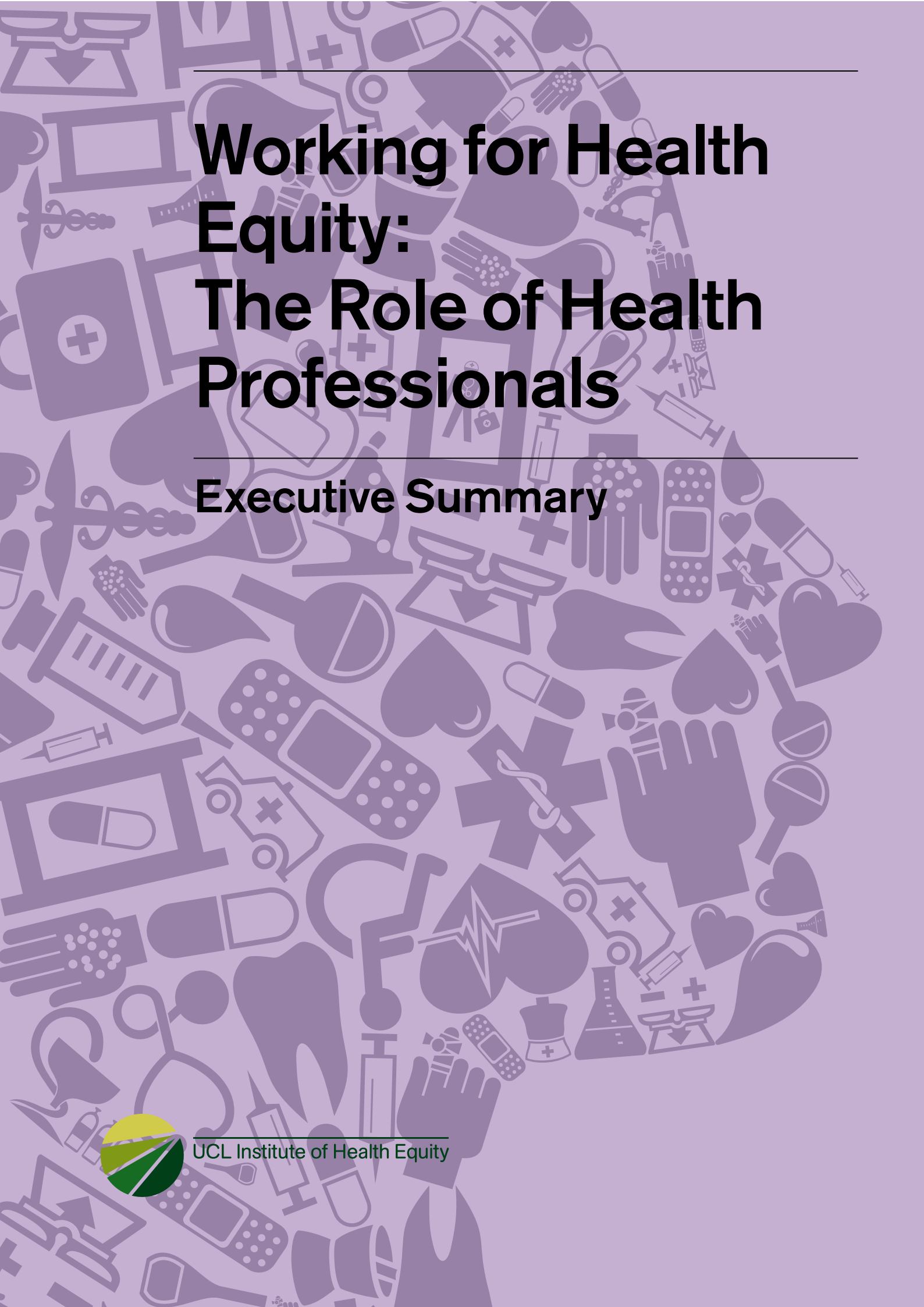
Working for Health Equity: The Role of Health Professionals

Executive Summary



UCL Institute of Health Equity

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with
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Statements for action were written by the following:

