work is of a good quality, as discussed in the next section.

CASE STUDY: TRANSITIONING THE LONG-TERM UNEMPLOYED INTO ALLIED HEALTH CAREERS [120]

In 2011, multiagency partnership was set up in North Carolina, USA, to address the relatively high long term unemployment rate at 9 percent, half of whom are unable to secure a job within six months. While job growth was stagnant generally with growth at 3%, healthcare jobs increased by 46 percent.

Stakeholders representing healthcare employers, community colleges, workforce development boards, social services, funders and the long-term unemployed living in rural communities identified four key challenges that the long-term unemployed in rural communities may experience as they navigating the career pathway of allied health professionals, including career guidance, limited resources, individual supports and employer collaboration.

As of March 2015, over 205 unemployed persons were assessed, enrolled into training, and supported to continue training. Services included career counselling, academic/training vouchers, books, uniforms, immunizations, 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. *(progress report from Alice Schenall)*

CASE STUDY: RECRUITING QUALITY COMMUNITY HEALTH WORKERS IN ZAMBIA

In 2010, the Government of the Republic of Zambia (GRZ) launched a program to create a new civil service position: the Community Health Assistant (CHA) in an attempt to formalise and professionalise community-based lay health workers 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 (e.g. 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. [121] Half of the districts had recruitment posters emphasizing the "social" benefits of becoming a CHA, such as serving and being a leader in one's community. In the other half, recruitment materials emphasized the "career" benefits of becoming a CHA, i.e. career development. Once deployed, actual benefits were identical between the two treatment groups, as a result, any difference in performance was due to the selection effect of the incentives. Career incentives attracted CHAs that were more qualified and had the same level of pro-social preferences as CHAs recruited by making social incentives salient. These CHAs consequently performed better on the job. CHAs in both groups lead to increased use of health services by rural communities, but this increase was higher in communities with CHAs recruited by making career

incentives salient (e.g. a 31% increase in women giving birth at the health centre). Applicants recruited by making career incentives salient were more ambitious regarding career advancement: a larger portion aspired to hold a higher-ranking government position in the next 5-10 years, such as a Clinical Officer, Nurse or Environmental Health Technologist. In Zambia promoting high-performing CHAs to nursing and other higher-level cadres is likely to be a benefit for the 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 inequality in three ways. Firstly, by advertising the career progression opportunities it lead to better health provision for rural communities and better uptake of health services by the community. Secondly, it provides health protective work to the rural community, where currently in Zambia the agriculture sector is the largest employer. This sector often doesn't pay for work (61% of women and 39% of men are not paid at all for their work. On the other hand, 85% of women and 91% of men in the non-agricultural sector are paid in cash). [122] Thirdly, by recruiting in local rural areas for entry level positions that include the possibility of progression in the health service, the GRZ increases the likelihood of having a more diverse 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 can greatly contribute to the elimination of the risks of associated with these sectors. This includes both the physical and organisational setting. The importance of this is increasingly recognised, and attention is focused on the elimination or mitigation of the causes of work related stress and other adverse working conditions by creating 'good work' [116].

While there is no universally accepted definition of what constitutes good work many of the different definitions available all share common features. For example the International Labour Organisation, the Trade Union Congress, and the Employment Conditions Knowledge Network, all highlight the following conditions that are associated with good work: something that both sustains the worker financially, providing security, but also enriches the worker's life through a good work-life balance and promoting good physical and mental health [123] [124] [125]

While not always the case, physicians often manage hospitals. Some research suggests that hospitals perform better when doctors manage hospitals. A cross-sectional study of the top-100 U.S. hospitals (according to the US News and World Report's "Best Hospitals" ranking of quality in 2009) in three specialties: Cancer, Digestive Disorders, and Heart and Heart Surgery, found a strong positive association between the ranked quality of a hospital and whether the CEO is a physician or not ($p < 0.001$). When physicians are in a position to manage staff, effort should be made to ensure that good physical and psychosocial work is provided to all staff, as the case studies demonstrate below.

