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How doctors can close the gap: tackling the social determinants of health

Stephen Atkinson and Ben Cottam

Introduction

The persistence of major inequalities in health has recently been emphasised and brought into sharp focus. Professor Sir Michael Marmot has been a key advocate for health equality and his report for the World Health Organization entitled *Closing the gap in a generation* identified the nature and causes of inequalities globally.[1] Yet they are not a problem restricted to poor or developing countries. More recently, the Marmot Review group's report *Fair society, healthy lives* highlighted the evidence that social inequity in the UK causes unjustifiable gaps in health outcomes.[2]

While these reviews have had a very broad scope, containing recommendations aimed at all sectors, this recent conference sought to explore specifically the role of the doctor in tackling the social determinants of health. The conference marked the culmination of two years of work, led by the Royal College of Physicians (RCP), and the launch of the RCP report *How doctors can close the gap*.[3]

In his welcome to delegates, Professor Sir Ian Gilmore called for a 'watershed in how doctors practise'. He emphasised the ties between this work and the drive for strong clinical leadership and physician engagement in developing services. Three conference sessions explored, in turn, the relationships between policy, medical professional culture and medical education, and training and the social determinants of health. Discussion was lively and future focused, with a real desire to identify the changes and actions required in order to 'close the gap'.

Opening the conference Dr Harry Burns emphasised the links between social communities and health. Reflecting on his own experience, he described the many ways in which the social and physical environment can generate biochemical adversity. The effects of deprivation start early in life and can be pervasive and long lasting. His description of the Dunedin cohort highlighted that those identified as 'at risk' aged three were at significant increased risk of unemployment, criminality and the metabolic syndrome in adult life.[4] If the health of patients is to be maximised, then the social environment needs to be comprehensible, structured and meaningful. Describing how the social determinants operate in Scotland, Dr Burns dispelled some myths around some of the public health issues that affect health inequalities in the region. He made the point that excess mortality in socially disadvantaged groups was predominantly caused by health problems linked to social dysfunction, particularly drug abuse, excess alcohol consumption and suicide.

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This conference was held at the Royal College of Physicians on 10 June 2010.

Social determinants of health and policy

'Health inequalities are not inevitable or immutable'

Addressing delegates by video conference, Professor Sir Michael Marmot emphasised that physicians have the knowledge and the means to address the problem posed by the social determinants of health. The widening gap between the health of the richest and poorest sections of society, however, should not be viewed as a step-change but a 'social gradient of health', applying to both mortality and disability-free life. Professor Sir Marmot cautioned against the traditional policy approach that focuses on the extreme ends of the scale, and argued that flattening the gradient will produce the major gains.

Some may cite the current economic climate as reason to defer action on the social determinants of health, but it appears that we cannot afford not to act. Increasing the retirement age in a society where 75% of the population do not have disability-free life over the age of 68 will simply transfer many individuals from pensions to disability benefits. Nor do interventions need to be expensive; reading to children every day, for example, can offset half the impact of economic deprivation. Outlining some of the key findings and recommendations from *Fair society, healthy lives* Professor Sir Marmot emphasised a need to create a society which enables and maximises the potential of individuals and communities, putting health at the centre of policy.

Professor Sir Ian Gilmore described the link between the Marmot Review and the RCP's publication *How doctors can close the gap*.[3] He argued that action on the social determinants of health is within the medical profession's jurisdiction and that the trust placed in the profession by the public was a unique tool. Doctors can make significant contributions by starting to put their own house in order – ensuring universal access to healthcare and working towards health promotion and ill-health prevention. Medical education and training require reform so that social determinants become the 'letters through the rock'. Health professionals can be advocates and work with and within other parts of the public and private sector.

