

THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA



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BEST ADVICE

Social Determinants of Health

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BEST ADVICE – SOCIAL DETERMINANTS OF HEALTH

This *Best Advice* guide, part of the CFPC's Patient's Medical Home (PMH) series, provides practical, hands-on advice for health professionals on how to improve their patients' social determinants of health (SDH). It is divided into four main sections:

- A background on the social determinants of health
- The importance of these issues for patient and population health
- Commonly identified challenges to action
- Incorporation of the social determinants of health into your practice

Further resources on the social determinants of health can be found in the Appendices.

BACKGROUND

Health and well-being are shaped by social and economic factors known as the **social determinants of health (SDH)**, which are defined as the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels.¹ The evidence base on the SDH dates back to the early 1800s and continues to expand. Many reports, summits, and studies corroborate the link between social factors and human health.

In Canada, the 1974 Lalonde Report encouraged health professionals to look beyond traditional medical care to improve the health of the population and to focus on prevention instead of mostly acute care.^{2,3} We have learned much about the mechanisms by which the SDH and health inequities operate. The idea that there is a social “ladder” to illness is widely accepted; the further you are up or down on this ladder, the better or worse your health outcomes are.



The SDH include, but are not limited to, the following:⁴

- | | |
|-------------------------------------|--------------------------------------|
| • Income (and its distribution) | • Food Insecurity (ie, hunger) |
| • Education | • Housing |
| • Unemployment and Job Security | • Social Exclusion |
| • Employment and Working Conditions | • Social Safety Net (welfare policy) |
| • Early Childhood Development | • Health Services |
| • Race | • Aboriginal Status |
| • Gender | • Disability |
| • Sexuality | |

For more information on the evidence base on the SDH, please refer to Appendix 1.

Like other professional health organizations, including the Canadian Medical Association (CMA) and the British Medical Association (BMA), the College of Family Physicians of Canada (CFPC) understands that there is sufficient evidence to take action on the SDH.

This paper aims to provide family physicians and their teams of allied health professionals with practical advice on how to address the SDH both in practice and through broader advocacy.

IMPORTANCE OF SDH

Attention to the SDH is integral to population health and family medicine. Many family physicians in Canada recognize that it is difficult to treat the immediate health concerns of their patients without addressing in some way the underlying social conditions that give rise to poor health. While most public health interventions target individual behaviours, an SDH approach reveals individual choice as being shaped and constrained by structural and environmental factors, often outside the direct control of the individual. For this reason, family physicians should work to intervene not just in the lifestyle and behavioural factors that impact individual patients' health but also in the social conditions that shape and constrain well-being.

The CFPC made the SDH and social accountability a central feature of its 2013–2017 [Strategic Plan](#). One of the six primary goals states that the CFPC should “*be socially accountable and promote social equity in all CFPC decisions and actions.*” The sub-goals under this category aim to enhance organizational awareness of the impact of the social determinants of health and to advocate for government policies that address them. A complete description of this goal and the CFPC Strategic Plan are located in Appendix 2. Through recognizing and pursuing this goal, the CFPC strives to improve the social determinants of health and health outcomes for all people in Canada.

The CFPC's commitment to action on the SDH is demonstrated through our vision for family practice known as [the Patient's Medical Home](#) (PMH). The PMH is a patient-centred family practice identified by its patients as the home base or central hub for the timely provision and coordination of all their health care needs. In the CFPC's [PMH Vision Paper](#), Goal 5.5 states:

Patients' Medical Homes should address the health needs of both the individuals and populations they serve, incorporating the effects that social determinants such as poverty, job loss, culture, gender, and homelessness have on health.

CHALLENGES TO ACTION

It is important to recognize potential challenges to taking action on the social determinants of health so that strategies for change can be developed. This guide will outline steps that providers can take to mitigate these challenges.

Family physicians identified time constraints as the most common challenge, followed closely by remuneration concerns. Almost all providers interviewed commented that fee-for-service (FFS) billing provided a disincentive to work with patients to improve their SDH. Many social workers

and family physicians felt that the undergraduate and postgraduate training provided for health professionals left them ill-prepared to deal with complex social support systems or to take the social history of a patient. The option to refer to a social worker was not available in all cases.