— Nurses
by the Royal College of Nursing
— Social workers and social care
by the Social Work & Health Inequalities Network
— Clinical Commissioning Groups
by the Royal College of GPs
— General practitioners
by the Royal College of GPs
— Paediatricians
by the Royal College of Paediatrics & Child Health
— Midwives
by the Royal College of Midwives
— Obstetricians and gynaecologists
by the Royal College of Obstetricians and Gynaecologists
— Hospital doctors
by the Royal College of Physicians
— Psychiatrists
by the Royal College of Psychiatrists
— Dentists and the oral health team
by the Faculty of Dental Surgery, Royal College of Surgeons of England; Dental Faculty, Royal College of Surgeons of Edinburgh; Dental Faculty, Royal College of Physicians and Surgeons of Glasgow; Faculty of General Dental Practice, Royal College of Surgeons of England; Dental Schools Council; British Association for the Study of Community Dentistry.
— Medical students
by Medsin
— Allied health professionals
by the Allied Health Professions Federation with sections on:
Music therapists
by the British Association of Music Therapy
Dieticians
by the British Dietetic Association
Occupational therapists
by the College of Occupational Therapists
Physiotherapists
by the Chartered Society of Physiotherapy
Paramedics
by the College of Paramedics
Radiographers
by the Society and College of Radiographers
Speech and language therapists
by the Royal College of Speech and Language Therapists

Foreword

The Merseyside Fire and Rescue Service made a lasting impression. When conducting the Marmot Review of Health Inequalities, published as *Fair Society Healthy Lives,* we partnered with the North West Region of England. On one of our visits to Liverpool, we were hosted by the fire fighters. Their compelling story was of going outside their core professional practice of fighting fires to preventing them, which entailed engaging with the local community. They then became involved in looking at quality of housing, and at smoking, which are fire risks, to more general issues that benefit the community, including activities for youngsters and older people.

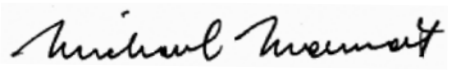
"If the fire fighters can do it, why not the doctors?" was a question I posed to the British Medical Association, during my time as President. Doctors are involved in treating illness but most accept they have an important role in prevention. If illness arises from the conditions in which people are born, grow, live, work, and age – the social determinants of health – should the doctors not get involved in the causes of illness and, indeed, the causes of the causes. The BMA picked up the challenge and produced a report on what doctors could do about the social determinants of health. But why stop at doctors? Other health professionals have key roles to play on improving the conditions of people's lives and hence could have profound effects on health inequalities. This report builds on the BMA's report and the inspiring work of health professionals.

Fair Society Healthy Lives laid out the evidence and made recommendations of what should be done on the social determinants of health in order to reduce health inequalities. Many of the recommendations were aimed at sectors other than health. But the medical and health professions are well placed to take action on the social determinants of health – they are trusted, expert, committed, and great powerful advocates.

One response to the evidence on social determinants of health is weary reluctance – it is simply all too difficult. The response we have had from colleagues who helped us with this report has been far from that. Nineteen organisations have contributed, including medical Royal Colleges, nurses, midwives, medical students, and several allied health professions. We appear to have struck a chord. And it is hugely encouraging.

The response can be summarised as: not only *should* we be taking action but there is ample evidence that we *can*. This report shows the evidence base for actions, the case studies present examples of organisations with effective strategies, and the statements for action put forward practical actions.

The report and statements make clear that action on the social determinants of health should be a core part of health professionals' business, as it improves clinical outcomes, and saves money and time in the longer term. But, most persuasively, taking action to reduce health inequalities is a matter of social justice. The enthusiastic response from medical and health professionals to the challenges of a fairer distribution of health contributes to what I have described as my evidence-based optimism: we are making progress in a good cause. Join us.



Professor Sir Michael Marmot
Director of the UCL Institute of Health Equity

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Executive Summary

Those in the health sector regularly bear witness to, and must deal with, the effects of the social determinants of health on people. This report will demonstrate that the health care system and those working within it have an important and often under-utilised role in reducing health inequalities through action on the social determinants of health. The health workforce are, after all, well placed to initiate and develop services that take into account, and attempt to improve, the wider social context for patients and staff.

This report launches a new programme of activities to tackle health inequalities through action by health professionals on the social determinants of health. It draws on many examples of inspiring and excellent practice which demonstrate what can be done. The report describes areas where greater action is necessary and possible and makes some practical suggestions about how to take forward action on the social determinants of health.

The report contains recommendations and analysis in six core areas, described below. It also contains nineteen Statements for Action about actions health professionals can take to tackle the social determinants of health through their practitioner role. These have been written by Royal Colleges and other representative organisations, and set out, for each profession, a rationale for action, practical guidance on what activities to engage in, and relevant case studies and further reading. Working with the authors of these statements, and other organisations, the Institute of Health Equity (IHE) will support and encourage health professionals to take greater action to tackle health inequalities.