CASE STUDY: HEALTHWISE: IMPROVING SAFETY AND WORK PRACTICES IN HEALTH CARE

The ILO and WHO have developed HealthWISE- a practical manual [126] and guide [126] that encourages managers and staff to work together to promote safe and healthy workplaces and to improve work practices. These include modules on topics such as controlling occupational hazards

and improving workplace safety; biological hazards and infection control; tackling discrimination, harassment and violence at the workplace; and promoting greener 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 sensitization of health workers in hospitals 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 practitioner 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, through that, health outcomes. It is important that healthcare commissioners consider local employment conditions when allocating resources. In England, research has shown[127] that by allocating additional investment and resources in areas with higher levels of socioeconomic deprivation, the health service has probably reduced inequalities in population ill health.

In the UK, by law, the social value of NHS commissioning must be taken into consideration[128]. The Royal College of Physicians has recently audited NHS trusts and found that 83 per cent report that fair terms and conditions are included in the procurement conditions and 68 per cent say that they insist on a living wage (around half of all NHS hospital trusts in total). In 2012 Blackburn with Darwen Care Trust Plus established and developed a Social Value Self-Assessment tool (joining the Dots paper) [129]. The Institute of Health Equity has written about how the social determinants of health approach could inform procurement and commissioning practices, so that procurement directly improves conditions in the social determinants. Figure X adapted from this [130]

FIGURE 5 HOW THE SOCIAL DETERMINANTS OF HEALTH APPROACH COULD INFORM PROCUREMENT AND COMMISSIONING PRACTICES [130]

Marmot policy objective	Social value areas for action
Best start in life	<ul style="list-style-type: none"> • Life course approach to planning services • Family friendly employment practices
Maximise capabilities and control	<ul style="list-style-type: none"> • Skill development programmes • Training and apprenticeships • Volunteering • Working with schools and young people, including curriculum support, careers advice • Building individual resilience and mental health protection • Supporting people with a learning disability or service users into training or employment • Training for existing staff
Employment and good work	<ul style="list-style-type: none"> • Local residents employed (in local labour market) • Reduce unemployment through targeted recruitment

	<ul style="list-style-type: none"> • Employment of particular groups e.g. ex-offenders and those with long-term health conditions • Youth employment • Local economic regeneration • Improvement in terms and conditions of employment, including security • Jobs with high level of control for employees
Standard of living (income)	<ul style="list-style-type: none"> • Debt and welfare assistance advice • Living wage • Increase in median wage of employees • Reducing gap between highest and lowest paid • Parity in income between employees
Healthy and sustainable places and communities	<ul style="list-style-type: none"> • Environmental improvements, including recycling, carbon reduction, energy efficiency and waste reduction • Stimulating demand for environmentally-friendly goods, services and works • Safety and anti-social behaviour projects • Community centres • Social inclusion and integration, and tackling social isolation • Investment in the local area e.g. via private sector through corporate social responsibility (CSR) strategies • Increase number of local organisations with social purpose linked to communities, socially responsive governance, with fair and ethical trading • Encourage local supply chains • Investment in particular programmes e.g. fuel poverty reduction
Public health and prevention	<ul style="list-style-type: none"> • Health improvements • Health and social care schemes • People supported to live independently (e.g. older people) • Reduce sick absence of employees through improved health and wellbeing support • Reduce avoidable hospital admissions

CASE STUDY USING SDH IN COMMISSIONING OF PRODUCTS AND SERVICES[130]

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

1. developing a local social value self-assessment tool and piloting it within specific public health contracts
2. analysing and maximising local public sector spend with local businesses
3. 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– that provides a drug- and alcohol-free venue for people in recovery. The council has also moved to an e-procurement system (the chest) that provides greater access to local, registered suppliers and thus increase 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: BRITISH MEDICAL ASSOCIATION: FAIR MEDICAL TRADE [131]

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 [132]
- Raising awareness amongst colleagues
- Campaign for their NHS organisation to purchase medical supplies ethically
- Ask 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 include a commitment in their CCG Constitution to only commission services from providers who can demonstrate a commitment to their social responsibilities and to sustainability principles.

