EFFECTIVE ACTION BY PHYSICIANS ON THE SOCIAL DETERMINANTS OF HEALTH

AN ENVIRONMENTAL SCAN

APRIL 22, 2016

Diana Daghofer
Wellspring Strategies
# Effective Action by Physicians on the Social Determinants of Health

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1.0 INTRODUCTION

The health care system is a small part of what shapes health and well-being, which are formed primarily by social and economic factors known as the social determinants of health (SDH).\(^1\) The distribution of money, power, and resources at global, national and local levels determine peoples’ health.\(^2\) Health inequity results when “preventable and avoidable systematic conditions constrain life choices.”\(^3\)

The World Health Organization classifies health determinants as either “structural” or “intermediary”. **Structural determinants of health** include:

- Income (and its distribution) and social status
- Education
- Employment and working conditions
- Gender
- Race/Ethnicity, particularly Aboriginal Status in Canada
- Culture.

These structural determinants define an individual’s socioeconomic position, and act through a set of intermediary determinants to shape health outcomes. The intermediary determinants of health include material and psycho-social circumstances, and the health system, as follows:

**Material circumstances:**
- Housing
- Food Security
- Physical environment

**Psycho-social circumstances:**
- Social environment
- Social support/exclusion
- Personal health practices and coping skills
- Healthy child development

Given their critical role in health, SDH have been identified by the College of Family Physicians of Canada (CFPC) as “integral to population health and family medicine.”\(^4\) A SDH approach to medicine recognizes the limitations of trying to improve patients’ health by focusing on lifestyle and behavioral factors, and focuses instead on the social conditions that “shape and constrain well-being”.

2.0 HOW ARE DOCTORS CURRENTLY INCORPORATING THE SDH INTO THEIR PRACTICES?

Given the lack of standardized procedures, physicians incorporate SDH into their practices in a variety of ways that suit their experiences, practice settings and personalities. Some physicians appear to come to medicine with a strong social conscience that automatically includes concerns about social conditions. Others find themselves practicing in low-income, marginalized neighbourhoods where questions about income and housing arise naturally. Still others are influenced by their peers, community partners or education on the SDH to work to incorporate attention to social conditions into their patient interactions. In almost all situations, except clinics embedded in poor communities, the application of a SDH approach currently appears to be sporadic and context-specific.
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There are factors that support SDH-oriented practice and those that hinder this approach, as reviewed below.

“In the past, our approach was pretty ad hoc. We work with different organizations in the community; we have social and outreach workers as part of our interdisciplinary clinic; and we try to be mindful of social circumstances, but it’s not as systematic as we would like. That is changing, though, with an online Poverty Intervention Tool we are now working with.” Ryan Meili, Saskatoon

2.1 Facilitators to action

The following factors have been identified in the literature and by key informants as supporting a SDH-approach to practice:

**Champions** – Canadian and international research has shown that both individual and organizational champions are key to moving a SDH agenda forward. Individuals in influential positions, including physicians, can play an important role in initiating and promoting SDH-oriented practice and outcomes. Organizations can both influence individual practitioners and take action at a policy level, through their clout in advocacy.

Key informants pointed out that champions tend to self-identify, noting that time is better spent nurturing and supporting these individuals than in seeking out new champions. However, the education and training of physicians can also play a role in cultivating SDH champions. While SDH are addressed in educational curricula, the role of physician as advocate is given only passing mention in most schools.

A challenge for those who champion the SDH is that they can sometimes become marginalized as working outside the “core job” of health care.

**Relevant data** – Local, specific data has been repeatedly cited as an important starting point for clinicians in establishing a practice oriented towards the SDH. Analyzed so it can identify the differential outcomes among different economic groups, local data can be part of a powerful argument for action among clinicians, decision-makers, politicians and the public. This is expanded upon later in this paper.

**Practice Structure** – A practice that is oriented around SDH has a different way of operating. The receptionist is welcoming and understanding; schedules respond to the needs of the patients; and those who miss appointments are met with understanding. Staff accommodate the needs of the clients, rather than expecting patients to work around their schedules and needs.

Such practices are often established in interdisciplinary clinics or community health centres, and provide services beyond the clinical, often including social workers, community health workers, nutritional support, subsidized housing and outreach staff to support those with complex needs. Practitioners who

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1 Turnbull J, Telephone interview, September 2015
2 Turnbull J. Telephone interview, September 2015
3 Turnbull J. Telephone interview, September 2015
4 Turnbull J. Telephone interview, September 2015
5 Turnbull J. Telephone interview, September 2015
6 Turnbull J, Meili R, Bloch, G. Telephone interview, September 2015
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combine such a structure with an interdisciplinary approach to patient care have the benefit of a full team dedicated to the wide needs of patients addressing ill health with limited means. vi

Senior Management/Systemic Support – A number of clinicians and health regions have focused on securing senior management support before proceeding with further action on SDH. 11 12 13 Buy-in, particularly in the form of a written position statement, institutionalizes a SDH approach into work practices and quality measures. 14 vii Each practitioner or office may implement the approach in a unique way, using various tools and approaches, but a SDH focus is established system-wide.