Less commonly identified challenges included attitudinal issues, particularly stigma on the part of providers. Several participants had experienced prejudice toward people in poverty from fellow providers, or felt that the stigma around poverty precluded individuals' comfort in discussing their living conditions and income.

Another concern was the feeling of powerlessness. Physicians have not traditionally viewed the SDH as under their purview. Despite the growing attention in medical education to the SDH, and increased awareness of the impact of SDH on patients, some physicians do not see it as an area in which they can intervene. As one participant said, "I feel badly about the person's situation, but this is not something I can help with."

The CFPC believes that family physicians are often the best-situated primary care professionals to act on issues that affect the SDH of their patient population. Despite the aforementioned challenges, family physicians and allied health workers can play a role to improve the SDH at both the patient and population health levels.

The data for this section are derived from hour-long interviews with family physicians, nurses, social workers, and legal professionals working in health-related fields across the country. For more information on the interview protocol and methodology, consult Appendix 3.

INCORPORATING SDH INTO YOUR PRACTICE

Below are steps physicians can take to address the challenges associated with the SDH of their patients and the broader Canadian population. The recommendations focus on the three levels at which this work can occur:

- **Micro:** In the immediate clinical environment, work done on a daily basis with individual patients and predicated on the principles of caring and compassion
- **Meso:** In the local community, including the patient's community, the community of medical providers, and the "civic community," in which health professionals are citizens as well as practitioners (also includes education, training, and continuing professional development [CPD])
- **Macro:** In the humanitarian realm, where physicians are concerned with the welfare of their entire patient population and seek to improve human welfare through healthy public policy (such as reducing income inequality, supporting equitable and progressive taxation, and expanding the "social safety net")

Many of the activities enumerated in the Meso and Macro sections are predicated on health advocacy. The CFPC views advocacy as core to the work of family medicine. It encompasses many aspects, such as how family physicians are advocates for their individual patients, how physicians act as a resource to and advocate for their communities, and the role that family medicine plays in advocating for improved living conditions and healthy public policy for all people in Canada.

The guiding framework for advocacy is found in the CanMEDS–Family Medicine (CanMEDS-FM) Physician Competency Framework,* which describes the knowledge, skills, and abilities that family physicians need to improve patient outcomes. Many family physicians are familiar with the CanMEDS-FM Physician Competency Framework, as it is a central feature of postgraduate family medicine training. Most are aware of the Health Advocate role but have trouble identifying ways in which physicians can effectively advocate for their patients. For more information on the CanMEDS-FM framework, please consult Appendix 4.

MICRO – IN PRACTICE

1. Regularly screen patients for poverty, and intervene where necessary.

The Ontario College of Family Physicians' (OCFP's) Poverty Committee developed a [Poverty Intervention Tool](#) that uses a simple verified question with high sensitivity for detecting those living below the poverty line.^{5,6} It is easy to ask and should be included in routine visits: “Do you ever have difficulty making ends meet at the end of the month?”⁷

As most providers know, it is unethical to screen for something for which you are unable to provide an intervention. However, there are many interventions available for patients living in poverty. While some resources listed in this tool are Ontario-specific, many of the assistance programs it links to are federally administered. There are also several provider groups working to adapt the Poverty Intervention Tool to other provincial and territorial settings. For example, the Divisions of Family Practice in British Columbia have [adapted the Poverty Intervention Tool](#) for use across BC. This approach of poverty screening, risk adjustment, and intervention has gained major uptake across the country—most of the social workers and legal professionals interviewed were familiar with the Poverty Intervention Tool, whereas awareness of the tool among family physicians was lower. The CFPC encourages the consideration of poverty in a periodic health exam. The CFPC endorses the [Preventive Care Checklist Forms](#), which include an “Income Below the Poverty Line” checkbox.^{8,9} There are continuing

*Adapted from Frank JR, ed. *The CanMEDS 2005 Physician Competency Framework. Better standards. Better physicians. Better care.* Ottawa: The Royal College of Physicians and Surgeons of Canada; 2005. Available from: www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds/resources/publications/framework_full_e.pdf. Accessed 2015 Jan 23.



medical education (CME) modules available on this topic through the Canadian Medical Association's [website](#).