Exploring the process of 'making it happen' Dr Ruth Hussey emphasised the importance of leadership and widespread

Conference programme

Opening address
Dr Harry Burns, chief medical officer, Scotland

The social determinants of health: a policy overview

The Marmot Review – a springboard for action
Professor Sir Michael Marmot, professor of epidemiology and public health, University College London

The Marmot Review – doctors meeting the challenge
Professor Sir Ian Gilmore, president, Royal College of Physicians and commissioner on the Marmot Review

Strategies for local implementation of integrated programmes to tackle the social determinants of health
Dr Ruth Hussey, regional director of public health, NHS North West

European perspective on the social determinants of health
Mr Michael Hübel, head of unit, Health Determinants, Health and Consumer Protection Directorate General, European Commission

Panel discussion
Dr Harry Burns; Professor Peter Goldblatt, Senior Research Fellow, Marmot Review, UCL; Professor Sir Ian Gilmore; Dr Ruth Hussey; Mr Michael Hübel

Changing professional cultures within medicine towards the social determinants of health and sustainability

How can secondary care clinicians best work to ameliorate health inequalities?
Dr Kiran Patel, consultant cardiologist and honorary senior lecturer, Sandwell and West Birmingham Hospitals NHS Trust

What are the co-benefits for health of action on climate change and sustainability?
Professor Ian Roberts, professor of epidemiology, London School of Hygiene and Tropical Medicine

How can all doctors best advocate for culture change and interdisciplinary working to tackle health inequalities?
Dr Sam Everington, general practitioner, Bromley by Bow Centre

Panel discussion
Dr Kiran Patel; Professor Ian Roberts; Dr Sam Everington

The social determinants of health: implications for the education and training of doctors

Students' advocacy on health inequalities; why do we need a change in learning?
Mr Mustafa Abbas, medical student, UCL

How can we better incorporate the social determinants of health into undergraduate education?
Professor Peter Rubin, chair, General Medical Council

How can we better embed the social determinants of health into postgraduate medical training?
Professor Alan Maryon-Davis, president, Faculty of Public Health

Panel discussion
Mr Mustafa Abbas; Professor Peter Rubin; Professor Alan Maryon-Davis

mobilisation to achieve large-scale change. If we focus upon disease models and specific health behaviours the wider issues fall by the wayside. Success requires a focus upon the promotion of wellbeing and thus consideration of economy, wellness and environment. This requires that all investment decisions, such as housing, transport or green space projects, must take account of their potential to impact on health.

The link between economic development and inequality is increasingly recognised. Michael Hübel discussed the social determinants of health from a European perspective and advocated making inequalities in health an indicator of economic progress of a country. International collaboration on health should include consideration of inequalities. He discussed how the framework of the EU could be used to develop actions and tools for professional training in how to tackle health inequalities and to support coordination and exchange of best practice between member states.

Action on health inequalities is both possible and within the remit of doctors. What then is required of the profession to stop and reverse the current trend for an ever-steeper social gradient of health? Discussion pointed towards a need to change attitudes from disease treatment to promotion of wellbeing and from health improvement to life improvement. Debate considered less whether to act but more how doctors should act. It was recognised that much of what had been discussed was predicated upon doctors being part of the solution but are they currently part of the problem? The need to ensure that the provision of health services did not contribute to inequality was seen as key. Working with disadvantaged and marginalised sections of society to co-produce services would be one solution. Beyond this, doctors must also consider a more active and politicised role advocating on wider issues, such as free school meals, which impact upon health inequalities. Concerns were raised, however, that without effective tools to quantity equality and attention to the 'softer' side of health behaviours in clinical practice, and a corresponding measurement focus, attention would continue to be diverted.

Changing professional cultures within medicine towards the social determinants of health and sustainability

Opening this session Dr Kiran Patel highlighted the importance of ensuring that the launch of the report was supported by activity to ensure that all clinicians can relate its messages to their individual work. Without this it is unlikely that desire will translate into reality. Drawing attention to the superior cost-effectiveness of upstream interventions over therapeutic measures he lamented a situation in which only two acute trusts in England are accredited stop-smoking providers. Clinicians must change their perspectives and realise that health services themselves form a significant part of the problem and thus the potential solution. Such a change in thinking would support a focus on partnerships. He stressed

that opportunities exist for doctors to get involved to remedy this situation, for example by conducting equality impact assessments on services and care pathways. Dr Patel concluded with the call to arms that 'the unthinkable is achievable'.

Professor Ian Roberts continued to challenge delegates to maintain wider perspectives and whole population views. The manner in which society has developed has created structural problems and an over-reliance on fossil fuels. This single issue has been to the detriment of the environment and the population's health. Actions on climate change and health improvement initiatives have synergistic potential, generating significant 'co-benefits'. Active transport policies to reduce car usage and increasing access to green space are good examples. Tackling climate change could represent the next great medical advance.