Embedding SDH into quality reporting is one way to ensure it is given adequate focus. The BC Health Quality Matrix includes equity as one of its dimensions of quality. 15 However, while the Provincial Health Services Authority is in the process of developing health equity indicators, few are being measured in BC Health Authorities. 16 Toronto Hospitals now include SES and other demographics questions during intake, hospital-wide, to ensure that physicians have access to this information for all patients.

In Ontario, Health Quality Ontario 17 is an arms-length governmental organization that reports on health systems performance. Its regional quality champions report annually to the Ministry of Health and have recently taken on the task of examining how health equity is applied to the delivery of health services across the province. Its report will provide family practitioners with profiles of their populations, the health services available to them, and the services accessed by various population segments – valuable information for developing practices oriented towards SDH. viii

<table>
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<tr>
<th>Incorporating SDH into Quality Initiatives</th>
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<td>Saskatoon Health Region (SHR) has embedded SDH into its Lean Quality Process. 1 The Lean approach has the entire health system focused on a particular issue for 90 days. When SHR examined health equity, it discovered that cultural safety was an issue. Its review of hospital-standardized mortality rates, analyzed by socio-economic and ethnic groups, showed differential rates, even after adjusting for acuity. A closer examination revealed that cultural safety was one concern at the heart of the issue. People who don’t feel safe in their encounters with health system may delay seeking help, resulting in more severe cases presenting to hospital. Identifying the issue and training staff in cultural sensitivity is designed to reduce hospital stays and improve outcomes. Similarly, if readmissions are high for patients coming from a particular neighbourhood, community supports can be examined, looking upstream to reduce use of the health system and improve patient outcomes. This work often takes place in conjunction with community organizations and social services, engaging them not only to build a more robust support system for patients, but to help collect socio-economic data for future planning.</td>
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vi Meili R. Telephone interview, September 2015
vii Neudorf C. Telephone interview, September 2015
viii Turnbull J. Telephone interview, September 2015
System-wide support, more common in hospital than community settings, can include access to services such as the legal department and social workers. A physician can make a referral to these resources as they would any other specialist, and often sees immediate results. For example, a paediatrician may need to prescribe a special diet to address a child’s seizures. The physician may know of an income supplement available for that purpose, but unfortunately, the child’s father has not filed taxes in five years, making the family ineligible for the funding. The social worker is called in to help the family file its taxes and receive the special diet supplement. ix

**Systemic Support for Group Practice**

Similar to BC’s Family Practice Incentive Program, Ontario’s Health Links is designed specifically to promote equity in health access by encouraging physicians to form group practices. Local Health Integration Networks (LHIN) provide funding for one additional nurse, a business manager to coordinate patient care, and electronic data reports on patient practices (e.g. hospital and ER visits) to better support high-needs patients in eligible practices (those with a patient population of at least 50,000 people and a minimum of 65% of primary care physicians involved). About 70% of Ontario family physicians now part of a Health Links practice.

*Source: Transforming Ontario's Health Care System, Ministry of Health, Ontario*

**Early successes** – As with any initiative, early successes help demonstrate the effectiveness of a SDH approach to physicians, other practitioners, senior management and health boards. Careful monitoring and evaluation of efforts must be in place to accurately measure the impact of various initiatives.

**Effective, appropriate tools** – Providing effective tools is an important step to engaging practitioners in concrete action and establishing self-efficacy in SDH practice, advocacy and research.18 19 Physicians are sometimes reluctant to raise social causes of ill health with patients, if they feel unprepared to deal with the outcomes. The tools described later in this paper can be used to provide physicians with a clear path to treatment that addresses the determinants underlying ill health.

**Education & Training** – The social determinants of health are usually mentioned, but not embedded in the curricula in most physicians’ training. x This appears to be changing, with medical students and new clinicians showing greater appreciation for the impact of poverty on health, but ongoing training is required to reinforce SDH concepts. xi The Canadian Medical Association (CMA) and the Ontario College of Family Physicians (OCFP) are now offering training and resources to support SDH in practice (described later in this paper). In addition, some physicians suggest exposing clinicians to populations with multiple social challenges, and to make clear the expectation that they address SDH and reach out to services beyond the clinical. xii

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ix Orkin J. Telephone interview, September 2015
x Turnbull J. Telephone interview, September 2015
xi Meili R., Turnbull J. Telephone interview, September 2015
xii Meili R. Telephone interview, September 2015
2.2 Barriers to action

A growing number of physicians recognize that they can support their patients’ needs more fully by addressing the SDH and that this is “the right thing to do”, from a professional ethos perspective. What stands in their way? A number of barriers have been identified, from time, to funding, to a lack of knowledge of what to do, to a health system that does not support practice oriented to SDH. These are explored below.

**Funding** – Fee-for-service funding structures pose significant barriers to addressing SDH. Some physicians are calling for this formula to be replaced with incentives for team-based practice, capitation formulas (which provide fees per patient, rather than service), or a billing supplement or “complexity modifier” to allow more time for complex patients.

Those in salaried positions have more flexibility to spent additional time with challenging patients. This could be supplemented with performance incentives for dealing with diverse or complex populations (e.g. low income neighbourhoods, high immigrant population, etc.). For those physicians committed to fee-for-service, fee codes could be made available for the consultation required to address SDH issues.