Many provinces have a billing code for filling out social assistance forms. While poverty screening and intervention might not always be sufficient to completely mitigate a patient's social and economic circumstances, using the poverty tool in practice is the best available method to begin connecting patients to programs that can help improve their living conditions.

2. Ensure your practice is accessible to all patients, especially marginalized populations.

Providers should consider and shape how their care environment presents itself to marginalized populations such as refugees, low-income patients, LGBTQI (lesbian, gay, bisexual, transgender, queer/questioning, intersex) individuals, and those with disabilities or developmental delays. One practice funded a token bin for low-income patients

to use for public transit to and from appointments. Another installed a public bulletin board for community members to share local events, activities, and community meetings. Providers should consider wearing casual clothing to make patients less aware of social class distinctions and power imbalances that can exist between providers and patients. These imbalances were identified as impediments to patients' feeling comfortable talking about their income or living conditions. Truly accessible care is centred on the patient. It is crucial to allow patients to fully voice their concerns, and to validate patients' complaints by acknowledging the effect of their problems on their lives.

Further, the principles of caring and compassion must underpin every PMH-like practice and be present in the pillars of the medical home.

For more information on how to ensure your practice is patient-centred, please consult the PMH Best Advice guide "Patient-Centred Care in a Patient's Medical Home."

patientsmedicalhome.ca/files/uploads/BA_PatCentred_EN_WEB_FINAL.pdf

See the PMH Best Advice "Timely Access" guide for more information on how to incorporate advanced access into your practice.

patientsmedicalhome.ca/files/uploads/PMH_Best_Advice_Enhancing_Timely_Access.pdf

3. Offer advanced access and same-day scheduling.

Making practices genuinely accessible can entail more than geographic accessibility. Scheduling flexibility and sufficient appointment length are also key elements of an accessible practice. The PMH model uses advanced access booking systems, which allow patients same-day appointments or

appointments when they want to be seen. Advanced access also works by suggesting patients wait for an opening if they arrive late rather than by automatically canceling appointments.

4. Build an antipoverty team that is shaped around your community's needs.

Team-based care—a pillar of the PMH model—is another strategy that is well-suited to dealing with a patient's diverse care needs, including their social and economic circumstances. PMH models are structured around addressing the health needs of the populations they serve, which makes them adaptable to local demographics and health needs.

This means that if your population has a large proportion of new immigrants and/or refugees, your team might include a part-time legal aid professional and/or a social worker familiar with the local service environment for newcomers. Conversely, if a region experiences significant joblessness or layoffs, it is imperative that the practice includes access to a social worker with employment counseling training, given the strong link between income and health.

Where co-located, team-based care is unavailable or unfeasible, a PMH model of care can adapt to patient needs with virtual care, Telehealth, and other e-health solutions such as email communication and videoconferencing options.

Demographic data for your community might be found through Statistics Canada, academic data collected by local researchers, or a local government representative.

5. Understand and provide forms for provincial/territorial social assistance programs.

Responding to patients' individual needs often means filling out forms for provincial/territorial and federal social assistance programs; for this reason, it is important that family physicians be familiar with these forms and have them available in the office. Many providers encounter federal social assistance forms on a near-daily basis, yet most have not received formal training on how to fill out the forms. Moreover, their awareness of the purpose of the forms and the fee codes associated with them varies widely. Some physicians reported knowledge of practices

While filling out social assistance forms, family physicians aim to provide objective medical advice. FPs are not the gatekeepers for income security programs. All that is required is the provision of complete and detailed information that accurately portrays a patient's health status and/or disability.⁷

that charge patients a fee for completing these forms. In some cases this might impose additional financial barriers to patients' accessing income benefits such as disability supports, special diet allowance (Ontario only), transportation allowance, and disability tax credits.

Providers (as part of their CPD/CME) can and should

The following programs are administered at a federal level and are available for patients across Canada:

- ♦ **Old Age Security pension/ Guaranteed Income Supplement**
- ♦ **Canada Pension Plan (CPP) Disability Benefit**
- ♦ **Veterans' benefits**
- ♦ **Employment Insurance (EI)**
- ♦ **Disability Tax Credit (DTC)**
- ♦ **Registered disability savings plans (RDSP)**

Eligibility requirements vary by program.

