

Taking action on the social determinants of health in clinical practice: a framework for health professionals

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For podcast: "CMAJ Podcasts: author interview at <https://soundcloud.com/cmajpodcasts/160177-rev>

There is strong evidence from around the globe that people who are poor and less educated have more health problems and die earlier than those who are richer and more educated,¹ and these disparities exist even in wealthy countries like Canada.² To make an impact on improving health equity and providing more patient-centred care,³ it is necessary to better understand and address the underlying causes of poor health. Yet physicians often feel helpless and frustrated when faced with the complex and intertwined health and social challenges of their patients.⁴ Many avoid asking about social issues,⁵ preferring to focus on medical treatment and lifestyle counseling.

It is increasingly recognized that to improve population health, health equity needs to become a priority in the health sector, and measures to reduce disparities must be integrated into health programs and services.⁶ Training physicians, nurses and other allied health workers to address the social determinants of health is considered one of the key principles for promoting more equitable health outcomes for patients, families and communities.⁷ Indeed, health professional schools are socially accountable to contribute to meeting the needs of the local community. However, what exactly should health workers do to make a positive impact? In this review, we identify the concrete actions that clinicians can use to help address the social determinants of health as part of their routine clinical practice (Box 1; Appendix 1, available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.160177/-/DC1).

What are the social determinants of health?

The World Health Organization (WHO) defines social determinants of health as follows:

“the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems.”⁸

The social determinants of health include factors such as income, social support, early childhood development, education, employment, housing and gender.⁹ Many of these can result from even more upstream and insidious structural forces at play. For instance, in the case of First Nations, Inuit and Metis peoples, ongoing challenges from the impacts of colonization, intergenerational trauma from residential schools, systemic racism, jurisdictional ambiguity and lack of self-determination exert a further influence on health and its determinants.¹⁰

How are social determinants linked to health outcomes?

Certain subgroups of the population, particularly those who are less empowered and who have lower socioeconomic status, tend to live and work in more degraded environments and have a higher exposure to risk factors for disease, as well as physiologic impacts from chronic stress.¹¹ Consequently, they have worse health and shorter lives.¹²

Competing interests: None declared.

This article has been peer reviewed.

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CMAJ 2016. DOI:10.1503/cmaj.160177

KEY POINTS

- Although physicians generally recognize that social determinants (e.g., income, education and social status) influence the health of their patients, many are unsure how they can intervene.
- An increasing body of evidence provides guidance on a number of concrete actions that clinicians can use to address social determinants in their clinical practice to improve patient health and reduce inequities.
- At the patient level, physicians can be alert to clinical flags, ask patients about social challenges in a sensitive and caring way, and help them access benefits and support services.
- At the practice level, physicians can offer culturally safe services, use patient navigators where possible, and ensure that care is accessible to those most in need.
- At the community level, physicians can also partner with local organizations and public health, get involved in health planning and advocate for more supportive environments for health.
- Growing numbers of clinical decision aids, practice guidelines and other tools are now available to help physicians and allied health workers address the social determinants in their day-to-day practice.

The field of medicine continues to operate under a “risk factor” paradigm focused on behavioural modification for high-risk groups as the main strategy for preventing disease (e.g., smoking cessation, decreasing salt and fat intake and reducing sedentary lifestyle).¹³ However, this approach has not proven to be effective,¹⁴ largely because individuals are often not in control of the factors that make them sick and respond unconsciously to environmental cues.¹⁵ Therefore, reducing unhealthy behaviours requires creating more supportive environments that make the healthy choices the easy choices.¹⁶ For example, neighbourhood socioeconomic disadvantage and higher concentration of convenience stores have been linked to tobacco use. Similarly, lower availability of fresh produce, which — combined with concentrated fast food outlets and few recreational opportunities — can lead to suboptimal nutrition and less physical activity.¹⁷ Therefore, in addition to individual counselling, broader interventions are needed, such as urban planning to create parks and bicycle paths to promote active transport and community gardens and mobile markets to increase access to healthy foods.