**Time** – All clinicians, whether salaried or paid though fee-for-service, seem pressed for time to meet all their patients’ needs in a day. Adding social issues to an already crowded schedule can sometimes feel overwhelming.

Even simple steps, such as asking about income or housing issues, add time to a patient meeting or registration process. Patients living with limited means often have complex, very high needs, so many hours can be spent connecting people with the services and supports they need.

Solutions are being found to the “time crunch”. Research is being conducted in various centres across Canada to use on-line tools to improve the registration process and reduce the amount of time spent, allowing time to add new questions. BC’s Basics for Health and Health Connect programs take the load off physicians by training student volunteers to conduct SDH questionnaires and connect patients to the support services they need. Finally, research is beginning to demonstrate that time spent on ‘upstream’ issues is saving the health system time and money in the long run, by reducing the number of patient visits and the time spent in hospital. This type of data will be important to focus healthcare resources in ways that improve efficiencies in a number of ways.

**Lack of experience/feelings of efficacy** – While many physicians are aware of the impact of SDH on health access and impacts, they may not feel that they have the knowledge and skills to act on them. Some believe that SDH are outside of their ‘core work’. This is understandable, given that medical training emphasizes clinical acumen, and diagnostic and clinical skills.

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xi Turnbull J. Telephone interview, September 2015
xiii Meili R. Telephone interview, September 2015.
xiv Orkin J. Telephone interview, September 2015
xvi Moore K. Telephone interview, September 2015.
xviii Moore K. Telephone interview, September 2015.
xix Bloch G, Neudorf C. Telephone interviews, September 2015
Our health system operates in a culture where the professionals, particularly physicians, are positioned as the experts. They are expected to have solutions to patient problems, and in fact, are trained with the understanding that it is unethical to screen for issues for which they have no treatment plan. Action is further confounded by the fact that physicians tend to be the gatekeepers of patient care planning and are socialized and trained to work very independently. Most clinical decisions are made in isolation, where physicians rely first on their training and education. When physicians do seek advice, they most often refer to their peers. Next, they refer to reference books and journal articles, but that is becoming increasingly rare. In short, physicians prefer to trust themselves and known associates when looking for clinical guidance.

In addition, existing practices tend to become ingrained. Inertia takes hold, whereby trying to convince physicians to do anything out of their normal routine is a challenge. Given the daily pressures of practice, it is understandable that people do not want to take on anything they see as additional work. This especially true of the solo doctor who works in a fee-for-service arrangement. They are less likely to change their hours of operation and way of working to focus on SDH.

Part of developing physician confidence in asking about SDH lies in familiarity and comfort with the types of questions to ask. Few people who become physicians in Canada come from disadvantaged backgrounds, and may be uncomfortable probing issues of poverty. A script may be helpful to some. Establishing some sort of rapport before-hand may also be helpful. (Although some also point out that asking about a patient’s living conditions is a good way to develop rapport on its own.)

The physicians who developed the Poverty Intervention Tool aimed to reframe poverty to look more like other health issues. The tool is designed, structurally, to look like other clinical tools physicians are used to. It aims to get the conversation going and bring social issues closer to the forefront of physicians’ minds, moving social issues from the margins to the mainstream. The tool is built as much on hard evidence as possible, building a compelling argument for SDH-focused practice.

**Physician attitudes** - A mental, and some say cultural, shift is required before physicians embrace SDH within their practices. Physicians tend to have conservative values, and most have not experienced social vulnerability first-hand. In addition to all the other barriers, there is also a ‘class gap’ to bridge before physicians fully embrace the impact SDH have on people’s lives. This may present itself to patients in the way physicians dress, their jewelry or the décor in their offices.

Culture change requires work at a number of different levels – education, on-going awareness and training, clinical tools that are embedded in practice processes, and easily accessible support services. Physicians need to feel they can be effective in addressing the SDH, in simple, efficient ways.

**Lack of information/evidence** – Some physicians feel they lack the clinical evidence and research on effective interventions to address SDH. While a great deal of information exists on the role of SDH on

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xx Bloch G. Telephone interview, September 2015  
xxi Orkin J. Telephone interview, September 2015  
xxii Meili R. Telephone interview, September 2015  
xxiii Bloch G. Telephone interview, September 2015  
xxiv Meili R. Telephone interview, September 2015  
xxv Bloch G. Telephone interview, September 2015  
xxvi Orkin J. Telephone interview, September 2015  
xxvii Orkin J. Telephone interview, September 2015
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health, it may be that it is not presented in clinically-oriented formats or through channels in which they normally receive information.

**Lack of information about programs/services** – Programs and services for those with social and/or economic challenges are provided by a number of levels of government and a plethora of social organizations, faith groups, health organizations and special interest groups. Becoming informed and staying abreast of these services is challenging, and may not be the best use of physicians’ time and training. This barrier may also exist because of an actual lack of services for patients, especially in rural or remote areas. In either case, partnerships with social workers or local community agencies can help identify the best options available to patients in need.