The Canada Benefits program provides a simple way to search through federal and provincial government benefits.

Please consult the [Canada Benefits](#) website for more information on these and other programs.

familiarize themselves with the fee codes in their province/territory associated with these forms. As a matter of equity and social accountability, patients—many of whom are already experiencing marginalization—should not be charged a user fee for paperwork related to social assistance.



MESO – IN COMMUNITIES

1. Collect and utilize data on your local population's health and well-being.

As mentioned in recommendation four of the Micro section, part of a PMH model is ensuring that your care environment is responsive to the population health needs of your local community. This necessitates two things: first, ensuring that you have a defined patient population—this is best achieved through patient rostering—and, second, gathering data on your patient population.

Such collection can be greatly facilitated by the use of an electronic medical record (EMR). Several EMR vendors are currently developing generalized SDH questionnaires that collect data from patients on several relevant SDH indicators, including poverty, income, housing, citizenship, and sexuality. This data can then be anonymized and aggregated into community-level statistics for use in continuous quality improvement (CQI) activities.

Community-level data can also be collected in the absence of EMR functionality. This is best approached as a survey research project, rather than as an ongoing data surveillance task. Your practice would then use this data to critically examine where there might be a skills deficit in your team. You could make connections as needed with local providers, including housing workers, probation officers, and lawyers, when letters of support are required for patients in various situations.

For more information on rostering in family practice, please consult the PMH Best Advice guide “Patient Rostering in Family Practice.”

patientsmedicalhome.ca/files/uploads/PMH_Best_Advice_Rostering.pdf

2. Provide undergraduate and postgraduate experiential learning on the social determinants of health.

Many of Canada's 17 medical schools are already embracing curriculum that discusses the SDH at the undergraduate level. Getting students to look upstream and consider the determinants of population health is crucial, especially before they begin the regular practice of medicine. Most pedagogical studies demonstrate that typical learning styles are insufficient to convey marginalization and how SDH, such as migration status or income inequality, can affect community health. In order to appreciate the SDH in practice, students need to have practical, hands-on experiences within their local communities. Many medical students are already incorporating some form of experiential learning into their curriculum, with great success. Community interaction and volunteering should be integrated into the curriculum for all students, with the option for students to choose the SDH areas that interest them the most.

The practical exposure of future physicians should not be limited only to addressing SDH in practice, but should also include advocacy efforts, as described in the following section.

3. Act as a Health Advocate and utilize the CanMEDS-FM Framework as a guide.

Advocacy is central to the work of family medicine. Many providers advocate for their patients on a daily basis but do not consider their work as advocacy-focused. For example, an interview participant regularly wrote letters to a patient's landlord concerning the effect of mould in the patient's residence on his respiratory health. While this falls under the scope of direct advocacy, the individual saw it as part of her daily work as a family physician. This requires a reshaping of how providers view advocacy to understand how it operates on multiple levels.

The Health Advocate role, as described by the CanMEDS-FM Physician Competency Framework, provides a clear and measurable way to evaluate advocacy in training and practice. The framework defines Health Advocates in the following way:

Physicians contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when needed, and support the mobilization of resources to effect change.

Please refer to Appendix 4 for the key competencies entailed in a Health Advocate role.

4. Provide on-site care for those who cannot make it to a physical clinic.

As Dr Gary Bloch points out in his [TED^x talk](#) "If You Want to Help Me, Prescribe Me Money," poverty is not always self-evident in the appearance or demeanour of one's patients. Many individuals may "pass" as well off while struggling to make ends meet. While screening for poverty is one way of mitigating this barrier, an even better way is through providing regular home care.

When family physicians provide house calls, they are able to see patients in their own social contexts and living conditions, and better appreciate the community context in which they operate. This principle applies similarly to those who are homeless. Ensuring that physicians care for the most marginalized members of their community means considering those who do not or cannot make it in during office hours. While advanced access and extended hours can facilitate patient access, a PMH may need to be flexible in order to provide care wherever it is needed.

MACRO – LOOKING UPSTREAM

1. Join or create an organization to advocate both with and on behalf of communities.

Family physicians occupy a unique place of privilege and position in society. As part of this privilege that society has bestowed on physicians, they ought to be socially accountable to the populations they serve. There are numerous physician advocacy groups and networks across Canada that advocate for the health of Canadians. Physicians can join a local advocacy group to advance social accountability in their desired area of interest, and take a strong stance on the social determinants of health. Advocacy efforts should be directed at municipal, provincial, territorial, and federal levels of government for healthy public policies that improve “upstream” determinants of health.

The following are examples of advocacy groups:

- Canadian Physicians for the Environment (CAPE)
- Health Providers Against Poverty (HPAP)
- Canadian Doctors for Medicare (CDM)
- Doctors for Fair Taxation
- Canadian Doctors for Refugee Care (CDRC)
- Health for All (H4A)
- Upstream

The Canadian Medical Association (CMA) also provides physicians with [several advocacy tools](#) that help facilitate political action and engagement. CMA members can take advantage of their e-advocacy tools and their [MD-MP Contact Program](#), which matches CMA members with their local Members of Parliament.

What is Healthy Public Policy?

Healthy public policy is concerned with the health impacts of public policy decisions—including those that might not directly pertain to health and health care. The wealth of literature on the SDH is a resource that can help policy makers anticipate the potential health impacts—positive or negative—of a whole range of policies, from universal child care to increased university tuition rates. Understanding the evidence base on the SDH can also help providers assess the consequences of a decision by policy makers to *not act* on a particular issue or area. Through such *health impact assessments*, physicians can ascertain which healthy policy choices are best for Canadians.

Below are some examples of key areas where physicians are already working with communities to advocate for legislative change at the municipal, provincial/territorial, and federal levels of government:

- Social exclusion in Canada, including racism, ableism, xenophobia, homophobia, and transphobia
- Working conditions for temporary foreign workers
- Living conditions for migrants currently detained in Canada
- The effect of ongoing colonization on the living conditions of First Nations, Inuit, and Métis people
- Progressive taxation or policies aimed at reducing income inequality

It is important not to be discouraged when these broad issues come up in practice—family physicians are often the best-situated members of society to observe the direct health impacts of these upstream factors and to advocate for broad change.

2. Engage with medical, health care, and social service organizations to provide organizational advocacy for improved social determinants of health.

There are multiple avenues for CFPC members to volunteer their time to lobby for healthy public policies at the federal level. Members can liaise with their [local Chapters](#) to advocate at the provincial and territorial levels. We strongly encourage you to share your thoughts



and perspectives with one of the many medical organizations that are dedicated to serving you and your profession. The CFPC always welcomes your input and feedback on all of its documents, policies, and position statements, including its ongoing health policy and advocacy work. Your perspectives help ensure that the CFPC can act as the voice of family medicine in Canada.

Through sustained government relations activities, the CFPC has an extensive presence in federal health policy. The CFPC's [2013 Report Card](#) examines the role the federal government has had in various areas of health care. It gained national attention in the press, and specifically names and monitors federal inaction on key areas such as poverty, homelessness, and Aboriginal health. The Report Card is consistently utilized in our official responses to the federal budget and the Speech from the Throne. We have followed up the Report Card with recommendations to support better home care and child and youth health. Please see the CFPC's 2013 report on "[The Role of the Federal Government in Health Care](#)" and the subsequent "[From Red to Green. From Stop to Go](#)" document. We welcome your constructive feedback on all our documents, policies, and position statements.

There is also a critical role for medical, health care, and social service organizations (such as the CFPC, CMA, RCPSC [Royal College of Physicians and Surgeons of Canada], CNA [Canadian Nurses Association], and CASW [Canadian Association of Social Workers]) to play in advocating for a more fair and evidence-based health system in Canada. Many organizations, including the CFPC, advance the idea of a national pharmaceutical strategy and national home care program. And the CFPC has called on the federal government to end child poverty by 2020 as well as to explore strategies to support consumption of healthful foods. Many of these ideas are financially sound and make sense from an equity and SDH perspective. The CFPC is a member of the [Choosing Wisely Canada Initiative](#), which is focused on providing patient-centred care that is evidence-based, without excessive testing, harm-free, and necessary.

Your support for such initiatives, in whichever form you choose to provide it, aids organizations in their advocacy efforts.

Advocacy Works

There are many examples where sustained advocacy can lead to policy change. Since 2012, the CFPC has been a vocal critic of the federal government's decision to cut supplemental health benefits for refugee claimants under the Interim Federal Health Program (IFHP). Along with a coalition of health organizations from across Canada, the CFPC remained steadfast in its public opposition to the IFHP cuts, and shared multiple letters outlining the negative impacts the cuts would have on the health of refugees—some of the most marginalized and disadvantaged people in Canada. On July 4, 2014, [the Federal Court ruled](#) that the federal government ought to reverse their "cruel and unusual" cuts to refugee health care.

3. Advocate for remuneration arrangements and funding that incentivizes SDH care.

While many providers identified time and money as the key constraints to doing more “upstream” health work, it is possible to circumvent these barriers with proper structural supports and incentives. A PMH model of care facilitates team-based patient management, which can free up more time for complex cases, more likely to be present in marginalized populations.

For example, Ontario Community Health Centres (CHCs) feature team-based care and salary/alternative remuneration strategies instead of fee-for-service payments. A 2012 ICES (Institute for Clinical Evaluative Sciences) study showed they were more likely to serve populations from lower-income neighbourhoods, including vulnerable populations such as newcomers and those on social assistance.¹⁰

Where appropriate health professionals (social workers or mental health specialists) are not readily available and provincially funded, providers should advocate for their patients to have universal access to quality social care.

The model of remuneration employed by each PMH will vary based on local needs, but there is a clear requirement that funding be stable, sustainable, and supported by all levels of government.

4. Collaborate with other organizations to establish broad intersectoral support for healthy public policies that address upstream determinants of health.

It is also critical to establish intersectoral partnerships and collaboration—that is, partner with those outside the traditional health community—to ensure that the voices of other expert groups and communities are at the forefront of advocacy efforts. There is a clear need to



advocate for changes to social policies that are not under the traditional purview of the health sector. For example, many physicians and health policy experts are linking with advocacy organizations to explore and push for a basic guaranteed income for all Canadians.

5. Advocate for increased focus and exposure to SDH in undergraduate and postgraduate medical education.

Part of ensuring that family physicians see SDH work as within their purview is attitudinal, and established early on in a career of lifelong learning. The issues here are similar to those faced by rural and remote communities in recruiting and retaining skilled health professionals. While loan forgiveness programs are effective in the short term, changing the type of candidate that gets into medical school is imperative. The Northern Ontario School of Medicine has demonstrated that the best way to ensure physicians will practise in underserved rural and remote communities is to recruit directly from those communities. Similarly, if medical schools recruit candidates who are from marginalized communities, these students are more likely to understand and identify with the challenges that disadvantaged communities can face across Canada. Medical schools should consider policies that ensure the composition of their student body is reflective of the broader race, class, and gender demographics of the Canadian population.

CONCLUSION

Family physicians play a vital role in improving the social determinants of health for their patients and all Canadians. The recommendations provided in this guide are just a starting point for future work. The tools and incentives to do work that focuses on SDH are being expanded across the country, and a PMH model of primary care helps facilitate incorporating the SDH into family practice. Implementing even one of these recommendations will go a long way to improving the social determinants of health for your patients. The evidence on the SDH is sufficient to merit action, and we at the CFPC are here to help translate that evidence into action.





Appendices

Appendix 1 – Additional resources on the SDH

The idea that health is influenced by social factors is not a new one. The French physician Louis-René Villermé observed in 1830 that mortality patterns were almost perfectly correlated with the degree of poverty in the districts of Paris. The English social reformer Edwin Chadwick noted the differences in living conditions between tradesmen and labourers in 1842 England and their subsequent impact on life expectancy. In 1848, Prussian physician Rudolph Virchow was tasked with writing a report on the typhus epidemic in Upper Silesia. Upon investigating this phenomenon, Virchow noted that the epidemic was intrinsically linked to people's living and working conditions—particularly substandard housing. His solution was simple but novel—he called for “education, freedom and prosperity” as a lasting solution to the region's material inequities and poor health outcomes.

