

Social Determinants of Health – What Doctors Can Do

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Foreword by Sir Michael Marmot

It has been an honour to serve as President of the British Medical Association. During my tenure I have been struck, but not surprised, by members' utter commitment to improving the health, not just of individual patients, but of society as a whole.

However, as I mentioned in my presidency acceptance speech, I was surprised at being approached to be president at all. My work has been focused on inequalities in health where I have emphasised the circumstances in which people are born, grow, live, work, and age rather than anything specifically to do with health care provision. I have emphasised not just the causes of health inequalities—behaviours, biological risk factors—but the causes of the causes. The causes of the causes reside in the social and economic arrangements of society: the social determinants of health. More than that though more recently my work has looked at what can be done to address these issues across the life-course.

As the year progressed I could see more and more how my tenure at the BMA and my work on the social determinants of health were a perfect fit. Time after time I was faced with examples where doctors were working tirelessly to increase fairness and social justice by acting on the social determinants of health to reduce health inequalities. Some of these fantastic examples are included in this report.

Just as completing my most recent work, *Fair Society, Healthy Lives*, was not the end of my journey to address health inequalities, neither does the end of my Presidency signal an end to what I think doctors can do to address the social determinants of health. I urge you to look at the population you serve, the communities in which you work, the people you employ and the teams in which you work to think about how you can use the evidence and examples in this paper and others to take ever more action to reduce health inequalities.

As I said at the close of my acceptance speech last year, dream with me of a fairer world, but let us take the pragmatic steps necessary to achieve it. I am delighted that the BMA has taken the opportunity to write this paper to take this issue further.

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Introduction

In June 2010 Sir Michael Marmot made his inaugural address to the British Medical Association's annual meeting. He presented his work on the social determinants of health, and received a standing ovation. Association members recognised his call to action to make a difference to reduce the numbers of lives blighted or wasted to preventable causes, the social determinants of health. Members recognised the important role they have and that, as a matter of social justice, welcomed the concept that measurements of population health and well-being is also a matter of social capital. The BMA committed to working with Sir Michael, beyond his presidency, to make a difference to the effect of these social determinants on the health of their patients.

It has long been recognised that there are significant differences in the life and health expectancy between populations within every country. In the United Kingdom the evidence comes from, amongst other sources, the Whitehall studiesⁱ and more recently Sir Michael's review of health inequalities in England, *Fair Society, Healthy Lives*ⁱⁱ. In essence these show that the differences in health and life expectancy follow the same gradient as wealth and social class. Recognising this, it becomes clear that while the poorest are seriously disadvantaged in health terms, so is everyone except the wealthiest, highest social class. By concentrating our efforts on helping the poorest we omit the help needed by the majority of the population.

Fair Society, Healthy Lives recommended action on the six following policy objectives, expanded versions of which can be found in Annex A

- A - Give every child the best start in life
- B - Enable all children, young people and adults to maximise their capabilities and have control over their lives
- C - Create fair employment and good work for all
- D - Ensure healthy standard of living for all
- E - Create and develop healthy and sustainable places and communities
- F - Strengthen the role and impact of ill health prevention

Doctors worldwide recognise the importance of health inequalities. Historically many considered the main reason to be lesser access to health care, and concentrated on improving access. They now know this is only part of the picture. Today they are

increasingly aware of the social gradient and its impact, as well as the impact this should have on the targeting of care and ill health prevention. They recognise that health inequalities are related to structural determinants such as age, income, education, occupation, gender, ethnicity and place of residence. Many feel unable to make effective changes to any of these for their patients and their communities and are often frustrated by their inability to make a difference. Such despondency is unnecessary as there is much that is already being done, and can be built on, by doctors and their teams. In England health and life expectancy are steadily improving, but the poorest, the lowest socio-economic groups, are improving the least and differences across the gradient are increasing; doctors are seeking ways to reduce the gradient.

The magnitude of the social gradient in health is not fixed; it varies between countries and, indeed, within regions in Britain. Such variation shows that, in principle, it should be possible to attain the level of the best. While gradients between countries are not the major focus of this report they do need attention. It is worthy of note that the social gradient exists in all countries, even the poorest, but the slope of the gradient and therefore the scale of inequalities is amenable to action.

This paper will set out, very briefly, some of the evidence and examples of actions that doctors can take to affect the social determinants of health and reduce the social gradient. We hope that doctors will use the examples in this report to effect change themselves.

We recognise that not every doctor has the opportunity to change the social determinants of health throughout the life course of individual patients and have thus included other ways in which they can make a difference, as doctors working as community leaders.

The BMA hopes that this report will help doctors identify actions that will make a positive difference to overall population health. These actions are not all medical or require medical knowledge, but are things that doctors can do as doctors or as community members and leaders. They can be sorted into a number of headings as set out in the grid below. Examples have been drawn, predominantly from health settings in the UK. These actions can be performed by doctors themselves, their teams or in partnership with other agencies of professions.

Doctors can help by intervening with individual **patients**, their families and contacts, using clinical tools including social prescribing and brief interventions. They can work within **communities**, for example, by commissioning measures including health promotion and ill-health prevention that will affect changes to the social determinants and are effective in the whole community including those who are traditionally hard to reach.

Doctors can use **evidence** and **influence** to have a positive impact on health inequalities. Doctors can use their position and their expertise to **advocate** for change to areas outside traditional medical areas, and to promote the generation of **research**, especially on the efficacy of prevention measures.

Doctors should ensure that the organisations to which they belong, including the BMA and the medical Royal Colleges, act to reduce the impact of social determinants of health.

In all these actions doctors can work **locally, regionally, nationally** and **internationally**.

For illustrative purposes, actions have been sorted under the areas highlighted in bold above in a grid on page 24. Examples of existing or suggested actions can be found as boxed texts throughout this paper and have been drawn, predominantly from health settings in the UK. An example of working with Royal Colleges follows.

The Royal College of Obstetrics and Gynaecology is now actively considering a life course approach to women's health, including consideration of the social determinants affecting their patients, and affecting the likely outcome of a pregnancy.