The report also sets out a series of commitments made specifically for this report and future work programme, from twenty relevant organisations. These cover each of the six priority areas in this report, and display an impressive ambition to take forward action on the social determinants of health. Organisations have committed to work in partnership to implement the recommendations of this report by producing educational materials, developing new research and publications, setting up networks, embedding the social determinants of health in current work and disseminating information to health professionals. These commitments are described throughout the document at the ends of chapters, and a full list can be found on the IHE website (1). They will form the basis for an on-going programme of work led by IHE in partnership with Royal Colleges, the Academy of Medical Royal Colleges (AoMRC), the British Medical Association (BMA), the Canadian Medical Association (CMA), the World Medical Association (WMA), and other organisations and institutions. These commitments will extend and develop over time, but are included in the full report in their current form in order to give an indication of future steps. As we continue the programme of work over the next few years, these will be developed, tested and implemented further.

Background

Evidence presented in the Marmot Review 2010 (2), and many other evidence-based analyses of health inequalities (3-6) show a clear social gradient in health outcomes, which closely relates to social and economic factors: the conditions of daily life. Most of the factors influencing health lie outside the immediate reach and traditional remit of the health system – early-years experiences, education, working life, income and living and environmental conditions. The recommendations of the Marmot Review were therefore mainly focussed on actions which could be taken outside the health care system to reduce health inequalities. This report now focuses on actions and strategies that can be developed within the health care system, and particularly the health workforce, where there is great scope. It builds on and learns from other recent initiatives (7-9).

While inequities in access and care within the NHS do exist, they do not account for a large proportion of health inequality, particularly when compared to the powerful influence of social and economic factors on health (10-12). This report demonstrates that there is much that the health system can do to influence these wider social and economic factors, beyond ensuring equity of access and treatment. Those working within the health system have an important, albeit often under-utilised, role in reducing health inequalities through action on the social and economic factors: the social determinants of health. Tackling health inequity is a matter of social justice; it is also essential in order to provide the best care possible. Preventive measures that improve the conditions in which people live can lengthen people's lives and years spent in good health, improve services and save money (2).

The report is based on literature, case studies, and other evidence about how health professionals and organisations can influence social determinants and tackle health inequalities in a systematic and

effective way. Many relevant organisations have had direct input into the report, and this input forms much of the basis for the analysis and recommendations. We organise this analysis into six areas in which actions will be particularly effective: education and training, working with individuals, action by NHS organisations, working in partnership, workforce as advocates, and opportunities and challenges within the health system. These are described briefly below and in greater detail in the main report, where they are also accompanied by case studies, recommendations and commitments.

Part A
Ways for health professionals to take action on health inequalities

1 Workforce education and training

In order for the health workforce to successfully tackle health inequalities and take action on the social determinants of health, the right education and training are essential. Good education on the social determinants of health will not only inform but also empower the health workforce to take action. Changes should take place within undergraduate education, postgraduate education, Continued Professional Development, and other forms of training.

There are two important actions in this area. Firstly, professionals should be taught about the nature of the social determinants of health, and what actions by those within, and outside, the health system have been successful in tackling them. Education should include information about the graded distribution of health outcomes, how social and economic conditions can help to explain these unequal outcomes, and what practical actions can be undertaken by health professionals to decrease these inequalities. This teaching should take the form of dedicated compulsory and assessed modules, and should be included in other specialised courses, for instance a course on cardiovascular disease should include information on the social determinants of that disease (13).

This first area can then be supplemented by a second action, the teaching of skills: that is, how to reduce inequalities within professional practice areas. Some necessary skills are more general and have broad application – for example, skills of communication, partnership and advocacy are all essential for tackling health inequalities. There are also specific strategies which have been shown to be effective, for example, taking a social history and making patient referrals to external support services. Teaching skills in these specific practice-based areas should be a core element of all health courses.

Seeing the effects of social and economic inequalities will ground and 'realise' the knowledge described above. For this reason, student placements are central to learning. They should take place in a range of non-clinical settings, for example with social services or with a debt advice service, and should be designed to expose students to disadvantaged areas and needs. It is also important that access to health professions is made more equal.

Within England, action across the areas discussed above is the responsibility of Health Education England, Local Education and Training Boards, the General Medical Council, medical schools, NHS organisations, and professionals and students in advocacy roles. IHE will work with these organisations to embed the recommendations below.