**Structural barriers** – As mentioned above, the flip-side of team-based practices that are designed to facilitate practices oriented to address SDH, are sole-physician practices, which tend not to be structured to take advantage of the full range of clinical and community support available. In addition, the lack of integration between acute care and primary care, and between health and community-based services pose challenges to those trying to provide integrated care. Tools such as the [SHIIP data system](#) currently in place in KFLA Health Region in Ontario (described below) aim to provide physicians with information to access health care providers to support better patient care.

**Patient Privacy and Confidentiality** – Some key informants noted that issues of privacy and confidentiality may form barriers to asking questions regarding income, housing and other demographic questions. A number of studies have reviewed processes for collecting personal data from patients.27 28 There is mixed evidence on public support for collecting race and ethnicity data. One literature review noted that there is generally strong public support (ranging from 80-88%) for such action. However, a 2011 Canadian study found that nearly half of patients (48%) did not believe it was important for hospitals to collect individual-level socio-demographic data.29 More than half, particularly visible minorities, had concerns that the data could be used to negatively affect their or others’ care. The greatest discomfort was shown in providing household income (65%), sexual orientation (38%), and education background (37%), particularly for those older than 35 years of age. The study found that people were most comfortable providing personal information to their family physician (68%), followed by completing a hospital form (49%) or telling a hospital clerk (48%).30 US data showed that most people were comfortable reporting race/ethnicity to a clerk (85% with high or moderate comfort level).31 However, this figure dropped to less than half among Black respondents. Computerized data collection tools have also been recommended, to allow for analysis at different levels of complexity.

When collecting data on race and ethnicity, the “gold standard” has been identified as self-reporting, to ensure accuracy and completeness of information.32 Staff are reasonably accurate only when identifying white or black race; less so with other races.

High quality information can be collected if processes respect patients’ needs, ensure confidentiality and take into account patients’ concerns. It is also important that physicians have the skills required to pose the questions, provide context for the information-gathering and be prepared to answer any related questions.33 xxviii One physician commented that they, “…ask about very sensitive issues, such as bowel

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xxviii Meili R, Orkin J. Telephone interview, September 2015
movements and sexual function, so something like housing is not that intimate.\textsuperscript{xxix} If doctors take the time to build respectful relationships with their patients, and explain why information on employment, income and other issues is important to health, most patients have no problem answering such questions.\textsuperscript{34} It was also noted that the more often such questions are asked, the less stigma there will be.\textsuperscript{xxx}

Taking the process one step further, patient experience surveys, patient councils or participation groups can be valuable sources of feedback into the daily workings of a practice to help develop responsive health services.\textsuperscript{35}

### 3.0 REVIEW OF STRATEGIC APPROACHES

Just as physicians introduce SDH in various ways, depending on their philosophies and backgrounds, the approach they use to apply a SDH lens varies. Some focus only on their role as physicians, others embrace the need for broader social change and become community leaders or advocates. A strong contingent believe that data is at the heart of promoting practice that focuses on SDH, and begin their journey as researchers.

As described above, a number of factors are required to create a supportive environment for SDH-oriented practice. This section describes how these facilitators support physicians as clinicians, community leaders, advocates and researchers, or as identified by the College of Family Physicians of Canada (CFPC), action at the micro (in the immediate clinical environment), meso (in the local community) and macro levels (in the humanitarian realm).\textsuperscript{36}

#### 3.1 Acting as physicians

Several physicians believe that SDH must be presented as a health risk factor. Gary Bloch advises his fellow physicians to, “Treat poverty like a disease.”\textsuperscript{xxxi} Lee MacKay questions the value of time spent on annual physicals, when a poverty screening process would be far more pro-active in dealing with potential health issues.\textsuperscript{xxxii} He stresses that poverty must be screened for, just as any other disease, and uses public health data to highlight the impact of poverty. Cancer and cardio-vascular disease account for 31% and 18% of life years lost, respectively, while poverty accounts for 24%.

Clinical tools and processes that embed SDH into existing quality initiatives are two ways that present social issues in ways that resonate with physicians. Group-based practice and ongoing education and training, including Continuing Medical Education (CME) are other effective ways to integrate SDH into practice. In all cases, SDH should be made as relevant to physicians’ practices as possible.

A number of groups have suggested concrete steps physicians can take to incorporate SDH into their work, including the CFPC\textsuperscript{37}, the CMA,\textsuperscript{38} and the World Medical Association (WMA) (as noted by Sir Michael Marmot, President-Elect of the WMA, speaking at the 2015 Global Symposium on the role of physicians in addressing SDH).\textsuperscript{39}

\begin{itemize}
  \item [xxix] Meili R. Telephone interview, September 2015
  \item [xxx] Orkin J. Telephone interview, September 2015
  \item [xxxi] Bloch G. Telephone interview, September 2015
  \item [xxxii] MacKay L. Telephone interview, October 2015
\end{itemize}
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**Practice-Level Recommendations**

1. Regularly screen patients for poverty, and intervene where necessary (using a Poverty Intervention Tool and other tools designed to intervene and support patients.)
2. Provide physicians with tools to determine the impact of social and economic causes of ill health on treatment design.
3. Adopt equitable practice design, such as collaborative team-based practice.
4. Ensure that all patients are treated equitably and practices are accessible to all patients, especially marginalized populations. Offer advanced access and same-day scheduling (as per PMH “Timely Access” guide).
5. Build an antipoverty team that is shaped around your community’s needs. Team-based care should reflect the demographics of the patient population and focus on their health needs.
6. Ensure that clinical practice guidance and treatment plans incorporate considerations of patients’ social and economic circumstances. (Including, for example, asking patients if they can afford prescriptions written for them.)
7. Use knowledge of the local area to identify areas of disadvantage and multiple SDH risk factors.
8. Link patients to supportive programs, including provincial/territorial social assistance programs and community services. Local databases of community services and programs (health and social) should be developed and provided to physicians.
9. Advocate on behalf of individual patients.