WHAT THE WMA CAN DO

- access to health professional training and employment: The WMA should devise an action plan of what can be done to improve access to 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 by all populations to health care provision
- 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
- advocate that all staff working within the health care sector are treated with respect and are enabled to live with dignity, including being able to feed and house themselves

WHAT NMAS CAN DO

NMAs should work to improve access to the healthcare professions and to protect the working conditions of people working in the healthcare profession:

- access to the health profession: Promoting access to the health profession by people from lower socioeconomic positions and marginalised groups should be a key priority for NMAs
- promote a safe working environment for all health care workers, 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 to encourage/foster greater equity
- support health care systems considering the welfare of those providing resources, and ensuring no workers are exploited unfairly

WHAT DOCTORS CAN DO

- as commissioners: Often healthcare systems choose the cheapest option, and do not cost the social value. When commissioning primary care and community clinics, and hospitals, commissioners could look for more than just medical care. They could 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, be that having health trainers, navigators or community-based services.
- support staff: Consider and where possible advocate for the working conditions of lower skilled, low paid professions in healthcare, including carers and volunteers.
- as managers of hospitals: Include patients social status and complexity as a component of ward budgets; have the goal of health equity at all levels; develop expert clinics for marginalised groups e.g. migrants. Ensure that your hospital has an active occupational health policy
- get involved in local outreach as a community member as well as in your medical role

5. WORKING IN PARTNERSHIP: WITHIN THE HEALTH SECTOR AND BEYOND

As described above, the most significant influences on population health lie outside the health care 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 inequality must therefore be based on partnerships with all these sectors. Health care 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. [133]

PARTNERSHIPS OUTSIDE THE HEALTH SECTOR

Partnerships between the health sector and those outside the health sector can have a significant impact on health inequality, but are often underutilised. Any action with health services will be strengthened if wider policies in other areas are also being implemented. The CSDH 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. [23] These partners could include other sectors, local government, police and fire services, charities, the private sector, places of work and schools [6]. The social determinants of health can inform these partnerships through taking a life course approach to health, highlighting the need for proportionate universalism as mentioned in the introduction. Two examples below highlight the lasting benefits to local communities and a reduced pressure on the healthcare system when these are taken in to consideration.

CASE STUDY: BROMLEY BY BOW CENTRE [134] [135]

Bromley by Bow centre is a healthy living centre that has been part of the community for thirty years. It provides the community with a range of services that are available to everybody. There is a GP surgery along with a diverse range of services for the community. This includes accredited educational and learning courses including English for Speakers of Other Languages (ESOL), 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 co-operative in nature. This approach enables GPs to refer patients to services that help to tackle the social determinants of ill health, including welfare, employment, housing and debt advice services. Their services are tailored to the needs of the whole community, and allows for focused interventions for specific groups - families, young people, vulnerable adults and elders. This model is 73% social (employment, enterprise, arts, skills, welfare etc.) & just 27% clinical.

They aim to support people across a range of projects and services in 4 main ways:

1. supporting people to overcome chronic illness and unhealthy lifestyles;
2. enabling people to learn new skills;
3. supporting people to become less grant dependent and to find work;
4. providing people with the tools to create an enterprising community.

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.

SUCCESSFULLY INTEGRATING EARLY YEARS INTERVENTIONS INTO THE HEALTH SERVICE- FROM HOSPITALS TO COMMUNITIES: MALNOURISHED CHILDREN'S PROGRAMME JAMAICA [136]

Health services are often the only government sector routinely making contact with children under 3 years in Jamaica, and in many LMICs. Therefore integrating early year's interventions into healthcare services is a relatively cost effective way to promote health equity in LMICs. 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 that recovered and were sent home, had to be re-admitted for the same condition after a comparatively short time. A number of interventions such as nutritional supplements, psychosocial stimulation, mother and family support have been evaluated in isolation and in combination since then. The results demonstrated 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.

