EDUCATIONAL GUIDE

TRAINING HEALTH PROFESSIONALS: ACHIEVING HEALTH EQUITY AGENDA IN NONCOMMUNICABLE DISEASES

December 2017
INTRODUCTION

This guidance is a training support for health workers in order to firstly, raise awareness about inequities in risk and prevalence of Noncommunicable Diseases (NCDs) and secondly to describe the role of health workers in tackling inequalities in risk of NCDs through action on the social determinants.

The document describes actions health professionals can take, presenting specific case studies from different contexts around the world.
The Social Determinants of Health (SDH) - the conditions in which people are born, grow, live, work and age have a profound impact on health and inequalities in these conditions lead to inequalities in health [1]. Health workers play an important role in addressing inequities in risks of NCDs through action on social determinants. As the UCL Institute of Health Equity and the World Medical Association (WMA) showed, there are many possible and effective actions which could be undertaken to tackle inequalities in risk and prevalence of NCDs [2].

As Figure 1 illustrates, the following six actions have been identified through which health workers could contribute:

1. Improving education and training
2. Building the evidence
3. Working with and for individuals and communities
4. Enhancing healthcare organizations
5. Working in partnership
6. Advocating for change

Figure 1. Guidelines for doctors in tackling health inequalities [2].
1. IMPROVING EDUCATION AND TRAINING

Undergraduate and postgraduate education could include social determinants of health as a mandatory topic and could provide specific practice-based skills such as communication, partnership and advocacy. Moreover, student placements in a range of health and non-health organisations could be included in the course.

Additionally, Continued Professional Development for health professionals should broaden knowledge and expertise about the social determinants of health and NCDs, and describe and require capacity and skills to tackle these. In this regard, online courses can represent an effective way to reach a great number of health professionals improving their knowledge on SDH [3] [4].

Considering ways to address the training of health professionals in tackling health inequality, it is possible to follow the four Cs, elaborated in the Commission on the Education of Health Professionals for the 21st Century.

- **Criteria for admission**: equity in admissions, ensuring that health workers represent the communities for which they are working.
- **Competencies**: training on competences needed to tackle the SDH, such as communication, partnership and advocacy skills.
- **Channels**: mobilising different learning channels to their full potential to reach as many people as possible and to develop skills.
- **Career pathways**: developing concepts of social justice and social agency.

**HEALTH WORKERS CAN:**
- Educate themselves and colleagues on what the SDH are and how to tackle them
- Promote and advocate for the SDH approach inclusion in education and training
- Ensure that SDH is a required component of progression as managers and teachers
- Advocate for a greater focus on the SDH in practice and education for all health professionals

**Box 1: Case study on incorporating environmental determinants of health into medical training and linking research to training and practice, University of Cape Town, South Africa [5]**

The University of Cape Town employs a novel case study to teach medical students of the importance of doctors engaging in wider determinants of health; in this case, the use of pesticides. Many low socioeconomic communities face large burdens from domestic pests,
common in many developing countries, leading to the wide use of pesticides sold in unregulated markets. As a result, childhood pesticide poisoning due to the presence of toxic chemicals used for domestic vermin control is a common but unreported problem.

Research in the Division of Environmental Health in the School of Public Health and Family at the University of Cape Town found that intervening by providing informal vendors to replace the highly toxic pesticides sold illegally on the streets with mechanical rat traps was effective in reducing small children’s exposure to chemicals and was well received by township residents as a safer pest control method. Linked to this research was the development of a point chart and cell phone app to assist in the identification of pesticide agents, improve diagnosis and enhance reporting for surveillance purposes. This research is used in teaching to illustrate how important environmental determinants of health are for students in the health professions. This includes:

- Medical students learning to identify and list the environmental exposure risks relevant for patients’ socioeconomic status.
- Training all medical students on how to conduct an ‘environmental history’ with patients as part of their diagnostic screening tools, particularly using the mnemonic CH2OPD2 – community, home, hobbies, occupation, personal habits, diet, and drugs [6].
- Improving the notification of medical notifiable conditions linked to environmental factors by training students to identify and link environmental linked diseases.
- Training medical students to identify pesticide exposures and poisonings, particularly linked to products that are unlabelled and decanted [7].
- Participating in 2015 and 2016 in an International Association for Medical Education (AMME) symposium on building environmentally accountable curriculums for medical students and medical schools.
- Providing medical students with an understanding of climate change impacts on health, opportunities for improving health through climate change mitigation measures, and illustrating the active role

2. BUILDING THE EVIDENCE

Building evidence though international, national and locally disaggregated data to design services. These systems should incorporate health outcomes such as life expectancy and morbidity with wider society level data that are known to impact on health, for example, socio-economic status, housing situation, employment, education, ethnicity and levels of social protection available.