The CMA also suggests that physicians be provided with best practice examples and training and education.41

Key informants suggested working with innovators/early adopters and building momentum towards a more systematic approach.xxxiii The work of early adopters can show that gaps in health between high and low-SES patients can be narrowed with focussed effort. The rewards of this approach to practice should promoted, with practitioners identified as exemplars

> “Physicians who practice using the social determinants of health should be celebrated as the heroes of Canadian medicine.”

Dr. Jeff Turnbull, Chief of Staff, Ottawa Hospital

Systemic measures include a workforce that is representative of the patient population, steps to establish cultural safety, tools such as health equity audits and gauges, and on-going monitoring of SDH for all clients. A SDH lens should be integrated into care and discharge planning as well.

Several approaches were identified by experts across Canada to promote SDH-oriented practice:

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

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xxxiii Moore K, Neudorf C. Telephone interviews, September 2015
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support organizations (e.g. through Grand Rounds, CMEs). Mentorship could be used to reinforce classroom learning with peer leadership.  

It is suggested that presentations will be most effective if they draw on local data, show differential health outcomes based on SES status and living conditions, and demonstrate the results of focused efforts. Discussion time should be included. Additional information should be provided in formats physicians are familiar with – clinical practice guidelines and tools – to make the new approach more manageable.

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

Another way of detecting disease early in the process is to screen all patients with a poverty tool, and then look more closely for diseases associated with low income.

Either way, setting targets for improvement in specific diseases among targeted populations, and then rewarding performance based on those targets can be a strategy to achieve measurable gains in health status.

3. **Focus on populations/geographic areas** – Some populations, such as Aboriginal peoples, immigrants to Canada and single-parent families would benefit more than others from a targeted approach to care. Mapping by SES and other indicators, as has been done with the SDOH Mapper in Ontario, helps identify geographic regions where focused attention may be required.

Physicians can benefit from having a first-hand understanding of the conditions in their communities. KFLA Public Health (Ontario) organizes walking tours of disadvantaged neighbourhoods for health practitioners, to point out issues such as a lack of grocery stores or transportation options. Staff that reflect the focus population and know patients and their families personally, can help create cultural safety, community connections and relationships to help support efforts. Public health colleagues, too, can be important sources of information about community conditions.

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**Footnotes:**

xxxiv Meili R, Neudorf C. Telephone interviews, September 2015
xxxv Neudorf C. Telephone interview, September 2015
xxxvi Moore K. Telephone interview, September 2015
xxxvii Moore K. Telephone interview, September 2015
xxxviii Neudorf C. Telephone interview, September 2015
3.2 Acting as community leaders

Since most action on the SDH must take place outside the health system, it is important that physician leaders work beyond their profession in the broader community. Building respectful relationships with community organizations is critical to identifying partners who can provide the support services required of high-needs patients, as well as being important sources of local data.\textsuperscript{44, 45}

### Engaging the Local Community

The Saskatoon Health Region’s (SHR) population health research revealed considerable gaps in the health status of its residents. Prior to releasing *Health Disparity by Neighbourhood Income*, the team engaged over 60 community organizations in consultations, recognizing that most solutions to health inequities were based in the community.

Also, knowing that public opinion can have a strong influence on decision-makers’ priorities for action, SHR conducted a cross-sectional random survey of 5,000 Saskatoon residents. The results showed that residents had not known the magnitude of the health differences between income groups in their city. Once enlightened, most expressed the view that even small differences in health status between income groups were unacceptable, and voiced strong support for interventions that act upon health disparity, particularly among children.

*Source: National Collaborating Centre for Determinants of Health. Improving health equity in Saskatoon: From data to action, 2012. Antigonish, NS.*

Education about the impact of SDH on health must be presented in terms that resonate with audiences. For example, church groups may be more moved by issues of social justice, whereas Chambers of Commerce may relate more to the potential return-on-investment of addressing the SDH. Most people respond to stories of patient experiences, so to help build empathy for individuals’ circumstances, presentations need to ‘paint pictures’ of patients’ needs. Ideally, audiences should visit centres, such as homeless shelters, to meet those dealing with social challenges.\textsuperscript{xlix}

The CFPC suggests that physicians work with “the patient’s community, the community of medical providers, and the ‘civic community,’ in which health professionals are citizens as well as practitioners” to support action on SDH, as follows: \textsuperscript{46} (Note: CFPC list augmented with CMA and WMA advice.)