The programme aims to address early deficiencies of children hospitalised for malnutrition by conducting follow-up home visits to monitor children who are discharged from the hospital. Home visits are organised with the aim of identifying specific and interconnected social determinants of children's and their families' health. Paraprofessional health staff (health aides) delivered 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 three, 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 is not sufficient to reduce the long-term effects of this health inequality. 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 control malnourished group. Their IQ levels were between both groups. Mothers in the intervention group had improved knowledge of child rearing and reductions in depressive symptoms. A twenty-two-year follow up study demonstrated benefits through to adulthood in areas such as cognition, educational attainment, mental health and reduced violent behaviour. [137]The group's research has also demonstrated that it is feasible and effective to integrate the interventions into primary care services with benefits to children's development and mothers' child rearing knowledge and practices. [138]

WORKING WITH COMMUNITIES

As discussed in section 3, there is a clear need to work with the communities that patients live in to understand and intervene on the social determinants of health for patients. 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 can be effective in tackling SDH and support health professionals more generally to take action on SDH. CHWs have been shown to be an effective way for health care systems to target marginalised communities with unequal access to health care, especially when recruited from populations they serve [139] [140]. In a review of 100 studies Prasad & Muraleedharan (2007) demonstrated the critical factors which influence the overall performance of CHWs includes the nature of employment, career prospects and incentives and training. A review [141] found evidence that CHWs and community participation were most effective when they were large in scale, and integrated throughout the health services and other sectors and services outside health care.. An example of doctors, nurses and community health workers working in partnership with communities to tackle health inequality can be found in Brazil, as outlined below.

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

Primary care teams, composed of a doctor, nurse and at least four Community Health Workers (CHWs) are a key part of the Brazilian governments' Sistema Unico de Saúde (SUS) or Unified Health System, providing universal care free at the point of delivery. SUS attempts to reach 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[142]. The method has been demonstrated to be cost-effective and has

high levels of user satisfaction [143]. The CHWs 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, 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 a community leaders themselves [144] Each CHW visits every household in their micro-area (approximately 100-150) every month. CHWs have been working in Brazil for over twenty years and as of 2013, there were 257,265 lay CHWs in Brazil, covering 54% of the Brazilian population. Since their implementation, Brazil has seen significant health improvements and a reduction in health inequality[145] which researchers have attributed to the programme[144]. Improvements include a reduction in infant mortality, hospitalisations due to primary care sensitive conditions, improvements in screening uptake, improvements in breast-feeding uptake, antenatal care, mental health problems and immunisation coverage[144].

SELF-EMPLOYED WOMEN'S ASSOCIATION (SEWA) HEALTH SERVICES IN GUJARAT INDIA [146] [147]

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 [147] Those in the informal sector 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. [148]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 have been engaged in many different forms of preventative and primary health care to its members, and the local community- particularly those not served by other health providers. Initially this included health education and provision of maternity benefits. They also work to build the capacity of local women (especially local midwives called dais). Today SEWA Health works with primary health care professionals in stationary health centres, mobile clinics, provides health education and training, local capacity building, 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 the population didn't 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 and 'warmth'
- services are generally free or low cost
- convenient times
- location in the community
- provided by a women led grassroots organisation generated a feeling of trust and security

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

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

CVD CHECKS IN FAITH AND COMMUNITY BASED ORGANISATIONS FOR SOUTH ASIAN POPULATION [149]

In the UK people of South Asian ethnic origin on average experience myocardial infarction rates at an earlier age than Caucasian populations. This is true for both migrant populations in high-income countries and 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, UK. The team included family doctors, health check team members and temple community leaders and a Bangladeshi community leader. All attendees of the check were positive about the checks, 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 leant itself to a patient-centred rather 'GP-centred' consultation. However, some disadvantages, such as concern that privacy was sub optimal and a need to better ensure data transfer to health services for follow-up as channelling high risk patients back into mainstream services is key.

Many of the community and religious leaders added to the programme in a number of ways. The health care 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 (e.g. healthy cooking classes), which created a community spirit and motivation to enact lifestyle changes afterwards.