Key recommendations:
Workforce Education and Training

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

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

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

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

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

2 Working with individuals and communities

The Marmot Review showed that if the conditions in which people are born, grow, live, work, and age are favourable, and distributed more equitably, people would have more control over their lives in ways that will influence their own health and health behaviours, and those of their families. Individual health professionals can tackle the social determinants of health by helping to create the conditions in which their patients can have control over their lives.

It is important that health professionals build relationships of trust and respect with their patients. This is good for the patient as control and reducing stress can have direct effects on health (14). It can also improve the uptake of public health messages and other strategies to reduce inequalities. Greater communication and better relationships can also enhance practitioners' knowledge and understanding of their patients and the local community, thereby improving the care that they are able to offer. Techniques such as motivational interviewing, a method that increases communication and collaboration between patients and providers, can help to build these relationships on an individual level. On a community level, professionals should be promoting and engaging in collaboration and communication with the local population.

In taking action to reduce inequalities, health professionals can focus on two key activities: gaining information, and providing information. Gaining information about patients is important in order to understand how social and economic factors are impacting on a patient's health. Taking a social history can enhance a medical history and enable professionals to provide the best care possible. This type of information is also essential on an aggregate basis, as it can help to influence and inform local commissioning and provision, both of health care and of other services within the community. Longitudinal social data can also enable organisations to measure progress and the effectiveness of interventions against health equity indicators.

Giving information that can help to improve the social determinants of health mainly consists of referring patients to non-medical services. These should cover a broad range of sectors and issues, beyond lifestyle and disease management programmes. For example, referral to Legal Aid, Relate, CAB, employment programmes or housing advice services can help patients to tackle the sources of ill health. By connecting patients to professional advice about state benefits, health professionals can ease patient anxiety and stress (15) and improve the context in which they live. Other referrals can help to tackle other social determinants of health. Such activity may reduce the number of consultations with and prescriptions from GPs (16). Referral of this type is particularly successful where the services are readily accessible or medical and non-medical services are co-located – for example, where Citizens Advice Bureaux are situated in GP surgeries.

There will be two types of changes needed: those requiring increased resources of time and money, and those that can be accommodated within existing structures and constraints. In the first case, professionals should be advocating for change and helping to build an evidence base to support the case. However, some changes can and should be made within existing structures and constraints.

Key recommendations:
Working with Individuals and Communities

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

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

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

3 NHS organisations

In addition to actions taken to improve the health and wellbeing of their patients, NHS organisations have a responsibility to ensure that health inequities among their employed staff are also tackled. The NHS is the largest employer in the country with 1.4 million staff (17), plus staff employed in non-NHS commissioned services. Health professionals have opportunities in their roles as managers, commissioners and employers to ensure that workforce health and wellbeing are central to their activities.

Firstly, NHS organisations should be places of good quality work. Evidence has consistently shown that employment is better for mental and physical health than unemployment. However, this only applies to good quality work (2). Good quality work is characterised by a living wage, having control over work, being respected and rewarded, being provided with good quality in-work services such as occupational health services, and with adequate support to return to work after absence.

The importance of these areas was recognised by Carol Black's review of the UK's working age population (18), and was applied to NHS workplaces in the Boorman Review (19). Managers should be ensuring that all staff, including contracted staff, are provided with good quality work in line with the recommendations of the Boorman Review. IHE have produced a strategy for Barts and the London Trust which set out how to implement the recommendations of the Boorman Review and the Marmot Review (22). Implementing these strategies across the workforce is likely to reduce inequalities as there is a gradient in quality of work: those from lower socio-economic groups currently tend to experience worse quality work.

NHS organisations, and therefore their staff, have considerable influence through their sizeable purchasing power, both as employers and contractors of staff and as commissioners of services. One literature review found that the health sector often accounts for 15–20% of a local community's employment and income (20). This gives health organisations significant power to affect the health and wellbeing of their local population. Public bodies also have a legal duty to consider how procurement might improve the economic, social and environmental wellbeing of their area (21). Employment should be designed to be particularly beneficial for those from lower socio-economic groups, as this will reduce inequalities. In addition to providing a good quality place of work, this can be achieved by ensuring that there is security and flexibility of employment and retirement age, and that jobs are suitable for lone parents, carers and people with mental and physical health problems (22).