1. Collect and apply data on your local population’s health and well-being, first by defining your patient population (through rostering, as described in *Patient Rostering in Family Practice*) and gathering data on your patient population, preferably using an electronic medical record (EMR).
2. Provide undergraduate and postgraduate experiential learning on the social determinants of health.
3. Act as a Health Advocate to improve the social and economic circumstances of the community, using the CanMEDS-FM Framework\textsuperscript{48} as a guide. (See *Section 4.0 – Tools* for details.)
4. Provide on-site care for those who cannot make it to a physical clinic. In other words, make house calls.

\textsuperscript{xlix} Turnbull J, Telephone interview, September 2015
\textsuperscript{xli} Turnbull J, Telephone interview, September 2015
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Looking at the medical community specifically, delegates to the 2015 Global Symposium on the role of physicians in addressing SDH suggest the following actions for health care providers:49

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

3.3 Acting as advocates

Beyond the community, action is often required at the policy level to enact changes that will help those living in poverty. Advocacy can be a complicated affair, but it starts by having a credible voice, something physicians can certainly bring to the issue. The right individual, with the right data, can make compelling arguments for social support to decision-makers, if that argument is framed correctly. As noted previously, financial arguments are most compelling to health systems planners.

The CFPC views advocacy as “core to the work of family medicine”, 50 (p.4) for individual patients, certainly, but also for communities and beyond, through improved living conditions and healthy public policy for all Canadians. CFPC advises that physicians seek to improve the welfare of their entire patient population by influencing policies to reduce income inequality, support equitable and progressive taxation, and expand the ‘social safety net’. 51

Additional suggestions include:

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

Appropriate language to “sell” SDH still requires work, but generally it entails leaving value judgements at the door, and speaking in terms that people of all political stripes can relate to.52 For example, “Conditions for better health are also better for the community. They reduce violence and crime, and allow people to move out of challenging circumstances to become tax payers,” or “All children should have the same opportunities to health and prosperity.”xi

Some organizations have institutionalized advocacy. Toronto’s Mount Sinai Hospital, for example, has created the position of Director of Equity and Human Rights, committed to “identifying inequities and putting strategies in place to address them” 53
Organizations of medical practitioners play a strong role in legitimizing advocacy for SDH. The positions of groups such as the Canadian Medical Association, the Canadian College of Family Physicians, the Ontario College of Family Physicians, Registered Nurses of Ontario and the BC Nurses Union can have a big impact in influencing, not only their professional members, but political decision-makers and the public at large. Smaller groups such as Health Providers Against Poverty and Upstream can be more nimble, often leading efforts and encouraging the larger organizations to action. Even individual doctors can have an impact when they speak or write about SDH. While not all physicians are comfortable being vocal advocates, they can work in partnerships with advocacy organizations, including those focused on poverty such as BC Poverty Reduction, and Poverty Costs. Providing letters of support, including data to back up the case for SDH interventions, can be powerful tools to organizations seeking funding.

Finally, the media form a key avenue to reaching the public and decision-makers. The media are becoming more familiar with messages of health equity. However, carefully prepared and rehearsed messages remain important to ensure that physicians’ messages are clearly communicated.

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Child and Youth Mental Health and Substance Use Collaborative

The Child and Youth Mental Health and Substance Use Collaborative uses a community-based approach to addressing deeply-rooted, intractable issues. The Collaborative was begun in 2013 with the purpose of increasing the number of children, youth and families receiving timely access to integrated mental health and substance use services and supports. It began with 8 Local Action Teams (LATs) in the BC Interior and now has 65 groups operating across the province.

The Collaborative’s structure is based upon the Collaborative Model for Achieving Breakthrough Improvement pioneered by the US Institute for Healthcare Improvement (IHI). The model is based on action towards addressing priorities identified by local teams. Children, youth and their families work with a broad range of health professionals and community members to address the deep-rooted issues affecting their mental health. LATs may include family doctors, psychiatrists, pediatricians, social workers, school counsellors, substance use counsellors, Aboriginal services, advocates, parents, youth, RCMP officers, health administrators and others.

Barriers to action at the systems level, identified by LATs, sponsors, funders, the Steering Committee and Clinical Faculty, are being addressed by nine working groups, working closely with the ‘Healthy Minds Healthy People’ Assistant Deputy Ministers Committee.

All activities of the Collaborative are “person-centred”. Families and youth are part of all decision-making as active members of their LAT. Beginning with the child or youth’s story, “family journey mapping” takes place, and community members, including educators and the RCMP, bring in data that help describe key issues in the community. From there, each LAT creates a “chartlet” to document and address the priorities raised. Processes are adapted to meet the needs of participants. The main mode of operation for LATs is to learn from those in the room, and govern based on their needs, building on the leadership and participation of youth and parents, described as the Collaborative’s biggest strength.

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xii Bloch G. Telephone interview, September 2015
3.4 Acting as researchers

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

Clear, standardized data on health inequities, including health outcomes and use of the health system, is a critical in promoting health equity. Data can demonstrate (1) the need for focused attention on particular patient groups; (2) changes in health status by SES status; and (3) reduced costs to health systems, information that has the power to attract a broad base of supporters. Compared to the US and UK, Canadian health care organizations collect very little demographic information, particularly on race/ethnicity and language.