These national and local level data can help health workers to develop appropriate strategies and actions to prioritise and deliver actions proportionate to levels of need. At the hospital
level, collecting data on SDHs enables hospitals to concentrate resources where on local areas
and communities where they are needed most.

HEALTH WORKERS CAN:
• Develop social histories of patients
• Request training in monitoring and evaluation at all levels of education
• Share experiences with other social and healthcare professionals
• Take in consideration the information obtained from monitoring systems

Box 2: Case study: Dutch National Survey of General Practice [8]

The Dutch Ministry of Health has conducted a series of National Surveys of General Practice
(DNSGP1 and DNSGP-2) to monitor public health and health inequalities in the Netherlands
through general practice. In the Dutch healthcare system almost all Dutch residents are
registered with a GP, who are based in communities, and the accessibility of general
practice is considered to be good.

The data collected includes background information on patients collected via a census,
approximately 12,000 health interview surveys per time point and more than one million
recorded contacts of patients with their GPs in two survey years. The results clearly showed
that while low educational attainment played no part in presenting health problems to the
GP in the Netherlands, it was associated with the development of chronic conditions and
self-reports of good health. This was particularly evident for diabetes and myocardial
infarction.

3. WORKING WITH AND FOR INDIVIDUALS AND COMMUNITIES

Working with and for individuals and communities by building relationships of trust and
respect with patients is crucial. The relationship between patient and health worker is a
fundamental element of healthcare. Health workers should be able to spend enough time for
the adaptation of the consultation to the different needs of patients. The partnership
approach in consultation should be promoted providing other professionals and services
available to patients. Health workers should be taught effective techniques to motivate
patients and co-create care or pathway plans, especially in NCD prevention and control.

Taking a complete social history of the patient is central and it should incorporate more
detailed questions in these six categories: individual characteristics, life circumstances,
emotional health, perceptions of healthcare, health-related behaviours and access to and
utilisation of health care [9]. Social history is also related to social prescription, which is relevant to identify and support non-clinical needs of patients which impact on their health, and to refer them to appropriate non-clinical support in the community.

At community level, health workers should create networks in neighbourhoods. Evidence demonstrates that community and neighbourhood-level interventions can generally improve health outcomes, particularly for disadvantaged groups [10]. At the same time it is also important to involve organisations from beyond the health service such as social enterprises and voluntary organisations, which contribute to the effectiveness of the programme [11].

### Box 3: Case study on Rotherham social prescribing, UK [12] [13]

The Rotherham Social Prescribing Service helps people with long-term health conditions to access a wide variety of services and activities provided by voluntary organisations and community groups in the town. GPs lead case management teams and are responsible for identifying patients who are eligible for the scheme. This model includes Voluntary and Community Sector Advisors (VCSAs) who receive referrals from 28 GP practices in

### WITH PATIENTS HEALTH WORKERS CAN:
- Provide culturally appropriate care
- Take social histories of patients and incorporate this information into discussions and decisions about patient’s treatment.
- Design the clinic around the needs of the patient
- Advocate individually on behalf of patients and their families contacting services
- Examine their own prejudices, as these might impact on assumptions they make about patients

### WITH COMMUNITIES HEALTH WORKERS CAN:
- Make social prescribing to local services available
- Linking patients to supportive community programmes or, if it is not available, request provision of information about community support organisations and discuss with patients
- Act as local community employer involving local professionals and other employees from the local area.
- Use positions of influence and trust to improve the social and economic and environmental conditions of the community and reduce health inequalities in the local area
- Conduct community engagement demonstrating that together with healthcare professionals, all are part of the community
Rotherham. Patients’ progress towards social outcomes is measured through an ‘outcomes star’ style tool developed specifically for the service. Outcomes stars are a family of tools that aim to promote and measure behaviour change, and are used in a variety of contexts when working with vulnerable people [14].