Although there has been a lot of focus on supportive environments for physical activity and nutrition, the family environment in childhood is particularly important and can have far-reaching consequences on physical and mental health, as well as mortality.¹⁸ Children who experience multiple forms of abuse, witness

domestic violence and grow up in a household where family members are mentally ill, substance abusers or sent to prison, are “12 times more likely to have attempted suicide, 7 times more likely to be alcoholic, and 10 times more likely to have injected street drugs” by the time they reach adulthood.¹⁹ On the positive side, developing a relationship of support with an “alternative support figure” (e.g., grandparent, elder, friend or health worker) can serve as “a corrective emotional experience [that] allows the subject to work through his/her negative childhood experiences and acquire modalities of interaction that enable him/her to function more effectively in the world.”²⁰ This forms part of a continuum of strategies from victim identification and care to multisectoral structural interventions that better support parents and children, promote nurturing relationships, empower women and change social norms to ideally prevent violence in the first place.²¹

Physicians and other allied health workers already engage in a wide range of clinical preventive practices, intervening early with the aim of preventing disease and promoting health. Addressing the social determinants is an important and emerging area of practice that entails starting earlier and broadening the scope of interventions, thus making entire families and communities healthier.

How can health care workers influence social determinants?

There are many ways that physicians and other allied health workers can take action on the social determinants of health at the patient, practice and community levels.

What can be done at the patient level?

Depending on where clinicians are practicing, the types of disadvantage that they will encounter will vary and will not always be obvious just from looking at the patient. For instance, in a Canadian urban context, one might encounter single mothers, isolated older people, Indigenous youth who left their community to seek employment opportunities or escape violence, hidden homeless (e.g., couch surfers), nonstatus refugees, Indigenous youth and people with mental health or addiction problems. Physicians can better support patients faced with social challenges by asking about their social history, providing them with advice, referring them to local support services, facilitating access to these services and acting as a reliable resource person throughout the process.²²

Box 1: Evidence used in this review

A realist review methodology was used that is outlined in full in Appendix 1 (available at www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.160177/-/DC1). Broadly, multiple databases (e.g., Medline, Cumulative Index to Nursing and Allied Health Literature [CINAHL], EMBASE, ISI Web of Knowledge) were searched using the following search terms: Social near determinant* AND health OR Health near/2 *equit* OR disparit*, Health* worker* OR Health* professional* OR Health* provider* OR primary health care OR community health worker* and training* or education* or capacity strengthening OR capacity building. Additional searches of selected relevant websites were conducted, including those of the Canadian Task Force on Preventive Health Care, US Preventive Services Task Force, UK National Institute for Health and Care Excellence, National Guideline Clearinghouse and the Guide to Community Preventive Services. Grey literature was identified by Google searches, scanning reference lists, key informant discussions and postings on Internet listserves relating to health equity. This search identified almost 500 documents that were scanned for relevance, and a total of 71 documents were retained. Because this is a relatively new area of scientific inquiry that examines a variety of complex interventions impacting multiple health and social outcomes, a qualitative synthesis of the findings is presented that can be used as a framework for action on social determinants in clinical practice. With the exception of some clinical practice guidelines, most of the evidence on the effectiveness of physician intervention in social determinants is from smaller-scale observational studies and a few randomized controlled studies, as well as a growing number of qualitative and mixed-methods studies that are able to better assess the complexity involved and the role of context in influencing outcomes. Most publications pertain to low-resource settings within high-income country contexts, such as inner city neighbourhoods with high rates of poverty.

Although clinical practice guidelines in this domain lack evidence to recommend universal screening of asymptomatic patients,^{23,24} failure to identify hidden social challenges can lead to “misdiagnosis and a path of inappropriate investigations” (e.g., failing to ask about exposure to violence in the work-up of pelvic pain)²⁵ or inappropriate care plans (e.g., prescribing medicines that patients cannot afford).²⁶ In a study involving a survey of patient perceptions on care integration between mainstream health care services and community-based services that address the social determinants, more than 40% of patients reported that their family doctor was unaware of their struggles (e.g., obtaining enough to feed themselves, arranging transportation to clinic visits or paying for medicines).²⁷ Even when women presented with bruises and broken bones, only 14% had been asked about violence as a potential cause by their primary care provider,²⁸ although over 170 000 women in Canada are victims of violence each year according to police-reported data and over 1 600 000 according to self-reported data.²⁹ Therefore, recent clinical guidance has encouraged physicians to have a heightened awareness of clinical flags and patient cues, using “selective enquiry based on clinical considerations” to work social history questions into the patient encounter in a more seamless way.³⁰ Physicians who know how to ask about social challenges are more likely to report helping their patients work through these issues.³¹ Indeed, all patients may struggle with social challenges and require support in various spheres at different stages in their lives, and challenges such as discrimination, social isolation or exposure to violence can occur regardless of socioeconomic status.³²