A great source of concern for politicians, health planners and the public is the lack of sustainability of the health system. Some key informants believe that acute care and primary care need to work together more effectively to increase cost efficiencies. The SHIIP data system currently in place in KFLA Health Region (Ontario) provides physicians with real-time data on measures such as Emergency Room visits and hospital discharges, improving care coordination and allowing for more efficient follow-up, particularly important for people living with multiple or complex health conditions. An SDOH Mapper provides SDH data for the entire province of Ontario.

Such data systems can be used to provide economic arguments and incentives for SDH-focused care. In addition to establishing good evidence for improved health, performance measures can be embedded into systems, so that physicians are rewarded for the impact they are having on patients’ health. A combination of surveillance, data management, economics and training enables more efficient and effective health practices.

4.0 TOOLS AND TACTICS

A wide range of tools and approaches were uncovered while researching this environmental scan. However, the following list is not exhaustive and is not meant to be a definitive directory of resources available to address SDH in practice.

4.1 General Resources

- Health Equity and the Social Determinants of Health - Canadian Medical Association, including Physicians and Health Equity: Opportunities in Practice (2012) and Health Care in Canada: What Makes Us Sick? (2013) the report of a cross-Canada consultation on SDH.
- Health for All – a multidisciplinary group of migrants, healthcare professionals, students, activists and allies fighting for health for all, irrespective of immigration status, based on the belief that health requires not only access to services for maintaining physical and mental health, but full economic, social, environmental and political rights for all people.

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xliii Moore K, Neudorf C. Telephone interview, September 2015
xliv Moore K. Telephone interview, September 2015.
xlv Moore K. Telephone interview, September 2015.
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- **Health Providers Against Poverty** including [clinical tools, presentations and videos](#)
- **Poverty Series** - Ontario Medical Association
- **Primary Care Interventions in Poverty** - Ontario College of Family Physicians
- **Upstream** - a movement to create a healthy society through evidence-based, people-centred ideas. Upstream seeks to reframe public discourse around addressing the social determinants of health in order to build a healthier society.

### 4.2 Education and development

Most medical schools now provide some level of training in SDH, although it is not necessarily focused on interventions. The National Academies of Sciences, Engineering and Medicine developed a framework for educating health professionals to address the social determinants of health. The framework is based on the principles of lifelong learning; experiential, cross-sectoral, and inter-professional education; and close working partnerships between policy makers, educators, representatives of the health and non-health professions, and the community. These partnerships provide health professionals with vital exposure to the broader social, political and environmental context that determines health. Innovative forms of education, problem-solving and linkages between partners that reinforce equality are emphasized.

The framework encompasses life-long education, from foundational to graduate to continuing professional development, is built around three domains: (1) education, (2) community, and (3) organization.

![Figure 1: Framework for lifelong learning for health professionals in understanding and addressing the social determinants of health.](#)
Key informants identified the need for additional training, particularly on focused tools. The following provide examples of learning opportunities:

- **Treating Poverty: A Workshop for Family Physicians** (Ontario College of Family Physicians) – An interactive, half-day workshop offered to physicians practising in Ontario, with the goal of teaching a simple three-step approach to intervening in patients’ poverty through the development of relevant clinical skills and a deeper understanding of the federal and provincial income security systems and related resources. (Supported by a train-the-trainer program to foster and support local presenters across the province.)
- **What physicians can do about poverty in practice** (Canadian Medical Association) – The aim of this CME module is to raise awareness among Canadian physicians that poverty is a risk to the health of individual patients. It provides physicians with practical interventions for their practices.
- **Equity Action – Health System Tools for Health System Managers** (Canadian Population Health Initiative) – This course provides insight into how health regions across Canada are addressing health equity. It identifies how they use information, strategies, policies and programs to reduce health inequities, and access tools and resources to support the use and development of a health equity perspective.

### 4.3 Tools

#### 4.3.1 Poverty Intervention Tools

- **Poverty Intervention Tool** – adapted by Kootenay Boundary Division of Family Practice, based on **Poverty: A Clinical Tool for Primary Care (2013)** developed by Health Providers Against Poverty – *NB: The Ontario tool is currently undergoing a review process through the Centre for Effective Practice which may result in minor revisions.*
- **“We ask because we care”** – In use in all Toronto-area (LHIN) hospitals. Electronic version under development
  - **Toronto** – An electronic version is currently in use in selected Toronto-area hospitals, based on the OCEAN questionnaire
  - **Saskatoon** - Electronic version is being trialed this fall. Will be linked to EMR, with a score generated immediately for clinicians to access. Plan is to link directly to social workers and a 211 services database, to connect patients with needed services. Patients are asked to complete the survey, but have support if required.
  - **Multiple provinces** – a cross-provincial tool funded by the Canadian Institutes of Health Research, currently involving Ontario, Quebec and Manitoba. May also include Saskatchewan and BC.
- **Child Poverty Intervention Tool** – Developed by Health Providers Against Poverty and recently evaluated at Sick Kids Hospital in Toronto (report pending).
  - Aim is to include SDH question(s) in the Rourke Baby Record, a standardized test used in well-baby and well-child visits for infants and children from 1 week to 5 years of age.
4.3.2 Health Equity Tools