PARTNERSHIPS WITH CHARITY SECTOR

The charity sector often has a strong community focus and can be a key place to help shape the wider social determinants of health. Because of this doctors should consider their role in referring patients to charity and support services and health professionals providing advocacy and support to charities that are helping tackle SDH and improving health equity. For example the hospital charity partnership to tackle homelessness described below, demonstrate how this can be effective.

PATHWAY: CHARITY SECTOR PARTNERSHIP TO TACKLE HOMELESSNESS [150]

Homelessness is an independent risk factor for premature mortality [4] and is associated with extremes of deprivation and multi-morbidity. The annual cost of unscheduled care for homeless patients is eight times that of the housed population [1] and homeless patients are overrepresented amongst frequent attenders in the emergency room. The average age of death for homeless people in the UK is just 47 years (The most common age at death was 86 for men and 89 for women in 2011-2013). [151] Four acute hospitals, with a high proportion of homeless people who are frequent attenders, 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 with no fixed address or 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 patients discharge with the patient. One of pathways key recommendations following from reviews is the need for multiagency meetings to coordinate care. They found that attendance was improved by having the backing by a senior hospital staff member. These meetings are attended by ward staff, local housing options manager, social worker, drug and alcohol workers, psychiatrists, street outreach workers, hostel key workers and members of the pathway homeless team. From these, an ideal' multiagency plan is sketched for the homeless 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. [152]

NATIONAL PARTNERSHIPS

The need to address the wider determinants of health, and reduce the cost of health inequality has lead a number of governments to develop the Health in All Policies (HiAP) approach. When the HiAP approach is incorporated into policy making, the impact on the health of the population and health inequality are taken into account by all sectors and levels of policy-making (international, national, regional and local). The approach aims to create synergies between the health sector and other sectors and improve accountability of policymakers by emphasizing the impact to health systems, determinants of health and wellbeing of policies. This approach has been adopted in South Australia, [153] Finland [13] and Wales in the UK [154]. In Norway, the Public Health Act of 2012 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 [155] Doctors can play a leading role in developing HiAPs and assessing the likely impact of other policies on health and particularly health equity. The Finnish governments have adoption of this principle to ensure that health professionals are seen as partners in decision making is outlined below.

CASE STUDY: HEALTH IN ALL POLICIES- FINLAND

Finland is a world leader in public health and health inequalities has been high on the agenda since the 1980s, leading to the development of an inter-sectoral health policy was developed the National Health for All programme. [156] 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, they promoted the Health in All Policies agenda while EU presidents in 2006. Municipalities have a legislative duty to reduce health inequality, promote health and wellbeing and report annually on this. There are clearly defined responsibilities and co-operation between administrative sectors, private enterprise and other local actors. The health care sector contributes expertise around health [156].

For example, an unhealthy diet was common in the 1980s especially for people in lower socioeconomic groups, which increased the risk of CHD. In response the Finish government developed a health-based policy to 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 sectors 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 subsidized meals for students and workers were introduced to reduce health inequalities associated with diet and nutrition. While differences between populations is still significant, this collaboration and focus on health inequality are considered as having contributed to the Finnish diet becoming healthier and this gap being reduced [157]

At a symposium, Taru Koivisto, Director Ministry of Social Affairs and Health highlighted the importance of involving the health sector, which 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 their own health priorities and how these fit with the priorities of other sectors for mutual benefit. [58] This suggests that the development of the social agency of the medical profession should be encouraged throughout their education, as discussed in Section 1.