When doctors take actions to make an impact on the social determinants of health within their community they will, we hope, use the evidence and examples available in this report and in the source documents used in its production. We also hope that they will contact those who have provided examples of actions, and then in turn provide information on actions that have worked, to a web site that the BMA commits to maintaining to help further action.

What are the Social Determinants of Health?

The social determinants of health are those factors that impact upon health and well-being: the circumstances into which we are born, grow up, live, work and age.

These factors are not usually direct causes of illness but have been described as the causes of the causes of illness. Thus while smoking is the proximal cause of illnesses such as COPD, CHD and lung cancer, it is the social, including cultural, and environmental factors, that largely determines whether an individual is more or less likely to smoke, and if they do start to smoke whether they are likely to quit successfully.

These social determinants are not just the causes of the causes of ill health but also the causes of health inequalities. The health inequalities seen within England were set out in *Fair Society, Healthy Lives*. Information about health inequalities within and between countries, which should not be overlooked, are set out in the report of the WHO's Global Commissionⁱⁱⁱ. Unless otherwise specified, all charts in this paper are taken directly from *Fair Society, Healthy Lives*. Where charts are numbered, it reflects their sequence in the original report, not this paper.

The impact of differences in social determinants is a stark difference between the health and wellbeing of the best off members of society and that of the worst.

Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003

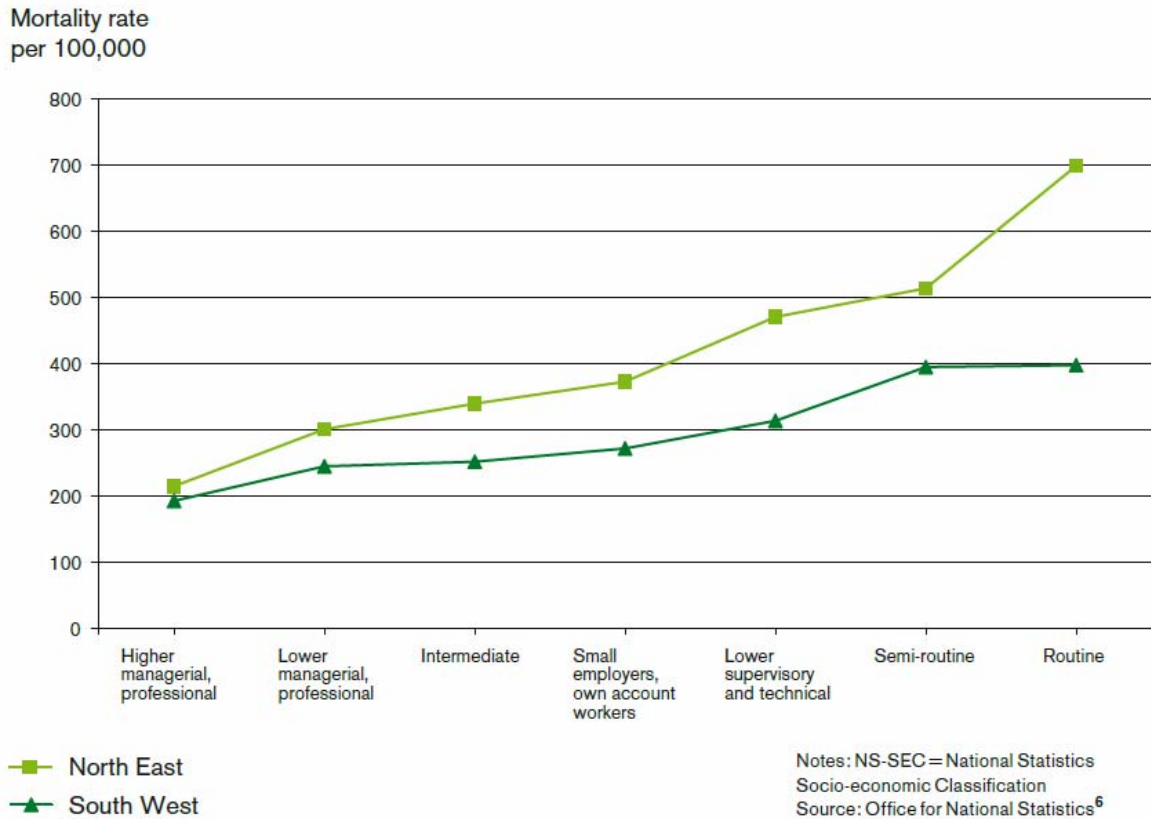


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Figure 1 shows the life expectancy (upper curve) and the disability-free life expectancy (lower curve) of people in different neighbourhoods in England. It is clear that the more deprived the neighbourhood the lower the life expectancy and the earlier a disability-free life ends. This matters. The gradient makes it imperative that actions are taken on the social determinants in all parts of society; concentrating all actions only on the poorest section will mean a failure to help a large proportion of the population.

This gradient, together with Figure 2, on life expectancy in SW and NE England also demonstrates that the effects of social determinants are not unalterable or invariably large.

Figure 2 Age standardised mortality rates by socioeconomic classification (NS-SEC) in the North East and South West regions, men aged 25–64, 2001–2003



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There are clearly differences in the social determinants in geographical regions. These produce mortality rate variations. If we understand and address these differences we will be able to reduce the pitch of the gradient. We, as doctors, can make a positive impact, and given the stakes involved, we must take action.

There is other evidence which similarly demonstrates that the way in which society is structured influences the way we lead our lives, and this contributes to the effect of the social gradient. Cities with high levels of poverty such as Liverpool with Manchester and Glasgow have significant levels of excess deaths in young men, with consequential major impacts on average life expectancy.