Much research has been undertaken since the early 1800s, and there are many resources that examine the SDH in great depth. These textbooks, reports, and scientific articles provide an empirical case for how the SDH impact human health through both material (living conditions and income) and biopsychosocial (stress, social cohesion, social capital, and relative deprivation) pathways. For more information, below are some of the key readings that have helped shape the evidence base on the SDH.

General resources on the SDH

Mikkonen J, Raphael D. *Social Determinants of Health: The Canadian Facts*. Toronto: York University, School of Health Policy and Management; 2010. Available from: www.thecanadianfacts.org/The_Canadian_Facts.pdf.

- This e-text is a valuable resource for health providers, academics, and policy makers in its accessibility and scope. It provides an overview of 14 key SDH and how they impact population health.

Wilkinson RG, Marmot MG, eds. *Social Determinants of Health: The Solid Facts*. 2nd ed. Copenhagen: WHO Regional Office for Europe; 2003. Available at: www.euro.who.int/__data/assets/pdf_file/0005/98438/e81384.pdf?ua=1.

- Originally released in 1998, this 2003 WHO document incorporated the latest and strongest scientific evidence from predominantly UK-based academics on the SDH. It contains information on 10 SDH including stress, early life, unemployment, transportation, and social exclusion.

Poverty, income inequality, and health

Link BG, Phelan J. Social conditions as fundamental causes of disease. *J Health Soc Behav* 1995;80–94.

- Link and Phelan developed the theory of fundamental causes to explain why the association between socioeconomic status (SES) and mortality has persisted despite radical changes in the diseases and risk factors that are presumed to explain it. They proposed that the enduring association results because SES embodies an array of resources, such as money, knowledge, prestige, power, and beneficial social connections, that protect health no matter what mechanisms are relevant at any given time.

Adler NE, Ostrove JM. Socioeconomic status and health: What we know and what we don't. *Ann N Y Acad Sci* 1999;896(1):3–15.

- This article provides a historical overview of the key eras of scholastic research into the SDH. It covers the causal direction of the SES–health gradient, especially from a life trajectory approach. It also explores the current trend of research into the mechanisms by which SES affects health.

Stress and health

Brunner E. Stress and the biology of inequality. *BMJ* 1997;314(7092):1472.

- Dr Eric Brunner is currently involved in the Whitehall II Study, a follow-up to the famous Whitehall Study that examined cardiovascular disease prevalence and mortality rates among British male civil servants. In this article, Dr Brunner describes the mechanism by which stress (particularly job stress) is related to hierarchy, social position, and cardiovascular disease.

Unnatural Causes: Is Inequality Making Us Sick? Public Broadcasting Service; 2008.

- This four-hour documentary series was met with critical acclaim when it was first broadcast in 2008. The first episode provides a useful overview of the social determinants of health and lays out the case for how the SDH are stronger predictors of health outcomes than an individual's genetics or behaviour. The film is focused on the United States but its findings are equally relevant in a cross-national context.

The population health approach and upstream determinants of health

Rose G. Sick individuals and sick populations. *Int J Epidemiol* 1985;14(1):32–38.

- Rose's 1985 article is fundamental reading in population health and is taught in introductory public health and epidemiology courses around the world. The paper's central idea is that individual and population approaches to improving health are fundamentally different and achieve different aims. This is useful reading for clinicians who are interested in considering “upstream” determinants of health and how they can affect clinicians in practice.

Coburn D. Beyond the income inequality hypothesis: Class, neo-liberalism, and health inequalities. *Soc Sci Med* 2004;58(1):41–56.

- This paper was a threshold moment in SDH research, in which the author presented a challenge to the income inequality and psychosocial model of health inequalities. Coburn argues that absolute, rather than relative, income differences underlie the relationships between income and health. He contends that widening income and wealth inequality is linked to worse population health outcomes. Coburn shows that nations that favour a “social democratic” approach to social welfare policy tend to have better population health than those that employ a “neo-liberal” approach.

Appendix 2 – Strategic plan

The CFPC’s Strategic Plan (2013–2017) was approved by the CFPC Board of Directors on November 12, 2012. It enumerates the CFPC’s organizational mission, vision, and six goals to work toward. Each of the six goals contains several sub-goals and objectives. The complete document can be found at www.cfpc.ca/uploadedFiles/Publications/CFPCStragicPlan.pdf.