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

In 1994 life expectancy in Rwanda was 28 years and 77.8% of the population was below the poverty line [158]. The 1994 genocide decimated an already weak health system and workforce who fled or were killed, infectious diseases and child mortality rapidly increased, with 25% of children dying before reaching the age of five. [159] However, years of intensive rebuilding has led to improvements, in 2011 life expectancy had increased to 63 years; the percentage of the population below the poverty line had reduced to 44.9% in 2012 and under-five child mortality reduced by 70.4% between 2000 and 2011. Rwanda is on target to achieve each of the health targets set in the Millennium Development Goals.[160] Strategic partnership between doctors, Rwanda's Ministry of Health, researchers, universities and development partners have led to a strengthened health system capable of delivering the government vision laid out in Vision 2020, [161]a strategy for social and economic development that incorporates health inequality. 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[162] 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 [163]. 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 roll out. Teachers and village leaders were enlisted in sensitization efforts and community health workers (CHWs) were mobilised to trace out-of-school girls, more likely to be in poverty. By doing this the principle of proportionate universalism was 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 it was planned during Rwanda's annual Maternal and

Child Health Week, which involves sensitisation about hand hygiene and reproductive health, delivery of mebendazole, 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. [164] School based HPV vaccination programme show the effectiveness of health authorities partnering with Ministries of Education, Gender, and Local Government as well as development partners, religious organisations, and community members.

The key lessons from this initiative include the value of cross-sectoral collaboration and planning, conducting sustained campaigns of communication and social mobilisation by using locally employed CHWs and partnering with local leaders to ensure that the universal service was delivered with effort proportionate to the needs of different groups.

INTERNATIONAL PARTNERSHIPS

Partnership is a key part of WMAs role, and they have an official relationship with the World Health Organization (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 to make joint statements, which adds extra authority to the statement. 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 [165] 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. 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. [166] In 2013, the WHPA issued a statement outlining the importance on inter-professional collaboration and the importance of health system infrastructure, governance, educational programmes, use of evidence and monitoring and the importance of person centred practice [167] Other international bodies are also vitally important for health such as ILO, UNICEF, UNDP and UNICEF. It is imperative to partner with a broad range of international organisations to effectively champion the SDH.

WHAT THE WMA CAN DO

- develop better inter professional understanding and thus partnership working
- develop ideas for collaborative work
- work with other health professional representative groups, and other agencies, and professions to prepare guidance and policy concepts to promote inter-professional and cross professional working, as well as community integration
- create online regional discussions between NMAs e.g. African Forum on the SDH.

WHAT NMAS CAN DO

- disseminating the message that physicians should be working in partnership with health professionals, local governments and communities
- producing guidance for physicians on partnerships in their country's context
- create networks of physicians to share good practice and develop best practice
- work with national governments to develop policies to reduce health inequality and incorporate health considerations into all policy decisions
- promote community ownership of public policy
- create action plans: Create working group to develop action plans to tackle health inequality that includes allied health professionals, and if possible: public health, primary and secondary providers. The involvement of the local community is also important.

INDIVIDUAL AND COMMUNITY

- support physicians in providing care that is empowering to the patient and utilises the strengths of the community
- involve community in partnerships with the health care sector to design and deliver health care action on the SDH.

With Wider Public:

- shape national narrative and debate by engaging policy makers and the general public utilising social media where appropriate

WHAT DOCTORS CAN DO

- work with others, including non-health workers to create networks based upon empowering patients and a person centred approach to care.
- share experiences of what works
- feed back to NMAs on the changes needed within health policy to reinforce best practice

6. AS ADVOCATES

A doctors' role as an advocate is stated in various professional charters and standards around the world. [168] 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 inequality. Doctors routinely use their knowledge and skills to advocate for health care and health care systems improvement; it is essential that they also advocate for broader changes that will reduce health inequities by tackling the social determinants of health. In its Declaration of Oslo the WMA has committed to this, and through this report and other work seeks to help physicians and national Medical Associations take effective actions. Based on their skills and experiences, doctors have substantial contributions to make at all stages of the decision-making process. 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 the population.

ADVOCATING FOR INDIVIDUALS AND COMMUNITIES

Advocacy for patients is generally considered an appropriate role for many doctors and other health professionals. This often includes advocacy outside the health care system. For example, a doctor could write to housing authorities on behalf of a child with asthma living in a damp home, on the need for refurbishment or rehousing. If a detailed social history is taken of patients, as outlined in the section on working with individuals and communities, a clearer understanding of the needs of patients can be understood, and therefore, more effective advocacy would be possible. Doctors have also gotten involved in advocating for the needs of specific communities, such as the collective advocacy of doctors in Spain following the Royal Decree- Law as outlined below.