The work of Dr Sam Everington and his team at the Bromley-by-Bow Centre demonstrates that a shift to a professional culture attending to the social determinants of health is both achievable and powerful. Their philosophy has sought to maximise individual potential and adopt a can-do culture. A collaborative, partnership-based approach has allowed creation of a social enterprise providing health and local services, owned by the community. Its implementation has constructively challenged doctors' traditional ways of working and simultaneously released their entrepreneurial spirit. Dr Everington urged delegates to consider the environments in which they seek to deliver healthcare, highlighting the importance of the design of buildings and bringing spaces alive.

Discussion recognised the failure of Payment by Results to support work on health inequalities and the importance of incentives to healthcare economies to deliver wellbeing. Without these, doctors may struggle to relinquish control of healthcare to communities. Perhaps it is this inability to give up power that is holding physicians back? Tackling this professional challenge may promote the re-evaluation of working practices and a greater role of patients in determining their healthcare. The possibilities offered by modern technology to go 'green' and revolutionise the dynamics and delivery of healthcare should not be underestimated.

Implications for the education and training of doctors

Mustafa Abbas' charismatic style contrasted with the description he gave of medical students' experience, and many delegates' recollections, of public health teaching. He described how undergraduate enthusiasm to act on inequalities remains largely unsupported by medical schools and their curricula. To equip doctors of the future with the skills to act on inequalities and maintain their will to engage with this challenge, undergraduate experience of public health must be revolutionised. A focus on people, stories and experiences should provide context for epidemiology and statistics. Medicine in the community should not be mistaken for community medicine. Medical schools and their deans and lecturers need to legitimise, recognise and incentivise medical student advocacy to widen and systematise participation, which will in turn lend intellectual capacity and institutional memory to these activities. Medical schools should also be careful not to forget their place in communities and their duties to them.

Professor Peter Rubin reminded us that we have been here before, drawing parallels between the current desire to act on social inequalities and the situation in 1944. Integration of the social determinants of health into the undergraduate curriculum is vital yet it is seen to be in competition with 'the real stuff'. Teaching must make the link between cells, biological process, people and social environment. Consultations must also reflect this; each is a challenge to put ourselves in patients' shoes.

Broadening the range of doctors acting on the social determinants of health will require reform of postgraduate training. Imagination is required to widen the options available beyond conventional routes to increase access to, and attainment of, public health competencies. Professor Alan Maryon-Davis described some of the possible models including dual accreditation (acquisition of two certificates of completion of training) and modular credentialing (specific certification in relation to certain elements of a specialty training programme). The latter option has the potential to generate an innovative, flexible workforce. Questions exist whether roles exist for individuals with such expertise. Work is already underway to explore the options with certain specialties, such as paediatrics.

Discussion recognised the need to imaginatively transform and integrate public health into medical education and training. Experiential modules and programmes need to be developed to complement academic learning and promote engagement. Once again the power of incentives to drive changes in practice at all levels within the profession cannot be ignored.

Concluding remarks

The proceedings of the conference indicate a sense of excitement that there is a genuine opportunity for the medical profession to act on the social determinants of health. To achieve this doctors must change their perspectives, approaches and working practices. There is a sense of increasing recognition of this within the profession but realising this culture change will require re-evaluation of systems, roles, incentives, teaching and training. The coalition government aims to give the medical profession greater ownership of the planning and management of services. Historically the profession has not capitalised sufficiently on moments such as this. Physicians must be ready to meet the challenge and take opportunities to act on health inequalities. Closing the conference, Sir Richard Thompson indicated his support for ongoing work by the RCP to lead the profession in action on health inequalities. This will be important, but greater than this is the need for all those in healthcare to recognise and respond to health inequalities in their everyday work.

References

1 Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health*. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization, 2008.

2 The Marmot Review. *Fair society, healthy lives. Strategic review of health inequalities in England post-2010*. London: UCL, 2010.

3 Royal College of Physicians. *How doctors can close the gap. Tackling social determinants of health through culture change, advocacy and education*. London: RCP, 2010.

4 Dunedin Multidisciplinary Health and Development Study. http://dunedinstudy.otago.ac.nz/

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