This report outlines many actions that can be taken by individual health professionals. They can start to take most of these actions straight away. However, in order for action to be comprehensive, systematic and sustained, these actions must be supported at every level. For this reason, managers and leaders should ensure that strategies on organisational health inequalities that incorporate the areas in this report are in place, with dedicated leads and budgets. They should be auditing proposed actions, monitoring progress and sharing good practice.

Key recommendations:
NHS Organisations

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

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

4 Working in Partnership

In order to take effective action to reduce inequalities, working in partnership is essential. Evidence shows that effective action often depends on how things are delivered, as much as what is delivered (2). A key element of this is collaborative, cooperative work that is either delivered jointly by more than one sector, or draws on information and expertise from other sectors. Since many of the causes of ill health lie in social and economic conditions, actions to improve health must be taken collaboratively by a range of agencies that have the potential to affect social and economic conditions.

Many health professionals work extensively and successfully with other health care staff. These partnerships within the health system often extend across primary, secondary and tertiary care; between nurses, psychiatrists, doctors, surgeons and more; and are a core part of day-to-day business for practising professionals. Partnerships should occur between different organisations, for example hospitals and community health services, and different professionals in the same organisation. They can help to improve patient experience and practitioner knowledge, and reduce inequalities in outcomes.

However, perhaps more importantly, partnerships between health and non-health professionals and organisations should be established, supported and extended. Integrated work should be broad, and include partnerships with local government, other public sector partners, the police and fire service, charities and other third sector organisations, private companies and places of work, and schools (2). There is a legal duty on Clinical Commissioning Groups and the NHS Commissioning Board to integrate services where this would reduce inequalities (23), and other professionals should work to support and extend this. Information-gathering and monitoring systems should be collaborative where possible. Joint planning, commissioning and delivery are particularly important for effective partnerships. Collaborative local strategies can provide effective ways of reaching shared goals and providing excellent services, as well as reducing inequalities, although partnerships must be carefully designed and assessed in order to ensure effectiveness (24).

Early years and childcare health are important examples of the value and necessity of partnership working. In order to tackle the root causes of ill health effectively, action early on in life is essential. This can change the conditions in which children are born and grow, and the care and opportunities that are made available to them. In order to take action in this area, partnerships should be established between Children's Centres, schools, social care, health visitors, midwives and other health professionals. When these different sectors communicate effectively, deliver joint programmes and tackle individual problems in a collaborative way, outcomes tend to improve (25).

Since the passage of the Health and Social Care Act 2012, a new form of partnership has been established – Clinical Commissioning Groups (CCGs). These are locally based consortia, made up of GP practices, which will commission care for the local community (26). The doctors and nurses who sit on CCGs have three important ways to tackle health inequalities: through their actions as health professionals; in their role on the CCGs, which includes making commissioning decisions; and in the way they use the CCG as a local advocacy and community asset. If CCGs and professionals are aware of and responsive to the social determinants of health in their local area, they will be able to tackle health inequalities while delivering clinical services.

Key recommendations:
Working in Partnership

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

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

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

5 Workforce as advocates

Every health professional has the potential to act as a powerful advocate for individuals, communities, the health workforce, and the general population. Since many of the factors that affect health lie outside the health sector – in early-years experiences, education, working life, income and living and environmental conditions – health professionals may need to use their positions both as experts in health and as trusted, respected professionals to encourage or instigate change in other areas. The medical Royal Colleges have a clear advocacy function, and regularly petition government for policy changes on behalf of their members and their patients. However, advocacy is also powerful and important for health students, qualified professionals, CCGs, NHS organisations and other professional bodies such as unions.

Acting as an advocate for individual patients and their families is often particularly helpful to improve the conditions in which people live. Professionals can use their understanding of the factors that are influencing a patient's health, and act as advocate in order to help these patients to access services both within and outside the health service. In a similar way, advocacy on behalf of communities is also important.

The actions proposed in this report will be most effective where they are adopted widely and supported at all levels – from central to local and individual arenas. This will ensure that strategies are in place to instigate change, to regulate action, to measure and reward progress, and to learn from others. This will require, in some cases, action that is beyond the remit of the individual professional. In these cases, professionals should use their position to advocate for the changes that are necessary, both within their organisation, and within other local bodies or central systems. For example, changes to education, as outlined above, will need the support and backing of health students and professionals.