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 mean that, increasingly, diseases and victims of violence were not identified and given the necessary care and treatment. Excluding vulnerable groups from access to healthcare will increase health inequality 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, 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 said that the law broke many existing international acts.

In 2012 the “Derecho a Curar” (Right to Care) campaign was launched by semFYC, MdM 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. They mobilised medical personnel, calling on them to object on grounds of conscience to the new measures. 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 for social media. . 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 re-launched in the social media in summer 2013 with the video series #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 recorded more than 1,000 cases of violation of the right to healthcare, and has prepared reports which have been submitted to the Health Commission of the Congress of Deputies and to the Ombudsman.

MdM and semFYC urges 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 health care to illegal immigrants.

In March 2015, just before a general election, government overturned the law. [169] 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.”* [170]

ADVOCATING FOR THE WORKING CONDITIONS OF DOCTORS, AND OTHER HEALTH STAFF

Adverse working conditions of health care staff (and students) will not only have an adverse effect on individuals health and wellbeing, but can lead to reduced quality of care for patients including patient safety.[171] Burnout is a long-term stress reaction often seen in human service professions. It is a “psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment”. [172] Changes in medical practice across the world over the last 20 years have resulted in a decline in autonomy, diminished status of physicians and increased work pressure has led to increased burnout in the profession. [173] Services to support the health and wellbeing of health professionals are inconsistent and often lacking. There is also inequality in who has access to these services when they are present. For example, in the UK an audit revealed that staff working in NHS services that are not directly contracted by NHS organisations do not have the same access to support as colleagues who are directly employed by NHS organisations, [171] Self-care and advocating for the health and wellbeing of all staff and students in the health system will lead to a workforce 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 their human rights.

MEDICAL PROFESSION AS ADVOCATES

WMA AS ADVOCATES

As the only organisation representing the voice of the medical profession globally, the WMA considers advocacy one of its key priorities on the international scene. The WMA has a long history of advocacy in a range of areas. In the field of ethics, WMA is celebrating the 50th anniversary of the Declaration of Helsinki, one of the WMA's best known policy statement of ethical principles for medical research involving human subjects, including research on identifiable human material and data. [174] 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 health care research. [175] 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 health status of all in areas such as tobacco control [176], violence against women [177] and the social determinants of health [18]. The WMA also has a role in encouraging and educating doctors in becoming leaders and advocates, and has done this through initiatives like the WMA Caring Physicians of the World Initiative described below.

WMA: CARING PHYSICIANS OF THE WORLD INITIATIVE [178]

The WMA advocates for the development of comprehensive, sustainable, fully functioning health care systems (including medical education). Past President of WMA Yank D. Coble Jr. MD (2004) introduced the Caring Physicians of the World Initiative. Its purpose was to celebrate and inspire doctors of the world, and 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 physician's leadership skills.

The Declaration of Oslo, on the social determinants of health has now been formally adopted by the WMA Council meeting in 2015 [19]. The WMA's role going forward is to build on this Declaration and utilise its influence and role as an advocate to push this agenda forward. The WMA should also support medical associations to create country specific action plans.

MEDICAL ASSOCIATIONS AS ADVOCATES

Many medical associations consider advocacy one of their core aims, particularly influencing public policy to promote best practice in healthcare, guaranteed to citizens. For example the Bangladesh

Medical Association states one of its aims 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.* [179] The Finnish Medical Association state that they ‘*believe that the expertise of doctors have a lot to add to public health policy.*’ [180] The Irish Medical Organisation have launched a campaign to ensure health care is centre stage at the next election, and have 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. [181] This role needs to be harnessed to address the social determinants of health in their own countries. NMAs 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 more incorporated in medical education, with individual patients, their local community, and those employed within the health sector. Their role as advocates should be supported by NMAs and WMAs, and encouraged through educational training, where skills and leadership training should be provided. Although not compulsory, doctors can also have a role in informing public debate and encouraging health protective policies, as the case study below demonstrates. This role is part of many charters on professional responsibility, such as the American Medical Association’s (AMA) Declaration of Professional Responsibility: *Medicine’s Contract with Humanity*, states that doctors should “*Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.*”[182]