The goal most relevant to the SDH is Goal 6:

Goal 6 Be socially accountable and promote social equity in all CFPC decisions and actions.	
6.1	Enhance organizational awareness of the impact of social determinants on the health and well-being of the people of Canada.
6.2	Advocate for government policies that address the social determinants of health.
6.3	Enhance awareness among medical students, family medicine residents, and practising family physicians of the social determinants of health and how they should be considered in every patient encounter, particularly when caring for underserved, vulnerable, and marginal populations.
6.4	Support our members in their role as advocates for improving the social determinants of health that affect the health status of their patients and communities.
6.5	Include the need to be socially accountable in the development and evaluation of all CFPC policies and activities.

Appendix 3 – Methodology

Data for the “Challenges to Action” and “Incorporating SDH into Your Practice” sections were derived from interview data. Interviews were conducted with 34 participants (21 family physicians, 7 social workers, 4 family practice nurses, 2 legal professionals). Interview questions were semistructured (7 base questions with 14 sub-questions), which allowed for more in-depth discussion in areas where participants had greater expertise.

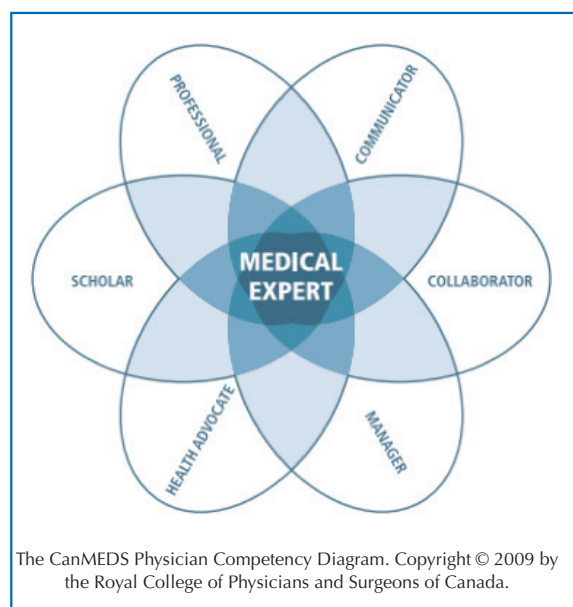
Interviews were transcribed and analyzed for thematic content, which informed the three levels of analysis and intervention in this paper (Micro/Meso/Macro). All of the recommendations were generated from interview data. However, they are not presented in order of thematic prominence but are instead organized under their level of analysis and intervention. Data on commonly identified barriers are presented in their order of prominence from the interview data.

If you have any further questions concerning the methodology used in this paper, please contact us at healthpolicy@cfpc.ca.

Appendix 4 – CanMEDS–FM competency framework and Health Advocate role

The complete *Draft CanMEDS 2015 Physician Competency Framework – Series IV*, the latest iteration of the competency framework upon which CanMeds-FM is based, can be located at the RCPSC’s website: www.royalcollege.ca/portal/page/portal/rc/common/documents/canmeds/framework/canmeds2015_framework_series_IV_e.pdf.

The competencies of the Health Advocate role within the 2015 framework* specify that physicians are able to:



1. Respond to an individual patient’s health needs by advocating with the patient within and beyond the clinical environment	1.1 Work with patients to address determinants of health that affect them and their access to needed health services or resources
	1.2 Work with patients and their families to increase opportunities to adopt healthy behaviours
	1.3 Incorporate disease prevention, health promotion, and health surveillance into interactions with individual patients
2. Respond to the needs of the communities or patient populations they serve by advocating with them for system-level change in a socially accountable manner	2.1 Work with a community or population to identify the determinants of health that affect them
	2.2 Improve clinical practice by applying a process of continuous quality improvement to disease prevention, health promotion, and health surveillance activities
	2.3 Participate in a process to improve health in the community or population they serve

*Sherbino J, Bonnycastle D, Côte B, Flynn L, Hunter A, Ince-Cushman D, et al. Health Advocate. In: Frank JR, Snell LS, Sherbino J, eds. *The Draft CanMEDS 2015 Physician Competency Framework – Series IV*. Ottawa: Royal College of Physicians and Surgeons of Canada; 2015 March.

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