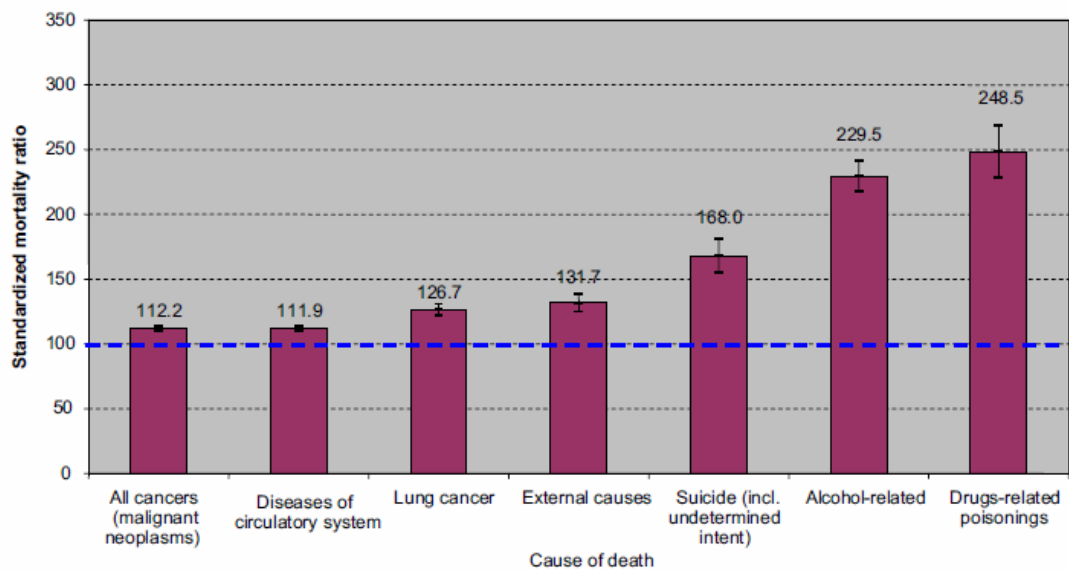
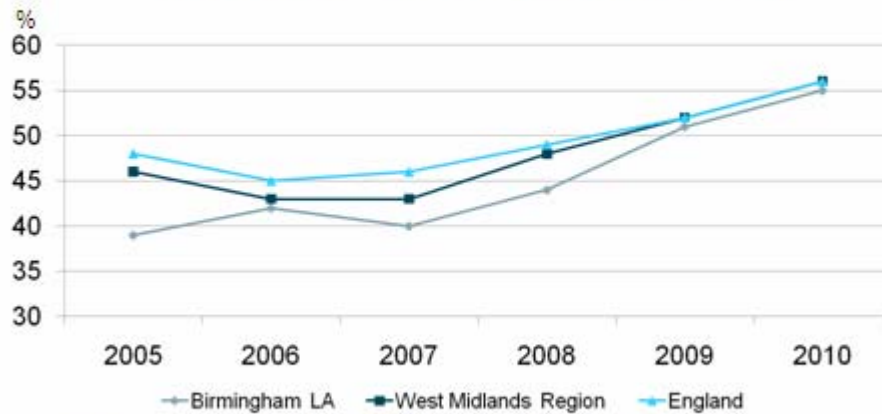


Figure 3 – Standardized mortality ratios 2003–2007 (indirectly standardized by 5-year age band, gender and income deprivation decile) for Glasgow relative to Liverpool and Manchester (combined), for seven causes/groups of causes.

As figure 3 above shows, the biggest differences (in this case with Liverpool and Manchester combined) can be attributed to psychosocial factors resulting in violence, drug use including alcohol, and suicide. Understanding and acting on the causes of the causes of excess deaths can improve the health of these populations.

To ensure that children get the best start in life and that all young people get the best possible opportunities, it is vital that their ability to benefit is assessed and they are helped to flourish. Assessments of the readiness of children for school demonstrates that just under 50% of children in England are not in fact ready; lack of readiness means they are less likely to thrive and learn, perhaps permanently setting back their learning. This is not an immovable or irremediable fact. Recent work in the city of Birmingham, demonstrated in the chart below has shown that levels of readiness in 5 year olds can be improved; they have improved from under 40% school readiness to approximately 50% in five years. This is faster than the region, or England as a whole, has improved.

Per cent 5 year olds achieving 'good development score',* Birmingham LA, West Midlands & England



*in personal, social and emotional development and communication, language and literacy

Source: Department for Education

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Work on childhood is especially important as action here will bear fruit throughout the lifecycle and, as Birmingham showed, that differences can be made in very short time periods.

Some of the work that can be done with children also demonstrates that health and well-being improvement can be very inexpensive. Evidence shows that when children are cuddled, talked to regularly and read to daily they thrive emotionally and improve their IQs. These are effectively cost free interventions; the major work for the state is considering how to improve parenting skills.

One example of the measurements made to assess the readiness of a child for school is set out below.

Emotionally, children usually in a positive mood, reasonably independent of adults, cope with rebuffs, have capacity to empathise, capacity for humour, have one or two peer friends and do not seem lonely.

Socially, enter a group successfully, express frustration and anger without escalation, take turns, show interest in others etc

Relationships, work with peers, accepted by others and may be invited to play and work, and named by others as friend

Motor coordination and physical health; adequately nourished and rested are key factors

Educational attainment is important as it affects gaining and keeping employment, the quality of the employment itself and the remuneration it attracts. Being unready for early school days sets children back, and they may never recover the lost opportunities.

Why should this be a concern of doctors?

Doctors see and treat patients from all parts of different communities. A major part of the work of doctors is to prevent ill health and to promote well-being. Prevention requires interventions that are essentially non-medical if the differences in health and well being are to be reduced.

Whilst there is a clear recognition by doctors of the medical consequences of social determinants of health, their interest in affecting those determinants and the impact they have on the health of individuals and communities is not medicalisation of the determinants. Instead it is a determination to use the evidence of medical harm resulting from socio-economic factors in order to lead to a reduction in preventable illness and an increase in general wellbeing.

The process of helping patients, recognising the signs and symptoms with which they present, adding to those the doctor's observations and making a diagnosis includes a great deal more than dealing with abnormal results from observations and tests of the physiology, anatomy and biochemistry of the patient. It also includes consideration of the patient as a person within the context of his/her family, community and workplace.

This is often called a holistic approach to medical practice. It has a natural home within general practice, as practitioners may live in the same communities as their patients, will know the communities in which their patients live, often treat the patient and his/her family, neighbours and workmates, and can clearly see the social, cultural and other environmental factors that affect the health of the population.

The Canadian Holistic Medical Association defines holistic medicine as follows^{viii}

Holistic medicine is a system of health care which fosters a cooperative relationship among all those involved, leading towards optimal attainment of the physical, mental, emotional, social and spiritual aspects of health. It emphasises the need to look at the whole person, including analysis of physical, nutritional, environmental, emotional, social, spiritual and lifestyle values. It encompasses all stated modalities of diagnosis and treatment including drugs and surgery if no safe alternative exists. Holistic

medicine focuses on education and responsibility for personal efforts to achieve balance and well-being.

Most western trained doctors would define holistic medicine differently, and are far less likely to include spiritual values as an element. The underlying connotation that drugs and surgery are last resort treatment would also be alien. But the fundamental message is that holistic medicine to the allopathic practitioner is a complex multi-dimensional construct. It is also one in which the social determinants can be seen to clearly interact with the health and well-being of the individual. Doctors would not define holistic medicine as above and would mainly find the following a closer match to their views as individuals.

Holistic medicine is a system of health care thinking which considers the patient as a person within their community, family and workplace. It includes consideration of factors that include the physical, emotional, environmental, social and lifestyle. It brings together concepts of well-being and wellness, including social functioning, ability to work, to form and sustain relationships, to learn, to enjoy social and other interactions as well as being free of avoidable illness, and to have unavoidable illnesses managed in ways which are acceptable to the individual.

Doctors in different specialities spend a considerable amount of time counselling patients, and supporting them to make changes to their lifestyles to embrace a healthier set of options. But in doing so doctors are aware that they are taking these actions late, when many of the environmental and socio-economic factors are already having an impact on patients. In addition, the doctors are aware that many of the factors that need to change are beyond the control of the individual patient and his/her family.

While individual patients can take action on issues such as diet, alcohol intake, exercise and smoking they can only do so in the context of the socio-economic factors that affect their decisions. In the last decade the concept of an obesogenic environment has gained currency. By this commentators are referring to the impact of factors such as culture, social norms, pricing and advertising of food, and the all pervasive presence of the motor car fostering a more sedentary lifestyle whilst making streets less safe places for children to play or anyone to walk or cycle, games desired by children have increasingly become more sedentary, such as computer games^{ix}

The rise in obesity has been too rapid to indicate that genetic factors are the primary cause. The epidemic must therefore reflect changes in eating patterns and levels of physical activity. We live in an environment that encourages and promotes high

energy intake, which can often undermine parental efforts to give their children a balanced diet and healthy lifestyle. In the literature this is sometimes referred to as an 'obesogenic' environment.

All of these factors make it more difficult for parents to successfully choose healthy dietary options for their children, who pester for the food they see advertised, and whose parents are afraid to let them use play and otherwise use the outdoors where they are more likely to engage in higher levels of physical activities.

Whatever doctors do, it is vital that they act in a cross-sectoral or intersectoral manner, working with others in areas outside the direct health systems they might traditionally, solely work in.

Practising Holistic Medicine

As stated above holistic medicine is practised when doctors consider the patient, his/her family, environment and workplace. This has a natural fit with taking action on the social determinants of health. Holistic action in this context includes helping the patient find satisfying, safe and reasonably rewarded work. It equally includes considering the impact of, for example, poor housing or social exclusion and seeking to provide help in those areas. The following section describes where doctors and healthcare services have been an integral part of addressing the social determinants of health, the boxed texts provide details of this activity.

Bromley-by-Bow Centre is located in one of the poorest and most deprived areas of the UK. Adult illiteracy, poor language skills, overcrowded and poor quality social housing are all above national rates. Some of the activities at the centre are listed below.

The Bromley-by-Bow Centre aims to serve the local community by providing a wide range of services and activities, which are integrated and co-operative in nature. They host the local GP surgery, a variety of social enterprises, a children's centre, artists' studios, a healthy living centre, and provide adult education courses, care and health services for vulnerable adults, outreach programmes and a range of advice services.

This approach enables GPs to refer patients to services that help to tackle the social determinants of ill health, including welfare, employment, housing and debt advice services. The centre has received international recognition for its social entrepreneurial approach to community regeneration and effective delivery of integrated services.

At the Royal United Hospital^x in Bath there was a recognition that profoundly deaf patients had a different experience of health care to others, and in particular had problems in becoming partners in their care because of the problems experienced in communicating with health care professionals.

The Royal United Hospital in Bath recognised that profoundly deaf British Sign Language users experienced worse health care and therefore health outcomes because of the barriers created by their deafness and the lack of understanding of communicating with a profoundly deaf person by the NHS.

Deaf Awareness training was provided to 250 hospital staff and the hospital also implemented and funded use of an on-line interpreter service, SignTranslate, using computers-on-wheels which are based in the Emergency Department but can be moved to wherever a deaf patient needs access to the interpreter service.

In Glasgow ^{xi xii} several overlapping projects address the needs of the homeless. Two of these projects are mentioned below.

The Homeless Families Healthcare Team (HFHCT) is part of a health service based in the centre of Glasgow. It provides health care to any homeless family living in temporary accommodation within Glasgow and includes a Homeless Addiction Team and Community Mental Health teams.

Many homeless families are fleeing violence and social unrest, and often have chaotic and numerous needs requiring a flexible, quick and outreach type of service. Many have experienced prior poor engagement with services and building relationships and trust is fundamental to the service. The vast majority have child protection and child welfare concerns or other vulnerabilities.

The HFHCT has a strong working relationship with partner agencies such as housing, social work and the voluntary sector. It receives referrals from housing and other agencies.

Homeless Health Services is based in the centre of Glasgow and works with an extended primary care team. The GP team member visits homeless units or hostels every day. Many of the hostel residents are housebound because of their addictions. The team use an assertive outreach twice weekly for open access, helping individuals register with GPs, get the health and social needs addressed and a referral for more suitable accommodation.

The team do not give up on the reluctant patients and work with other agencies to get the patient to accept help, such as alcohol detoxification, followed by rehousing.

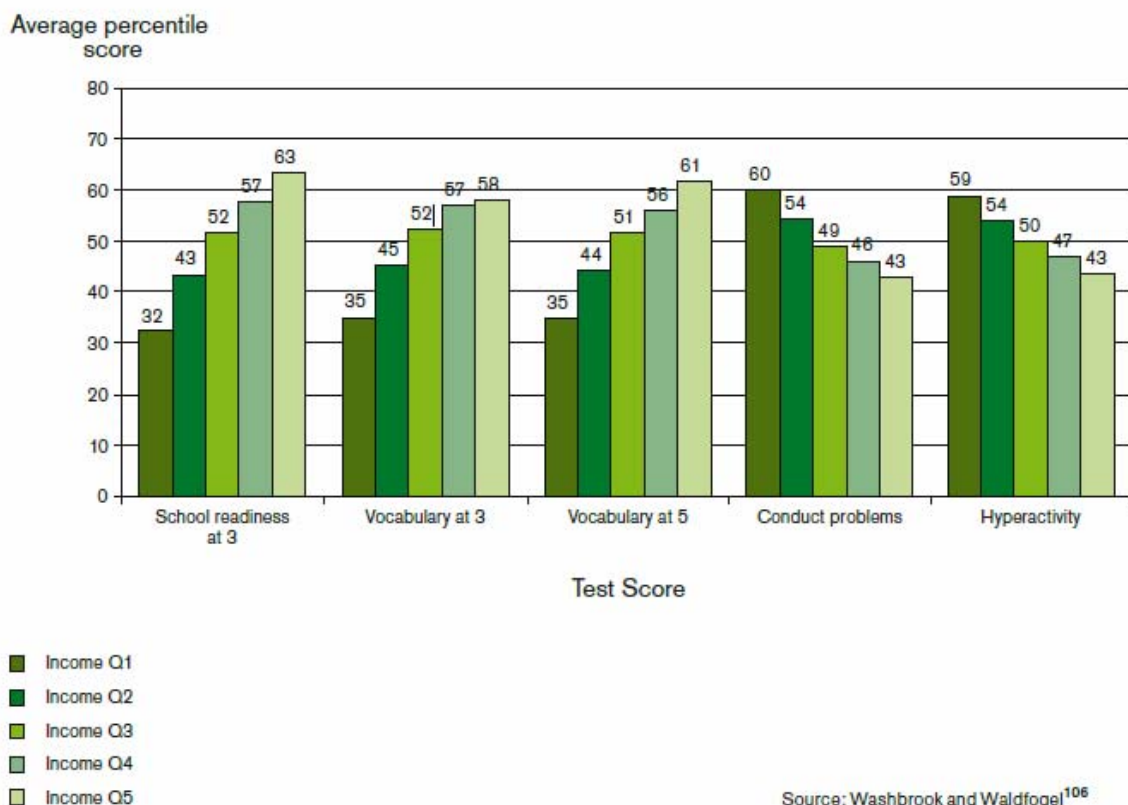
The interaction of social factors

Health and wellbeing are, as described above, affected positively and negatively by social circumstances in which people are born, grow, live, work, and age. These circumstances are linked to wealth and income but not completely. Low income does not inevitably mean adverse social determinants of health.

The factors also interact with each other. Inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills predetermine the likelihood of a child being able to take maximum benefit from educational opportunities. Poverty itself is also often associated with worse cognitive development. Figure 2.22 highlights this by demonstrating school readiness by parental income group. Some elements of this social gradient can be attributed to the quality of parenting, although there are also other proximal and distal factors. This explains in large part the reason for the first priority objective of the Marmot review.

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Figure 2.22 Indicators of school readiness by parental income group, 2008



Source: Washbrook and Waldfogel¹⁰⁶

Unemployment and Poverty

Unemployment, poverty and education are strongly linked. It is educational outcome and success that largely predetermines both the likelihood of having a job, and the nature of the jobs that may be available to an individual.

Poor educational achievement is almost always linked to poorly paid and often insecure work. These are also frequently linked to unemployment and both lead to low income, poor housing and fewer opportunities to make decisions for oneself about the way one would want themselves and their families to live.

To reduce the numbers of people living in poverty doctors must seek to work more closely with colleagues in education. Traditionally doctors have had relatively few contacts with the education sector, other than discussions about the nature of health education within different key learning stages. The need to address poor preparation for school challenges doctors to make closer links with partner organisations. Doctors and their teams have access to the population at key points of development which offers a unique opportunity to positively effect this issue.

Following the lifecourse approach education effects employment and there is a clear need for fair, secure and, indeed, fulfilling, employment for all.