PHYSICIANS FOR A BASIC INCOME GUARANTEE IN ONTARIO CANADA [183] [184]

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 “ensures everyone an income sufficient to meet basic needs and live with dignity, regardless of work status.” A BIG for all: “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 health care 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.” [185] A long-term aim of this policy would be to reduce health inequality.

STUDENTS AS ADVOCATES

As demonstrated in the example below, 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. [186] 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 [187] [188]. 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'. [189] While patients 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.

STUDENTS ADVOCATING FOR THE SOCIAL DETERMINANTS OF HEALTH: IFMSA[190]

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 propose that civil society groups, for example, 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 inequality were established and used for countries to measure progress. They 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
- promote SDH in all its publications, policies and speeches
- advocate at an international level for SDH and health inequality
- work with others, including the WHPA, to develop an inter-professional understanding of SDH

WHAT NMAS CAN DO

- advocate for change to the education system to include the SDH
- advocate for policy changes at the local and national level
- advocate on behalf of their workforce
- advocate at national, regional and local level for policies which recognise the importance of an SDH-based / life course approach including consideration of Health in All Policies
- undertake advocacy on behalf of their membership, involving those members who feel able to work as advocates
- advocate for individuals and communities

WHAT DOCTORS CAN DO

- use the available evidence in all discussions on health to demonstrate why the SDH matter and to promote their inclusion at the heart of policy making
- advocate for SDH to be more incorporated in medical education, with individual patients, their local community, and those employed within the health sector.
- advocate on behalf of individual patients and improvements in conditions in the SDH
- insist on their member organisations undertaking advocacy on a national basis
- provide materials including case studies to inform advocacy and to demonstrate the person at the heart of the activity
- advocate on behalf of communities and improvements in conditions in the SDH

WHAT STUDENTS CAN DO

- student groups could produce a co-written statement asking for the social determinants of health to be included onto the education curriculum
- student groups should work with trained colleagues to provide convincing arguments for reshaping curricula

CONCLUSION

The WMA has prioritised the importance of addressing the social determinants of health as key to tackling health inequality. [19] This is in response to a growing body of evidence demonstrating the powerful effect of doctors working at all levels to tackle health inequality. This ranges from consultations with patients to engaging in public debate. Doctors have always been at the forefront of tackling health inequality, and it is clear that doctors, NMAs and the WMA have a key role in tackling health inequality internationally, at a national level, at the local level, and for individuals and their families. In researching this report we have been inspired by the wide range of areas in which doctors are at the forefront of addressing the social determinants of health the world over. Whether it was students advocating for marginalised communities or senior doctors designing programmes to fit the needs of communities, or working with government to create more equitable health policies. This report aims to highlight these stories and to focus on the key areas by which doctors could influence health inequality. This requires action in the following areas:

1. the education and training of doctors: to equip doctors with the necessary skills and inspire them to take the agenda forward
2. effective monitoring and evaluation of programmes, to better understand the impact of the social determinants of health at the local and national level, and importantly to provide an imperative for action
3. working with individuals and communities: by 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 inequality within the health system: as a large source of employment the world over, the health system has a large ability to improve inequality by setting an example as a provider of good quality work to everyone it employs and set a standard in employment for those contracted through procurement.
5. working in partnership: can ensure that communities and the health service are effectively engaged to address issues at the local, national and international level
6. acting as advocates: doctors have a responsibility to advocate on behalf of patients, this should be extended to include broader social determinants of health.

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

This report is just the first step in a larger body of work to better integrate the social determinants of health into the everyday work of doctors the world over. The World Medical Association plans to be at the forefront of this shift in focus and harness the potential of doctors to reduce health inequality. It is clear that while much is being done, there is a need for doctors to do something, do more, do better.

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