A wide range of equity tools exist, as documented in an inventory that evaluated over 30 tools in use in Canada and internationally. Several are noted below:

- **Healthcare Equity Audit Kit and Gauge** (Saskatoon) - Saskatoon has developed a wide range of health status reports for use by health practitioners and community partners, including one to advance equity in health care (Better Health for All Series 3). A toolkit is available for use by health systems planners to review and report on progress made by applying SDH into practice. The tool scores department plans and intervention reports, based upon the presence of SDH best practices such as progress in care, diffusion of innovation, etc. Issues that arise frequently flag the need for efforts and/or validated tools to address them, e.g. cultural safety, staff in-service (education and orientation) to improve conditions.

- **Community View SDOH Mapper** – Several health regions use community mappers, including Kingston, Frontenac and Lennox & Addington Public Health in Ontario and Saskatoon Health Region in Saskatchewan. The maps bring existing SDH data into a more usable format, including various deprivation indices (based on 2006 census data).

- **SHIIP data system** - The South East Health Integrated Information Portal (SHIIP) is a secure electronic information portal that enables data to flow across all health care sectors and assists with care coordination, particularly for people living with multiple or complex health conditions. It provides primary care physicians with real-time data such as acute care and admissions to hospital, identifying patients and cross-referencing data on SDH. It colour-codes data to highlight high-risk patients and can prioritize patients who have just completed specified actions, such as an Emergency Room visit or release from hospital. The system includes a web-enabled version of the existing Health Links coordinated care plan that can be shared amongst health care providers with a patient’s circle of care.

- **Kingston Helps** – This interactive website provides simple, intuitive navigation to link people with social and community services, and includes a blog written by people living in vulnerable circumstances themselves. A Health-Links nurse, trained as an intermediary, supports the website to link patients with required resources. The website is promoted through the social media, and analytics show that it is heavily used.

- **Kingston Helps - Healthcare Providers** – This section of the website is dedicated to supporting practitioners in action on SDH. It includes a wide range of resources and information on neighbourhood tours. Training on the site is currently going on with medical residents.

4.3.3 Advocacy Tools

- **“MD-MP Contact Program”** – CMA tries to pair at least one physician with each MP across the country. Bring docs to Parliament Hill to meet with MPs. Are now advocating for SDH. Key to find right clinicians to join the program. Get training to do advocacy – important link for physicians. Similar opportunities for nurses, but work policies sometimes prohibit that.

- **The CanMEDS Framework – Health Advocate** – The Royal College of Physicians and Surgeons of Canada describes advocacy as “an essential and fundamental component of health promotion”. The Competencies lay out the knowledge, skills and abilities that specialist physicians need for...
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better patient outcomes through advocacy, including working with communities and societies to identify and collaboratively address the determinants of health.

5.0 KEY INFORMANTS

The following individuals kindly contributed to this report through telephone interviews with the author:

Gary Bloch - Family physician, St. Michael’s Hospital; Assistant Professor Department of Family and Community Medicine, University of Toronto.

Vanessa Brcic - CoFounder and Chair, Basics for Health Society; Clinical Instructor and Scholar, Faculty of Medicine, Department of Family Practice | Research Office, University of British Columbia

Lee MacKay – Family Doctor, Chair of the Board of Kootenay-Boundary Division of Family Practice, Nelson, BC

Ryan Meili – Family Doctor at the Westside Community Clinic; Executive Director, Upstream; Assistant professor, Dept. of Community Health and Epidemiology, College of Medicine, University of Saskatchewan

Kieran Moore - Associate Medical Officer of Health, Professor of Emergency Medicine, Queen's University

Julia Morinis Orkin - Staff Physician, Hospital for Sick Children

Cory Neudorf - Chief Medical Health Officer, Saskatoon Health Region; Assistant Professor, University of Saskatchewan, College of Medicine

Jessica Teicher – Research assistant, Hospital for Sick Children

Val Tregillus - Project Director, CYMHSU Collaborative

Jeff Turnbull - Chief of Staff, Ottawa Hospital
6.0 REFERENCES


10 Moore K, Advancing Health Equity and SDOH at a Local Public Health agency level in Ontario, Assistant Medical Officer of Health, KPLA Public Health. Presentation, Canadian Public Health Association (Vancouver), May 27, 2015.


Effective Action by Physicians on the Social Determinants of Health


23 Basics for Health Society [Internet]. What we do. Cited September 21, 2015 from: http://www.basicsforhealthsociety.ca/what-we-do


Effective Action by Physicians on the Social Determinants of Health

Effective Action by Physicians on the Social Determinants of Health

53 Mount Sinai Hospital [Internet]. Health Equity at Mount Sinai Hospital, (Toronto Canada). Cited September 18, 2015 from: http://www.mountsinai.on.ca/about_us/human-rights#sthash.SPO5o1fd.dpuf
57 South East LHIN [Internet]. South East Health Integrated Information Portal – SHIIP. (Belleville, Canada) Cited September 18, 2015 from: http://www.southeastlhin.on.ca/GoalsandAchievements/Technology/shiip.aspx