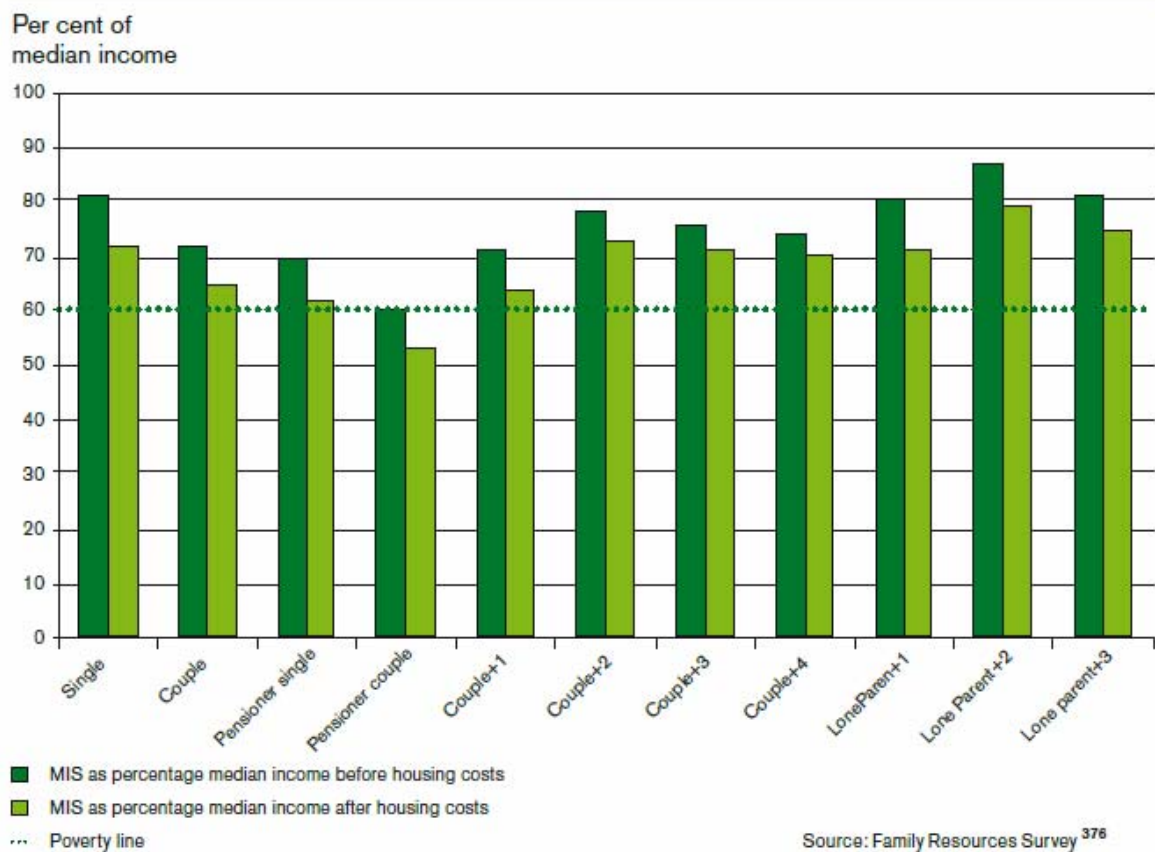
In addition to fair, secure and fulfilling employment being directly beneficial to health there are close links between income levels and the ability to live healthily. The income level needed for survival does not encourage or enable a healthy life and lifestyle and minimum income standards are currently contributing to the social gradient.

Figure 4.5 shows median income levels for different groups within society before and after housing costs. The dotted line shows the poverty line; clearly only pensioner couples have an adequate income to live a healthy life at and below the current poverty line. While pensioners are the worst off, they are currently less likely to have excessive housing costs, and thus are, relatively less disadvantaged. This has clear implications for the introduction of a real poverty line that guarantees an income sufficient to live a healthy life.

It follows that if unemployment and poverty have negative effects on health, that any broader social effects that reduce the likelihood of people gaining or keeping employment with a reasonable level of income, will be likely to increase the levels of damage to health and well-being. Given the extraordinary nature of the current global recession, and the impact already seen on employment, it is likely that health and well-being will be negatively affected.

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Figure 4.5 Minimum Income Standard as a percentage of median income, April 2008³⁷⁵



Of particular concern is that the current recession in the UK is appearing to disproportionately affect young adults. If young people are not in fulltime education, employment or training for a period, their likelihood of future employment drops. The recessions of the 1970's led to a generation in some sink estates of those who never attained regular employment throughout their adult lives; the current recession could produce another such group. Those in this group are particularly unreceptive to health

promotion and ill-health prevention messages. If you live the whole of your life in poverty, boredom and frustration you are unlikely to be willing to change your lifestyle to prolong that life; indeed you may not welcome the idea of a longer life.

The Charity “Stepforward” works in Tower Hamlets, one of the most deprived areas in England and works hard to support its local young people.

Within this vibrant, multicultural community Stepforward aims to attract and support young people who are facing poverty and disadvantage and enable them to thrive, develop, grow and reach their full potential in life. Amongst other services it offers a young people’s sexual health service and local specialist GUM service, a weekly drop in contraceptive service and sexual health services. Sex and relationship education sessions are run jointly during school holidays. User feedback led to the development of a weekly service for LGBT young people. They also provide counselling and family support services, with self referral. The mental health issues group offer support for, amongst other things, drug addiction and to young people affected by rape, sexual abuse and self harm behaviour. Learning and feedback is extensive and includes feedback to other services and networks.

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The work of Stepforward helps to ensure that young people are helped to attain the life skills that will better enable them to obtain and keep fair, secure and fulfilling employment, as well as the general health and wellbeing to enable them to work.

Housing

Housing has a major impact on health and wellbeing and is, itself, strongly affected by social class. At the most basic level the quality of housing is strongly related to income. Over-crowding, lack of privacy, lack of safe play areas, damp and inadequate food storage and preparation areas all have specific impacts on health.

The Marmot Review Team have just completed a report for Friends of the Earth on the issue of the health impacts of cold homes and fuel poverty^{xvi}. Currently some 4.5 million households live in fuel poverty. This has increased not least because of the sharp rise in fuel prices which is ongoing. The UK also has low levels of good household insulation, including double glazing and cavity wall insulation. This lack of insulation makes it difficult to keep homes at the recommended temperatures in winter and summer, and attempts to reach acceptable temperatures are expensive.

The Health Impacts of Cold Homes and Fuel Poverty report

Main findings of direct impacts:

- Countries which have more energy efficient housing have lower excess winter deaths (EWDs).
- EWDs are almost three times higher in the coldest quarter of housing than in the warmest quarter.
- Around 40% of EWDs are attributable to cardiovascular diseases.
- Around 33% of EWDs are attributable to respiratory diseases.
- Mental health is negatively affected by fuel poverty and cold housing for any age group.
- Cold housing increases the level of minor illnesses such as colds and flu and exacerbates existing conditions such as arthritis and rheumatism.

Main findings of indirect impacts:

- Cold housing negatively affects children's educational attainment, emotional well-being and resilience.
- Fuel poverty negatively affects dietary opportunities and choices.
- Cold housing negatively affects dexterity and increases the risk of accidents and injuries in the home.
- Investing in the energy efficiency of housing can help stimulate the labour market and economy, as well as creating opportunities for skilling up the construction workforce.