Initial analysis of this data by Sheffield Hallam University shows that patients are making positive progress: 78% made progress on at least one outcome after six months. The most common types of services that have been accessed are community-based activities, information and advice, befriending and community transport. Six months after the referral system was initiated, Accident and Emergency attendances declined by 21%, hospital admissions by 9% and outpatient appointments by 29%. Although it is not possible to directly attribute this change to the social prescribing intervention.

4. ENHANCING HEALTHCARE ORGANISATIONS

Employer, manager and commissioner of healthcare services play a key role in tackling health inequities and in reducing risk and prevalence of NCDs. This should be done through improved equitable recruitment and good quality work conditions throughout health care organisations. It is important to ensure that everyone has an opportunity to access these jobs, particularly people from disadvantaged backgrounds, impacting positively in deprived communities and reducing risk of ill health.

HEALTH WORKERS CAN:
• As commissioners: look for more than just medical care when commissioning healthcare services, focusing on improving the social conditions of local areas
• As support staff: advocate for good quality of all works, including volunteers
• As managers of hospitals: include patients’ socioeconomic position, living conditions and complexity as a component of ward budgets; have the goal of health equity at all levels; develop expert clinics for vulnerable people; ensure an active occupational health policy
• As community members as well as medical practitioners: get involved in local outreach

Box 4: Case study on Transitioning the Long-term unemployed into allied health careers, North Carolina, USA [15].

In 2011, a multiagency partnership was set up in North Carolina, USA, to address the relatively high long-term unemployment rate of 9%, half of whom were unable to secure a job within six months of being registered unemployed. While the job market was relatively
stagnant generally, with a small growth rate of 3%, healthcare jobs increased by 46%, presenting an opportunity to reduce unemployment.

To identify the challenges that the long-term unemployed in rural communities may experience as they navigate the career pathway of allied health professionals, a range of stakeholders were interviewed. These stakeholders included healthcare employers, community colleges, workforce development boards, social services, funders and the long-term unemployed that live in rural communities. The challenges identified centred around four key areas: career guidance, limited resources, individual support and employer collaboration or ‘buy in’.

As of March 2015, over 205 unemployed people were assessed, enrolled into training and supported to continue training. Services include career counselling, academic/training vouchers, books, uniforms, immunisations, transportation and professional development. Projections suggest that 25% or more will gain employment upon successful workforce training. Human Resource Development departments at community colleges have the ability to sustain the recruitment and implementation beyond the funding cycle of the project.

5. WORKING IN PARTNERSHIP

Working in partnership - promoting collaborations inside and outside health services - is essential to address SDH. Partnerships should be promoted with different sectors, such as the third sector, and at different geographic levels:

-locally: with community leaders and non-health care sectors, reaching populations and creating a culture which supports good health.

-nationally: promoting Health in All Policy (HiAP) approach which impact of cross sector national, local and international policies on the health of the population and health equity. The HiAP approach also aims to improve accountability of policymakers in all sectors for health and health equity.

-globally: by international actors such as WHO and WMA or international health professional, patient and student organisations.

HEALTH WORKERS CAN:
- Work with health and non-health sector workers in order to develop networks based on empowering patients and communities
- Share good experiences of what works in tackling health inequities
- Encourage within health sector the development of partnerships with other areas
Health services are often the only government sector routinely making contact with children aged under 3 years in Jamaica, and in many low and middle income countries. Therefore, integrating early-years interventions into healthcare services is a relatively cost-effective way to promote health equity and improve conditions in the early years. The Tropical Metabolism Research Unit of the University Hospital of the West Indies established the Malnourished Children’s Programme in Jamaica in 1994 after hospital personnel noted that many children admitted with malnourishment who recovered and were sent home had to be readmitted for the same condition after a short time. A number of interventions such as nutritional supplements, psychosocial stimulation, and mother and family support have been evaluated in isolation and in combination since then. The results demonstrate that biomedical interventions such as nutritional supplements were far more effective when combined with broader psychosocial interventions and family support. This points for the need to integrate a broader focus on early years than the traditional biomedical focus of health services.

Home visits are organised after the child is discharged from the hospital with the aim of identifying specific and interconnected social determinants of children’s health and that of their family. Paraprofessional health staff (health aides) deliver the intervention in addition to their usual duties. Staff focus on stimulation, environmental factors and nutritional status of children. They also work to increase the economic stability of families. