UCL Institute of Health Equity

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HEALTH PROFESSIONALS COMMIT TO UNPRECEDENTED ACTION TO REDUCE HEALTH INEQUALITIES

Health professionals from a wide range of royal colleges and professional organisations have joined forces to improve patients' health and reduce health inequalities by considering patients' social and economic circumstances as well as their medical history. This unprecedented commitment to act by more than 20 health organisations could save the NHS well in excess of £5.5 billion every year (1).

The action, which includes making 'social' referrals more important, is detailed in a landmark report *'Working for Health Equity: The Role of Health Professionals'. The Report* will be launched at a global conference at BMA House in London today, Monday 18th March.

There are numerous examples up and down the country where health professionals are already taking action to tackle the social and economic causes of ill health (see abridged list in table below and full list in separate documents). The country-wide action is being documented, assessed and driven by the Institute of Health Equity, based at University College London, and led by the global expert on reducing health inequalities, Professor Sir Michael Marmot:

'We have the most equitable health service in the world. Of that we should be extremely proud. But it is inequalities in social and living conditions that are driving inequalities in health. Even among health professionals who have this insight, there has been a sense that it is for others to respond, there is not much we can do. But the response we have had from the many organisations and individuals that have helped us with this report is not only SHOULD we be taking action but there is ample evidence that we CAN.

The report and statements from health professional organisations make clear that action on the social determinants of health should be a core part of health professionals' business – it improves clinical outcomes, and saves money and time in the longer term. In partnership with others in the wider society, health professionals can help reduce socially unjust and avoidable inequalities to ensure everyone has the same opportunity to live as healthy a life as the very best off.'

The Marmot Review of health inequalities 'Fair Society, Healthy Lives' highlighted that inequality in illness, in addition to health care costs, accounts for approximately £31-33 billion annually in productivity losses and lost taxes, and in higher welfare payments in the range of £20-32 billion (2). The government-commissioned review of health inequalities stated health could only be improved by considering an individual's social circumstances and taking action on the 'causes of the causes' or the 'social determinants' of health.

Health inequalities feature across all of society, apart from those at the very top (around 1% of the population) – there is a social ladder, or gradient, for ill health and life expectancy, with the most deprived suffering the most and everyone below the very top experiencing worse outcomes than the best-off (3).

The gap in life expectancy across England between the best and worst-off is seven years (4) (this figure is substantially more within local areas, for example, 17 years in some areas of London (5) and 28 years in Glasgow (6)). Disability free life expectancy (how long someone

can expect to live free of life limiting illness) has an even steeper gradient and wider gap – there's a 17-year difference between the best and worst off (7).

Every minute 463 people are seen by one of the 1.4 million people who work for the NHS – that's eight people every second (8). They see and understand how patients' socio-economic circumstances affect their health. Health professionals are highly trusted by the general public and therefore have a unique opportunity to support and improve their patients' social and economic situations. The NHS is therefore well placed to coordinate action on the social determinants of health to reduce health inequalities (9).

The Coalition Government has placed a number of legal duties on health professionals to reduce health inequalities through the Health and Social Care Act (see box in editor's notes). The Report's six main recommendations are designed to help satisfy these duties:

Summary of *'Working for Health Equity'* Recommendations (in full in editor's notes below and attached separate documents):

1. **Workforce education and training** – mandatory social determinants of health (SDH) training within under and post graduate education as well as continued professional development (CPD). Education should include practice-based skills such as taking a social history and referring to non-medical services, students placement within non-health organisations and widening access to health care careers to all socio-economic groups.
2. **Working with individuals and communities** – prioritise social history alongside medical information to understand root causes of ill health and provide best care including referral to range of medical, social services and other agencies.
3. **NHS organisations** – ensure good quality work for all employees, including minimum income for healthy living (MIHL), occupational health and other services, and use purchasing power to assess health equity rigorously within contracted services.
4. **Working in partnership** – make tackling health inequalities a priority within the health sector and with external bodies by supporting joint commissioning, data-sharing and delivery and measuring progress.
5. **Working as advocates** – individual health professionals, students and health care organisations should act as advocates for patients, their families and local communities to improve the social and economic conditions and reduce inequalities; and advocate for change within the health workforce and to national policy.
6. **The health system** – maximise the opportunities offered by legal duties under the Health and Social Care Act 2012 and through the Public Health Outcomes Framework to act on the social determinants of health to reduce inequalities.

Twenty-one health organisations have drawn up their own statements for and commitments to action (see editors notes below for list). There already exists many **case study examples** of how the agreed six recommendations work in practice, including:

Bromley by Bow Centre – a gold standard example of social referrals being considered as important as medical prescriptions in tackling ill health where a range of services designed to tackle social and economic inequalities in the local area are provided by an integrated health care approach and referring patients to services including employment programmes, benefits and housing advice and educational opportunities – many other areas have adopted some of these ideas and adapted to their own local context (10).
The **Workplace Wellbeing Charter** is a framework being piloted in six London boroughs that supports businesses to self-assess their current activities and work environment against recommended standards to improve health at work. Assessment standards cover leadership, health and safety, attendance management, physical activity, healthy eating, mental health and wellbeing, smoking

cessation and alcohol and substance misuse (11)
Socially isolated individuals are 2-5 times more likely to die prematurely than those with strong social ties. **A hospital aftercare project funded by Age England** provided short-term advocacy, information and support to facilitate older service users' re-engagement in social networks following discharge from hospital. Service user feedback indicated that friendship, recreational and family groups, health care treatment and locality-based organisations and contacts were accessed, contributing to restoring and sustaining health and psychological wellbeing (12)
GLOW referral in Blackburn is a systematic assessment of housing and health needs during patient contact with health and social care professionals to prevent winter hospital admissions by improving the quality of people's homes (13)
Obesity Atlas to target services for early years in Cumbria – public health specialist dietitian collates data from the National Child Measurement Programme (NCMP) on dental health, breastfeeding, school meal uptake, healthy schools and physical activity to map childhood obesity levels in the locality. Each local district council then commissioned a specialist team to deliver training to all childcare providers in the county to improve nutritional knowledge in early years workforce and facilitate development of food policies in child care centres (14).
Stoke Speaks Out – research indicated 70% of children entering nursery had some form of language delay in Stoke-on-Trent (10-12% of children nationally). A five-tier training framework for all practitioners working with children and their families was developed to resolve the underlying causes. In six years the percentage of children entering nursery with language delay fell to just under 40% (15)
East Midlands Ambulance Service developed a programme that mapped ambulance responses by pick-up postcode. This was compared to deprivation level, which showed a clear socio-economic gradient (highest deprivation more than four times higher than wealthier areas). Working with Government Office East Midlands and East Midlands Public Health Observatory to reduce crime and disorder by tackling alcohol misuse (16).
Oral health in Tameside – a training resource was developed by a group of nurses for Greater Manchester's oral health team to engage with reception/year 1 children and their families (210-212) to integrate oral health into other care pathways. The oral health fun pack was delivered alongside other screening initiatives, thereby providing joint working initiatives between the school nursing service and the oral health team (17, 18, 19).
Barts and the London NHS Trust – Barts Health has established a public health function under its medical director to address the issue of health inequalities in East London. The public health approach has three themes: making every clinical contact count for patient health; staff health and wellbeing, and; community employment and procurement (20)

The Institute of Health Equity will lead a programme of work to disseminate the messages in this report, encourage their practical application across the health professional workforce, and to extend the evidence base. The 'Working for Health Equity' programme is supported by the British Medical Association, the Academy of Medical Royal Colleges, and a range of Royal Colleges and other organisations, all of whom have made commitments to action in order to take forward this agenda.

Director of BMA Professional Activities, Dr Vivienne Nathanson, said:

'The BMA has a long history of working to combat health inequalities. As our President in 2010 Professor Sir Michael Marmot helped us raise awareness among our members about the social determinants of health.

Many BMA members are already using their position as doctors not just to focus on disease but also the wider social issues that contribute to their patients' ill-health. We need to spread the word about good practice so that doctors can learn from their colleagues who are successfully providing an integrated approach to healthcare, for example, by referring

patients to employment, debt or benefits advice centres when these factors go hand in hand with their health problems.

The BMA is committed to making a difference and helping more of our members understand how they can contribute to reducing health inequalities.'

Next month local authorities across England will take over responsibility for the prevention of ill health (public health) from the NHS, as recommended by 'Fair Society, Healthy Lives' (18). '*Working for Health Equity: The Role of Health Professionals'* only focuses on the role *health* practitioners can play in reducing health inequalities, it is not aimed at *public* health professionals. The Institute of Health Equity is in the process of drawing up a separate document geared towards public health professionals.

Editor's Notes

Journalists are invited to attend the Global Conference where the Report '*Working for Health Equity: The Role of Health Professionals'* will be launched at BMA House, London, Monday 18th March 2013 1400-1600. Please contact Felicity Porritt to reserve place.

Background

Evidence presented in the Marmot Review 'Fair Society, Healthy Lives' 2010 and many other evidence-based analyses of health inequalities show a clear social gradient in health outcomes, which closely relates to social and economic factors: the conditions of daily life. Most of the factors influencing health lie outside the immediate reach and traditional remit of the health services: early-hears experiences, education, working life, income and living and environmental conditions. The recommendations of the Marmot Review were therefore mainly focused on actions, which could be taken outside the health care system to reduce health inequalities http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review .

'*Working for Health Equity: The Role of Health Professionals'* focuses on actions and strategies that can be developed within the health care system, and particularly the health workforce, where there is great scope. The report demonstrates that there is much the health system can do to influence the wider social and economic factors that account for a large proportion of health inequality, beyond ensuring equity of access and treatment.
The report does *not* include the role of *public* health professionals. This is because the actions proposed are not just a public health issue for public health professionals – they concern all medical staff. The IHE will be publishing a separate report specifically around the work of public health professionals. Also, despite their undeniably important role, the report also does not address the huge contributions made by the wider health workforce – those working in arenas outside health, but whose work dramatically affects people's health – town planners, employers, the early-years workforce, teachers, trainers, transport managers etc. Existing IHE activities cover many of these sectors and it is envisaged future work will develop in these areas.

In April 2013, many public health functions will move to Local Authorities. However, this does not reduce the need for action to reduce inequalities within the NHS by medical and healthcare professionals. It also creates important opportunities for partnership work and integration between the NHS and local government.

Action by Health Professionals

'*Working for Health Equity: The Role of Health Professionals'* launches a new programme of activities to tackle health inequaliites through action by health professionals on the social determinants of health (SDH). It draws on many examples of inspiring and excellent practice, which demonstrates what can be done. The report describes areas where greater action is necessary and possible and

makes some practical suggestions about how to take forward action on the SDH. The report contains recommendations and analysis in six core areas:

1. Workforce Education & Training

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

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

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

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

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

2. Working with Individuals & Communities

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

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

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

3. NHS Organisations

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

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

4. Working in Partnership

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

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

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

5. Workforce as advocates

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

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

For changes to the health profession: Individual health professionals, students, health care

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

6. The Health System – challenges and opportunities

Legal duties in the **Health and Social Care Act 2012** act as an important lever in encouraging action**.** These duties apply to the **Secretary of State for Health, Monitor, NHS Foundation Trusts**, **NHS Commissioning Board** and **Clinical Commissioning Groups (CCGs).** The duties refer to the need to reduce inequalities of access and health outcomes of patients and integrate services.
Outcomes frameworks such as **Quality Outcomes Framework (QOF)** and the **Public Health Outcomes Framework (PHOF)** provide both opportunities and challenges.

Statements and Commitments for Action

'*Working for Health Equity: The Role of Health Professionals'* contains nineteen Statements for Action about actions health professionals can take to tackle the SDH through their practitioners role. These have been written by Royal Colleges and other representative organisations, and set out, for each profession, a rationale for action, practical guidance on what activities to engage in, and relevant case studies and further reading.

The Report also sets out a series of commitments made specifically for this report and future work programmes from twenty relevant organisations. These cover each of the six priority areas in the Report, and display an impressive ambition to take forward action on the SDH. The organisations that have contributed to a statement and/or commitments are as follows:

<u>Statements for Action</u>

The report provides statements for action developed by health professional organisations, which seek to give practical accessible tools for particular professionals to develop and use in their roles. These cover the following professions:

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

Commitments to Action

The following organisations have also made specific commitments to action that will form the basis of the 'Working for Health Equity' programme of work:

—Institute of Health Equity (IHE)
—Academy of Medical Royal Colleges (AoMRC)
—Royal College of Midwives (RCM)
—Royal College of Physicians (RCP)
—Barts and the London NHS Trust (Barts Trust)
—British Dietetic Association (BDA)
—Royal College of Paediatrics and Child Health (RCPCH)
—Royal College of General Practitioners (RCGP)
—Royal College of Speech and Language Therapists (RCSLT)
—Chartered Society of Physiotherapy (CSP)
—Dental Schools Council (DSC)
—Royal College of Obstetrics and Gynaecology (RCOG)
—British Association of Occupational Therapists and College of Occupational Therapists (BAOT/COT)
—Royal College of Psychiatry (RCPsych)
—Royal College of Nursing (RCN)
—Allied Health Professionals Federation (AHPF)
—Medsin —British Association for Music Therapy (BAMT)
—British Medical Association (BMA)
—NHS Alliance
—Social Work and Health Inequalities Network (SWHIN)
http://www.instituteofhealthequity.org/Content/FileManager/pdf/professional-statements-and-commitments-list.pdf