Housing and Fuel Poverty Forum, funded by DEFRA, developed the 'Central Clearing House' model. Their research concluded that a model of local area partnerships that linked health, housing and fuel poverty services was the most effective approach for directing services to the vulnerable. The CCH model identified the key systems and processes necessary to access the vulnerable fuel poor, identify high risk groups, streamline referral and delivery systems and implement monitoring and evaluation processes. The CCH model was piloted in Manchester, with the implementation of the Affordable Warmth Access Referral Mechanism (AWARM). Funded by the Department of Health, a pilot was a partnership with Salford City Council and Primary Care Trust. Greater Manchester invested approximately £100,000 each year into AWARM. Since April 2008 AWARM activity resulted in over £600,000 of investment in new and replacement central heating systems and insulation. During the first year of the project over 1000 referrals were made by frontline professionals from social services, voluntary, local government, housing and health sectors. In 12 months the programme trained 1,359 professionals, a third in health, with the remainder in social services, voluntary/community services, local government and housing.

The Climate and Health Council is an initiative formed by health professionals to inform and facilitate action to address one of the greatest causes of global health inequalities – climate change

The CAHC takes the health voice to climate negotiations. The poorest people in the world are not only those responsible for the smallest contribution to the emissions that cause climate change but they also suffer from the greatest health burden. Climate change is causing health threats, from food scarcity to the spread of infectious disease and disease vectors to flooding and other adverse weather events.

The CAHC is able to highlight the potential health equity gains of action to address climate change. There is great potential to address health inequities in all countries through advising patients and advocating for measures to facilitate lifestyles and behaviours that are healthier, cheaper and more sustainable, such as using active transport, insulating homes and eating less meat.

Ill health prevention strategies

Doctors are comfortable with their role in ill health prevention. For many active clinicians this is about secondary prevention; helping their patients to reduce the impact of disease upon them and upon their families. Equally clinicians work on primary prevention with individuals, helping to encourage them to improve their diet, moderate their alcohol intake, take more exercise, stop smoking and prevent communicable diseases.

Doctors are far less comfortable intervening on the factors that are the causes of the causes; in particular some may see this as outside their professional remit and may resist involvement. There are, however, a great number who have found ways to do so, and the BMA welcome this and encourage others to do the same.

Others are involved in community level actions to help change the circumstances in which they and their neighbours find themselves living.

In addition doctors individually and through their representative organisations are involved in lobbying for changes in the environment to help individuals improve their health, or to remove some of the factors which render making the healthy choices difficult.

The BMA has campaigned on tobacco control for more than three decades. The basic principle is to reduce the external pressures that encourage young people to start smoking, to help smokers quit, and to protect non smokers from second hand smoke. We have sought to persuade the UK government, and latterly the governments of the four nations, to legislate and regulate tobacco in ways which will support these ends. We have supported the development of smoking cessation services, of research that aids in the design of practical policies and of an integrated and holistic approach to tobacco control.

The BMA also worked internationally, not least through the establishment of a Tobacco Control Resource Centre, with free sharing of the resources and material it produced, with colleagues throughout Europe.

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The NHS as employer

The health care sector is a major employer in every country. In the UK the NHS, via its various sub-organisations, including foundation trusts and GP practices, employs around 1.2 million people. This makes it, by far, the largest employer in the UK. This gives the NHS and doctors themselves, as employers and managers a unique opportunity to impact upon the lives of a significant proportion of the UK population and their families, and to set a good example.

The poorest health is felt by the poorest members of our population, but there is a gradient across the whole population. The NHS has employees paid little more than minimum wage (often employed via agencies and providing essential services such as catering and cleaning). Doctors are well-placed, both in terms of their influence within their organisations and as employers themselves to seek to ensure that the most vulnerable in the NHS workforce receive a living wage. Other staff may be better paid, including the health care professionals, but they too will be affected by the gradient.

The NHS should provide better facilities and opportunities for all its staff to enjoy the best health and wellbeing. This must include better food, access to exercise opportunities and the provision of health promotion/ill health prevention materials.

Staff in the NHS can find themselves in stressful situations on a regular basis. The NHS must offer psychosocial support to those facing such stresses.

For its poorest paid staff, and especially those with limited skills, the NHS could do far more to help them improve their education and skills levels, so they can achieve better levels of personal development.

The NHS staff come from every ethnicity, and includes members of a wide variety of cultural and social groups. This gives them an opportunity to have a wide impact. These staff could also be motivated to become community activists. This would give a still wider impact than the relatively direct one on the NHS staff and their relatives.

Currently the NHS is not a perfect employer, and too often pays no more than lip service to the concept of being a healthy employer. It could do far more to offer help and support to its staff in improving their own life styles, and promoting health and wellbeing for themselves and their families. It could offer such support, and encourage all its staff to become engaged in community activity to improve the health of others, including some traditionally considered hard to reach.

This would produce an opportunity for focussed health promotion into many sectors of the population, including some traditionally considered hard to reach, and could have a measurable impact, especially if the staff engaged in community outreach activities.

Once the NHS has put its own house in order in terms of offering fair employment, help and support to its own staff it should work with other employers to ensure they do the same. This would leave those without work with less support; community outreach programmes supported both by the NHS and by other industries would help to reach this group.

Barts and the London NHS Trust have commissioned a strategy to be put in place to improve the health and wellbeing of staff, leading on from the publication of the Boorman Review of NHS Health and Wellbeing.

The Barts and the London Trust employs approximately 8000 people, some of whom are from some of the most deprived local authorities in England (Tower Hamlets and Hackney). The strategy focuses on improving the quality of work at the Trust, engaging staff and responding to their needs, increasing the scope of and improving access to preventive occupational health services, and supporting staff with their wider needs. They have determined a number of specific recommendations, and set out an organisational structure to deliver the strategy.

What can doctors do?