Asking patients about social challenges in a sensitive and caring way

The first step in addressing often hidden social issues is asking patients about potential social challenges in a sensitive and culturally acceptable way. There are a growing number of clinical tools to help frontline practitioners ask about problems such as lack of employment, food insecurity and discrimination;³³ generally taboo topics such as physical and sexual abuse, and history of psychological trauma;³⁴ or factors that can further complicate care such as low literacy, legal or immigration status issues, fears regarding health care or barriers to making appointments.³⁵ For example, a simple screening question such as “do you ever have difficulty making ends meet at the end of the month?” is 98% sensitive and 64% specific for identifying patients living below the poverty line.³⁶

Asking about these issues in a caring way is important in its own right, because there is evidence that compassion and empathy “makes patients more forthcoming about their symptoms and concerns, yielding more accurate diagnoses and better care... and leads to therapeutic interactions that directly affect patient recovery.”³⁷ Integrating information on social challenges into the medical record is also helpful in ensuring that the entire care team can take these considerations into account during care planning.

Referring patients and helping them access benefits and support services

Once a “social diagnosis” has been made, “social prescribing” involves connecting patients with various support resources within and beyond the health system, such as local women’s groups, housing advocacy organizations or employment agencies. A randomized controlled trial conducted in the United Kingdom involving 161 patients identified in primary care as having psychosocial problems found that referral to community-based support groups reduced patient anxiety and improved perception of overall health compared with usual general practitioner care.³⁸ In one pilot study, 35 out of 131 patients initially referred were still using these support services 4 weeks later.³⁹

Beyond referral, physicians and allied health workers can advocate for individual patients (e.g., by writing letters on the patient’s behalf to housing agencies, educational institutions or the courts).⁴⁰ They can also help their patients to access benefits or programs to which patients are entitled (e.g., tax credits, child and family benefits, home visitation programs, low-cost day care, parenting classes, school readiness programs or nutrition support programs).⁴¹ A recent cluster randomized trial involving eight community health care centres in Boston, Massachusetts, showed that systematic screening for locally relevant basic needs during well-child visits (i.e., child care, food security, household heat, housing, parent education and employment) and giving physicians a one-page list of local community resources led to increased provider referrals, family enrollment in support services, maternal employment, numbers of children accessing child care; and there was also a reduction in the use of homeless shelters at one year follow-up compared with standard clinical care (i.e., opportunistic screening and access to basic social work services).⁴² Thus showing the importance of asking about social challenges and referring to local support resources, as well as building upon patient strengths and resilience.⁴³

What can be done at the practice level?

Beyond the provider–patient interaction, practice-level interventions and broader systems changes are also important in promoting equity-oriented primary health care services. A mixed-methods ethnographic study identified four key organizational-level dimensions: inequity-responsive care, trauma- and violence-informed care, contextually tailored care and culturally competent care.⁴⁴ A multiple case study design is currently being used in an ongoing evaluation of the impact on patient outcomes and experiences of care that results from implementing these strategies as a multicomponent intervention in four primary health care clinics in Ontario and British Columbia.⁴⁵ Changes at the organizational level and senior management support can reinforce the social accountability mandate of physicians⁴⁶ and help marginalized individuals to have better access to health and social services, and navigate the system more easily.