Health professionals have great authority and expertise, and should also be using this to advocate for policies that will reduce health inequalities and against policies that will widen them. This should be targeted at central government departments as they consider policy change, but also towards newly formed bodies such as the NHS Commissioning Board, which are currently considering what to prioritise and what strategies to adopt. With concerted pressure from health professionals and the bodies that represent them, we have a great opportunity to ensure that tackling health inequalities is a central concern across the policy spectrum, and that all bodies consider the health equity impact of new and existing policies.

Key recommendations:
Workforce as advocates

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

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

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

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

6 The health system – challenges and opportunities

The Health and Social Care Act of April 2012 has led to significant changes in structure, provision, incentives, regulation, commissioning and monitoring within the health system (23). While the changes are challenging and disruptive, there are also new opportunities to tackle health inequalities and to embed an approach based on the social determinants of health across the new system. The new legal duties in the Health and Social Care Act can act as an important lever in encouraging action. In exercising their functions, the NHS Commissioning Board and Clinical Commissioning Groups must have regard to the need to reduce inequalities, both in terms of access and health outcomes of patients. They must also secure integrated provision of services, both within the health system and beyond it, where this would reduce inequalities in access or outcomes. In addition, there are duties on the Secretary of State, Monitor and NHS Foundation Trusts, all of whom must integrate these duties into their plans and report progress on them annually (23). The Equality Act 2010 states that public sector bodies "must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage." (27).

These duties mean that work by the NHS workforce to tackle health inequalities should be integrated into organisational strategies and plans, as well as being incentivised and monitored. Unfortunately, other mechanisms may make this harder. For example, the Quality Outcomes Framework is a powerful incentive system but tends to measure certain outputs rather than patient outcomes, weakening its potential to reduce health inequalities. On the other hand, the Public Health Outcomes Framework includes important social determinants of health indicators, but is not linked to financial incentives or requirements, decreasing its potential to leverage change and increase impact. There are other mechanisms which may provide opportunities or challenges: the NHS Commissioning Board and the NHS mandate, the NHS constitution, funding and allocation arrangements, monitoring and data-sharing procedures, and various mechanisms that impact on health education. This chapter in the full report sets out some initial conclusions from a working paper, which is available on the IHE website (1). IHE will be developing this analysis as part of the 'Working for Health Equity' programme.

Part B
Professions: Statements for action

The analysis set out in this report has been largely welcomed by health professionals and their representative organisations. But there is a need for health professionals to have brief, practical guidance for tackling health inequalities through the social determinants of health. To inform this report we asked Royal Colleges and other organisations to provide statements for action, to give practical accessible guides for particular professionals to develop and use in their roles. The result of an enthusiastic response, nineteen statements for action by different organisations are set out in the main report. These statements also include a rationale for action, case studies and further reading. During the implementation phase of our programme of work, we will be working with various organisations to drive uptake of these practical actions.

There are statements for each of the following professional groups:

— Nurses
— Social workers and social care
— Clinical Commissioning Groups
— General practitioners
— Paediatricians
— Midwives
— Obstetricians and gynaecologists
— Hospital doctors
— Dentists and oral health teams
— Psychiatrists
— Medical students
— Allied health professionals
— Music therapists
— Dieticians
— Occupational therapists
— Physiotherapists
— Speech and language therapists
— Paramedics
— Radiographers

Commitments and next steps

This report also sets out a series of commitments by the health workforce and other organisations to embed and develop action on the social determinants of health. These form the basis of an on-going programme of work led by IHE in partnership with Royal Colleges, the Academy of Medical Royal Colleges, and the British Medical Association among other organisations and institutions. The current commitments are placed throughout the document at the ends of chapters. These commitments will be added to over time. Please see the IHE website for an up-to-date list of commitments (1).

IHE will lead a programme of work to disseminate the messages in this report, encourage their practical application across the workforce, and to extend the evidence base. We have been sent many examples of excellent practice already taking place, and the 'Working for Health Equity' programme will be focussed on increasing the systematic and sustained implementation of this activity across the health system. This will be undertaken in partnership with organisations that have already been involved in the project by writing statements for action and commitments. IHE also welcomes other organisations to join the programme and share their experience, working together to achieve greater health equity through actions by health professionals and related organisations.

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Abbreviations

AoMRC	Academy of Medical Royal Colleges
BMA	British Medical Association
CAB	Citizens Advice Bureau
CCG	Clinical Commissioning Group
CMA	Canadian Medical Association
CPD	Continued Professional Development
GP	General Practitioner
IHE	UCL Institute of Health Equity
NHS	National Health Service
WMA	World Medical Association

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