It is clear that many of the six policy areas outlined in *Fair Society, Healthy Lives* require predominantly non-medical action. Many of them will also benefit from doctors intervention, especially in terms of taking direct action and repeating evidence on the effect of social determinants on health at times when decisions are being made. From the evidence cited in the report and this paper it is clear that actions of different sorts, by doctors and their teams, working at different levels and with relevant partners can have an impact upon the health and life expectancy of individuals and communities.

The grid below sets out the areas into which we believe the actions can be grouped. As stated above doctors can act when treating patients, as community leaders, as advocates and as researchers. Doctors can act within their workplace, their locality or regionally, nationally or internationally.

The examples set out above fit into different elements of the grid. Some include actions at different levels and across levels. The Climate and Health Council (CAHC), for example, involves doctors working as advocates at local, regional, national and international level. It also involves preparing material for individual doctors to use with their patients; telling patients who express concern for the environment what they can do to reduce their own impact, and how this will make them healthier. The CAHC is also seeking to encourage research on the health impacts of environmental change, fitting into the research sections of the grid.

This grid will be populated on the BMA website with examples of actions by doctors and other health care workers.

	Treating patients	Community Leadership	Advocacy	Research
Local	A	B	C	D
Regional	E	F	G	H
National	I	J	K	L
International	M	N	O	P

Conclusions

The BMA encourages doctors to act not only as clinicians but also as community leaders.

Doctors should work to raise the understanding of the impact of social determinants on health, and to reduce that impact by tailored interventions. We will keep examples of effective actions on our website, and encourage the World Medical Association to garner international examples, to aid doctors seeking ways to make a difference.

Centrally the BMA will continue to press the four UK governments to assess the health impact of all government policies and interventions with a special emphasis on the impact on the social determinants of health.

We will continue to press the General Medical Council and the medical Royal Colleges to include an understanding of the social determinants in examination syllabi.

Fair Society, Health Lives

Policy Objectives

Policy Objective A: Give every child the best start in life

- 1 Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic and social skills.
- 2 Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
- 3 Build the resilience and well-being of young children across the social gradient.

Policy Objective B: Enable all children, young people and adults to maximise their capabilities and have control over their lives

- 1 Reduce the social gradient in skills and qualifications
- 2 Ensure that schools, families and communities work in partnership to reduce the gradient in health, well-being and resilience of children and young people.
- 3 Improve the access and use of quality life-long learning across the social gradient.

Policy Objective C: Create fair employment and good work for all

- 1 Improve access to good jobs and reduce long-term unemployment across the social gradient.
- 2 Make it easier for people who are disadvantaged in the labour market to obtain and keep work.
- 3 Improve quality of jobs across the social gradient.

Policy Objective D: Ensure healthy standard of living for all

- 1 Establish a minimum income for healthy living for people of all ages.
- 2 Reduce the social gradient in the standard of living through progressive taxation and other fiscal policies.
- 3 Reduce the cliff edges faced by people moving between benefits and work.

Policy Objective E: Create and develop healthy and sustainable places and communities

- 1 Develop common policies to reduce the scale and impact of climate change and health inequalities.
- 2 Improve community capital and reduce social isolation across the social gradient.

Policy Objective F: Strengthen the role and impact of ill health prevention

- 1 Prioritise prevention and early detection of those conditions most strongly related to health inequalities.
- 2 Increase availability of long-term and sustainable funding in ill health prevention areas across the social gradient.

ⁱ The Whitehall Studies. Available online at: www.ucl.ac.uk/whitehallIII/

ⁱⁱ Marmot M, Allen J, Goldblatt P *et al* (2010) *Fair Society, healthy lives: strategic review of health inequalities in England post 2010*. London: Marmot Review Team. .

ⁱⁱⁱ World Health Organization Commission on Social Determinants of Health (2008) *Closing the gap in a generation: health equity through action on the social determinants of health*. Geneva: World Health Organisation.

^{iv} Marmot M, Allen J, Goldblatt P *et al* (2010, p.17) *Fair Society, healthy lives: strategic review of health inequalities in England post 2010*. London: Marmot Review Team.

^v Marmot M, Allen J, Goldblatt P *et al* (2010, p.17) *Fair Society, healthy lives: strategic review of health inequalities in England post 2010*. London: Marmot Review Team.

^{vi} Walsh D, Bendel N, Jones R *et al* (2010) It's not 'just deprivation': why do equally deprived UK cities experience different health outcomes? *Public Health* **124**: 487-95 (p.492, figure 3).

^{vii} Source: Department of Education <http://www.education.gov.uk/rsgateway/DB/SFR/index.shtml>, Prepared by The Marmot Review Team for BMA "Health inequalities: Role of the medical profession" Conference (10 February 2011)

^{viii} 'What is holistic medicine?' Canadian Holistic Medical Association. Accessed online: www.holisticmed.com/whatis.html 26 September 2011.

^{ix} British Medical Association (2005) *Preventing childhood obesity*. London: British Medical Association.

^x Personal correspondence from Dr Andrew Alexander, respiratory unit, Royal United Hospital, Bath.

^{xi} Personal correspondence from Dr Kerry Milligan, Homeless Health Services, Hunter Street, Glasgow.

^{xii} Personal correspondence from Dr Ruth M Spencer, Homeless Health and Resources Services, Hunter Street, Glasgow.

^{xiii} Marmot M, Allen J, Goldblatt P *et al* (2010, p.64) *Fair Society, healthy lives: strategic review of health inequalities in England post 2010*. London: Marmot Review Team.

^{xiv} Marmot M, Allen J, Goldblatt P *et al* (2010, p.120) *Fair Society, healthy lives: strategic review of health inequalities in England post 2010*. London: Marmot Review Team.

^{xv} Personal correspondence with Dr Tim Crocker-Buque.

^{xvi} Marmot Review Team (2011) *The health impacts of cold homes and fuel poverty*. London: Friends of the Earth & the Marmot review Team.

^{xvii} Personal correspondence from Dr Sarah Walpole and Dr Robin Stott, Climate and Health Council.