Improving access and quality of care for hard-to-reach patient groups

Clinical practices that want to reduce barriers to accessing care for underserved groups can use a range of approaches. These include: providing patients with bus fare and child care services to make it easier for them to attend appointments; documenting language preferences of patients, identifying language skills of practitioners and providing interpreter services; extending clinic hours and locating clinics close to where people live and work; offering a welcoming and culturally safe practice environment; providing health care workers with targets and financial incentives for meeting benchmarks and improving outcomes; and creating opportunities to provide health care services beyond the clinic walls, such as outreach to local schools or by partnering with community groups and religious organizations.⁴⁷

Patient experience surveys or setting up a patient council may also provide useful input toward redesigning clinical practices to be more accessible and responsive to patient needs.⁴⁸ Particularly isolated and hard-to-reach patients may require even more integrated and proactive approaches (i.e., assertive outreach, patient tracking and individual case managers).⁴⁹ Such actions can be further supported by health systems: for example, the Quebec Health Insurance Plan pays primary care physicians a small financial stipend for the care of vulnerable patients to promote quality care and compensate for the heavier case mix.⁵⁰

Integrating patient social support navigators into the primary care team

Several clinical practices have published evaluations of the effectiveness of hiring dedicated

facilitators or patient navigators to help patients access support services more easily. For example, a pilot project (COMPASS) commissioned by the National Health Service Greater Glasgow and Clyde (Scotland) showed how the primary care setting provided a “safe space” for identifying chronically unemployed patients who had multiple barriers to finding a job.⁵¹ Having an employment consultant who worked with patients at their own pace and “spoke their language” resulted in full-time paid employment for 57 of 117 patients, a 53.6% improvement in perceived health and a 25% reduction in repeat visits to primary care and in medication requirements for depression and addictions.

Although hiring patient navigators has cost implications, alternate models exist, such as task shifting and sharing among existing members of the care team, or the Health Leads model in the United States⁵² and the Basics for Health Society model in Canada,⁵³ which instead rely on trained volunteers who are located in clinic waiting rooms to assist patients in “filling social prescriptions” and navigating often complex and fractured support pathways.

What can be done at the community level?

Physicians need not confine their activities to the clinic or hospital but can also serve as effective health advocates and valuable resources for the community.⁵⁴

Partnerships with community groups, public health and local leaders

Improving individual and population health requires partnerships and intersectoral action to engage other sectors (e.g., education, justice and employment) in creating healthier environments.⁵⁵ There is a growing interest in “clinical–community relationships” to create multistakeholder, community-wide collaborative initiatives that can have far-reaching effects (e.g., offering low-cost daycare and early childhood education opportunities, introducing violence prevention programs in schools, increasing the number of parks and green spaces, banning soda-vending machines, creating bicycle lanes or introducing farmer’s markets to combat food deserts).^{56,57} The earlier and more substantively that physicians engage local leaders and other partners, the more pronounced the impact.⁵⁸ This can often be facilitated with the help of partners in public health who are already actively engaged in addressing social determinants through a growing number of community-based interventions for promoting health equity,⁵⁹ as well as community groups who are aware of what is happening

locally. Developing a common language and a shared understanding is important for establishing such collaborations.⁶⁰

Using clinical experience and research evidence to advocate for social change

Physicians, as well as medical students⁶¹ and other allied health professionals, have a powerful voice and can speak about the health impacts of social challenges to encourage broader policy responses and influence what gets onto local agendas.⁶² Physicians can engage in activism by supporting social movements and political parties that advocate for basic income, affordable child care, progressive taxation and other measures to reduce health disparities.⁶³ They can conduct locally relevant research and use social determinants data to better intervene in their own context and generate evidence as a lever for advocacy.⁶⁴ They can create their own organizations to defend humanitarian causes ranging from refugee care to climate change,⁶⁵ and they can ensure that the health system is “part of the solution,” for instance, by purchasing surgical instruments that are not produced using child labour or by challenging patent laws that restrict access to life-saving medicines for the world’s poor.⁶⁶

Getting involved in community needs assessment and health planning

Community-oriented primary care is the “integration of public health practice with the delivery of primary care services” with the aim of improving the health of a defined population.⁶⁷ Community-oriented primary care is a form of “community diagnosis” and “community treatment” blended with clinical patient care that has a long history⁶⁸ and continues to inspire innovative approaches to support disadvantaged patient groups.⁶⁹ In a study involving a cohort of over 1000 disadvantaged patients in San Antonio, Texas, a community-oriented primary care approach using health promoters acting as cultural brokers between patients and physicians, as well as helping to map out, mobilize and connect patients with resources in the local community, resulted in a 24% decrease in admissions to hospital and a cost savings of over US\$250 000 per year.⁷⁰

Community engagement, empowerment and changing social norms

Engagement and empowerment of the local community is needed to tackle deeply rooted challenges that become engrained in the social norm. For instance, violence against women can often be quite widespread and can become the “new normal” in some contexts, particularly

when the perpetrators themselves were abused and lack power in various domains of their life, which creates a cycle of harm.⁷¹ However, physicians and allied health workers can serve as important catalysts for change to spark community-level shifts in ways of thinking and acting by initiating a dialogue and helping identify local solutions.^{72,73} Community engagement is an ongoing process to “create opportunities for community voice and action to affect social and structural conditions that are known to have wide-ranging health effects on communities.”⁷⁴ Even the clinical setting can become infiltrated by broader social prejudices, such as structural racism against Indigenous peoples.⁷⁵ Yet, self-reflexivity about one’s own biases and stereotypes is a core skill that can be learned and an important starting point in the development of culturally safe relationships.⁷⁶

According to the recently released calls to action by the Truth and Reconciliation Commission in Canada,⁷⁷ cultural competency training should be provided for all health workers.⁷⁸ Physicians need to combine introspection with strategic thinking to move the health agenda forward. McKnight, in his seminal article on politicizing health care in 1978, wrote about health workers empowering communities to deal one by one with their pressing issues, from rounding up stray dogs, to lobbying local politicians to get better traffic controls and building greenhouses to grow fresh vegetables.⁷⁹ Today, such activities lead not only to improved health for marginalized and underserved groups but also to more cohesive and healthier communities.⁸⁰

What are the barriers to action and how can these be overcome?

Although physicians and allied health workers can take action at various levels, this review also identified multiple barriers to adopting a social determinants of health approach in clinical practice (Table 1). They include low perceived self-efficacy of health care workers, lack of training and role modelling, and the absence of communities of practice to bring together like-minded health professionals who can share their experiences and find support in helping disadvantaged patients with their challenges.⁸¹ Nonetheless, many of these barriers can be overcome.

Reminders and participatory approaches to go beyond the medical-model bias

Western medical culture is traditionally focused on disease management and “quick fixes” that “medicalise society’s problems” rather than

adopting a more biopsychosocial approach.⁸² Chart reminder and recall systems to flag patients at risk can be useful in triggering more holistic care. Participatory approaches that engage primary health care providers have also been helpful in creating a culture of reflection and “shifting work practice more upstream.”⁸³

Treating patients with dignity and respect and creating safe spaces for disclosure

Being open to different cultural backgrounds and avoiding stereotyping by understanding that the individual variation within groups is often more pronounced than the variation between groups⁸⁴ is important for developing the relationship of trust required to help patients disclose often sensitive and personal social challenges and to work with them in finding solutions.

A little extra time per consultation to address complex health and social needs

Although physicians are often overstretched and short on time, and fear the “Pandora’s box effect” of delving into social challenges, increasing the consultation time by even two or three minutes when dealing with complex cases can improve anticipatory and coordinated care, decrease the stress of health care workers and improve patient enablement.⁸⁵

Knowing about local referral resources for specific social challenges

Physicians often lack sufficient knowledge of problem-specific referral resources in their local community to address issues such as income insecurity, housing problems or domestic violence.⁸⁶ Access to a “well-maintained, locally relevant, and user friendly internet directory of community resources for use by practitioners” is considered a major enabling factor in helping frontline health care workers to better support their patients.⁸⁷

Resources, training and ongoing support of health care workers

Increasingly, there is a growing emphasis on the social accountability of medical schools and other institutions responsible for training health professionals to better serve disadvantaged patients.^{88,89} There are a growing number of examples of training programs that have improved attitudes, skills and competencies in addressing social determinants:⁹⁰⁻⁹² a community tour for medical students to better understand the population they serve,⁹³ a video curriculum to increase screening and referral for domestic violence by pediatric residents⁹⁴ and a practicum with underserved patient groups.⁹⁵ In the absence of such training, health care workers can get by using experiential learning,⁹⁶ but clinical practice tools and training are important facilitators, particularly if the intention is to create a widespread culture change in the way health care workers practise.

Which clinical tools help with social determinants in practice?

Box 2 provides links to some clinical practice tools that can help physicians and allied health care workers improve their performance in identifying and taking action on the root causes of poor health. For example, the CLEAR (Community Links Evidence to Action Research) toolkit was developed by an international collaboration of researchers and policy-makers to help health care workers assess different aspects of patient vulnerability in a contextually appropriate and caring way, and easily identify key referral resources in their local area.⁹⁷ The poverty toolkit, originally developed by Dr. Gary Bloch and colleagues (St. Michael’s Hospital, Toronto, Ont.) helps physicians to screen for low income and to assist patients in accessing various social benefits and tax transfers to which they are entitled in their province.⁹⁸

Table 1: Overcoming barriers to adopting a social determinants of health approach in clinical practice

Barrier	Facilitator
Medical model bias and the treatment imperative in health care	Health care provider reminder and recall systems to adopt a more holistic and biopsychosocial approach
Patients who experienced prior stereotyping and discrimination in clinical care	Treating patients with dignity and respect and creating “safe spaces” for disclosure
Physicians feeling overwhelmed, overworked and lacking time	Taking a few extra minutes per consultation to address complex health and social needs
Physicians not knowing what resources exist in the local community	Providing a mapping of benefits and local referral resources for specific social challenges
Physicians unsure of what concrete actions to take to address social determinants	Resources, training and ongoing support of physicians and allied health care workers

The increasing number of publications in this area shows how training and clinical practice tools are changing physician knowledge, attitudes and skills to support patients better, engage communities and advocate for social change. A key element is the local adaptation

process, whereby educators of health professionals map out local resources and decide upon the best strategies for soliciting information and supporting patients to provide physicians with locally relevant guidance to address social challenges. Another important element is

Box 2: Physician resources

Clinical decision aid to help physicians adopt a social determinants of health approach in everyday practice:

- The CLEAR toolkit: helping health workers address the social causes of poor health (www.mcgill.ca/clear/download)

Clinical practice guidelines and tools relating to specific populations:

- *People from diverse backgrounds*: Culturally effective care toolkit (<https://www.aap.org/en-us/professional-resources/practice-support/Patient-Management/pages/Culturally-Effective-Care-Toolkit.aspx>)
- *Indigenous persons*: Health professionals working with First Nations, Inuit, and Métis consensus guideline (<http://sogc.org/wp-content/uploads/2013/06/gui293CPG1306E.pdf>)
- *Immigrants and refugees*: Evidence-based clinical guidelines for immigrants and refugees (www.cmaj.ca/content/183/12/E824)
- *Gay, lesbian, bisexual or transgender (GLBT) youth*: Practice parameter on GLBT children and adolescents ([www.jaacap.com/article/S0890-8567\(12\)00500-X/pdf](http://www.jaacap.com/article/S0890-8567(12)00500-X/pdf))
- *Adolescents who are pregnant*: Adolescent pregnancy guidelines (<http://sogc.org/wp-content/uploads/2015/08/gui327CPG1508E.pdf>)
- *People with developmental disabilities*: Primary care of adults with developmental disabilities (www.cfp.ca/content/57/5/541.full.pdf and <http://www.cfp.ca/content/57/5/541.full.html>)

Clinical practice guidelines and tools relating to specific areas of action on social determinants:

- *Poverty*: Poverty: a clinical tool for primary care (<http://ocfp.on.ca/cpd/povertytool> [Ontario], http://cqmf.qc.ca/wp-content/uploads/2016/04/CQMF-Outil-LaPauvrete_Final.pdf [Quebec], www.gov.mb.ca/health/primarycare/providers/docs/clinicaltool.pdf [Manitoba]), Poverty intervention tool (<https://www.divisionsbc.ca/CMSMedia/WebPageRevisions/PageRev-3526/BC-Poverty-2015-Final.pdf> [British Columbia])
- *Food insecurity*: Individual and household food insecurity in Canada: position of dietitians in Canada (www.dietitians.ca/Downloads/Public/householdfoodsec-position-paper.aspx)
- *Housing instability*: General recommendations for the care of homeless patients (www.nhchc.org/wp-content/uploads/2011/09/GenRecsHomeless2010.pdf)
- *Substandard housing*: Excess winter deaths and illness and health risks associated with cold homes (<https://www.nice.org.uk/guidance/ng6>)
- *Mental health problems*: Common mental health problems: identification and pathways to care (<https://www.nice.org.uk/guidance/cg123>)
- *Alcohol misuse*: Problem drinking Part 1 — screening and assessment (http://www2.gov.bc.ca/assets/gov/health/practitioner-pro/bc-guidelines/problem_drinking.pdf)
- *Drug misuse and dependence*: Drug misuse in over 16s: psychosocial interventions (<https://www.nice.org.uk/guidance/cg51>)
- *Child maltreatment*: Child maltreatment: when to suspect maltreatment in under 18s (<https://www.nice.org.uk/guidance/cg89>)
- *Intimate partner violence*: Intimate partner violence consensus statement (<http://sogc.org/guidelines/intimate-partner-violence-consensus-statement/>)
- *Abuse of older adults*: Preventing and addressing abuse and neglect of older adults (http://rnao.ca/sites/rnao-ca/files/Preventing_Abuse_and_Neglect_of_Older_Adults_English_WEB.pdf)

Evidence and guidance for physicians in promoting broader action to create supportive environments for health:

- *Local action on health inequalities*: evidence papers (<https://www.gov.uk/government/publications/local-action-on-health-inequalities-evidence-papers>)
- *Promoting health equity*: community guide systematic reviews (www.thecommunityguide.org/healthequity/index.html)
- *A resource to help communities address social determinants of health*: (www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf)
- THRIVE: Community tool for health and resilience in vulnerable environments (www.preventioninstitute.org/component/jlibrary/article/id-96/127.html)

the need for rigorous implementation and evaluation research⁹⁹ to determine whether and how these clinical practice tools affect outcomes that matter most to patients, such as perceived mental and physical health, vulnerability to stress, social support, individual agency and sense of control over life decisions.

Conclusion

Although addressing the social determinants of health requires a broad range of actions that involve collaboration of multiple sectors (e.g., education, justice and employment) and local, provincial and federal levels of government,¹⁰⁰ physicians and other allied health care workers at the frontlines of clinical care are nonetheless important players and potential catalysts of change. They are well-positioned to support their patients in dealing with their social challenges; raise awareness of the human cost and suffering that results from poverty, discrimination, violence and social exclusion; and advocate for better living conditions to reduce health inequities and for more responsive health and social systems to care for those in need. Missed opportunities for prevention and inequitable access to care have been identified as major factors leading to inefficiencies in the health system.¹⁰¹ Therefore, leaders in Canadian health care increasingly recognize the need for a social determinants and population health approach “in reducing healthcare demand and contributing to health system sustainability.”¹⁰² Physicians are encouraged to implement their own creative solutions in their local context, measure the impact and share their successes in this important area of practice.

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Contributors: Anne Andermann drafted and revised the manuscript, approved the final version to be published and agreed to act as guarantor of the work.

Funding: The project is supported by Grand Challenges Canada, Canadian Institutes for Health Research, Fonds de recherche du Québec – Santé, Fédération des médecins spécialistes du Québec and St. Mary's Research Centre, Montréal, Que.

Acknowledgements: The author thanks Grand Challenges Canada, Canadian Institutes for Health Research, Fonds de la recherche du Québec-Santé, Fédération des médecins spécialistes du Québec and St. Mary's Research Centre, Montréal, for funding this work. The author also acknowledges Ali Okhowat, Gilbert Velasquez and Sonali Srivastava for contributing to the literature search, data extraction and preliminary thematic analysis. The author dedicates this article to the first-year medical students whom she teaches in their first month of medical school during a course called "Improving Health: From Molecules to Global Health." Finally, the author is grateful to the members of the Community Links Evidence to Action Research (CLEAR) collaboration for their ongoing support of this program of research (www.mcgill.ca/clear/about).