Organisations have committed to work in partnership to implement the recommendations of the report by producing educational materials, developing new research and publications, setting up networks, embedding the SDH in current work and disseminating information to health professionals. The commitments can also be found on the Institute of Health Equity's (IHE) website http://www.instituteofhealthequity.org/projects/working-for-health-equity-the-role-of-health-professionals

The commitments form the basis for an on-going programme of work led by the IHE in partnership with Royal Colleges, the Academy of Medical Royal Colleges (AoMRC), the British Medical Association (BMA), the Canadian Medical Association (CMA, which is introducing a similar programme of work in Canada), the World Medical Association (WMA), and other oganisations and institutions.

Health inequalities duties

The April 2012 Health and Social Care Act (HSCA) has led to significant changes in structure, provision, incentives, regulation, commissioning and monitoring within the health system. For example, Clinical Commissioning Groups (CCGs) and Health and Wellbeing Boards (HWBBs) must set local priorities for provision and commissioning of health and public health.

In exercising their functions, the NHSCB and CCGs must have regard to the need to reduce inequalities, both in terms of access and health outcomes of patients. They must also secure integrated provision of services, both within the health system and beyond it, where this would reduce inequalities in access or outcomes. In addition, there are duties on the Secretary of State, Monitor and NHS Foundation Trusts, all of whom must integrate these duties into their plans and report progress on them annually. A description of the content of these duties for each of the relevant bodies is available in the box below.

Health inequalities duties in the Health and Social Care Act

Secretary of State for Health: "Must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service."

Monitor [the sector regulator for health care]: "Must exercise its functions with a view to enabling health care services provided for the purposes of the NHS to be provided in an integrated way where it considers that this would […] reduce inequalities between persons with respect to their ability to access those services, or reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services." Monitor is also entitled to set or modify licence conditions where this would result in "reducing inequalities between persons with respect to their ability to access those services, and reduce inequalities with respect to the outcomes achieved for them by the provision of those services."

NHS Commissioning Board: "Must, in the exercise of its functions, have regard to the need to – a. reduce inequalities between patients with respect to their ability to access health services, and b. reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services". The Board must also "exercise its functions with a view to securing that health services are provided in an integrated way where it considers that this would […] reduce inequalities between persons with respect to their ability to access those services, or reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services". This duty to secure integrated provision additionally applies to integration of health services with health-related services or social care services.

Clinical Commissioning Groups: Each CCG "must, in the exercise of its functions, have regard to the need to – a. reduce inequalities between patients with respect to their ability to access health services, and b. reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services". Each CCG must also secure integrated provision of health services, and health services with health-related services or social care services, "where it considers that this would […] b. reduce inequalities between persons with respect to their ability to access those services, or c. reduce inequalities between persons with respect to the outcomes achieved for them by the provision of those services".

NHS Foundation Trusts: Trust special administration can be used if "ceasing to provide [a] service under this Act would, in the absence of alternative arrangements for its provision under this Act, be likely to – a. have a significant adverse impact on the health of persons in need of the service or significantly increase health inequalities, or b. cause a failure to prevent or ameliorate either a significant adverse impact on the health of such persons or a significant increase in health inequalities".

About the Institute of Health Equity (IHE)

The Institute was launched in November 2011 to build on previous work to tackle inequalities in health led by Professor Sir Michael Marmot and his team, including the WHO Commission on the Social Determinants of Health and 'Fair Society, Healthy Lives' (Marmot Review). The IHE is supported by the Department of Health, University College London and the British Medical Association. It seeks to increase health equity through action on the social determinants of health, specifically in four areas:

1. Influencing global, national and local policies – providing evidence and proposals to influence policy making at all levels through advocacy and advice
2. Advising on and learning from practice – influencing the delivery of interventions to ensure they incorporate action on health and social inequalities and learning from interventions and practice
3. Building the evidence base – ensuring that up to date, high quality research evidence is used in the design and implantation of polices and practices
4. Capacity building – developing capacity of the health workforce, community organisations, policy makers and related practitioners to understand and deliver on action to reduce health inequalities

More information about the IHE and their work locally, nationally and internationally can be found on the website: www.instituteofhealthequity.org

References

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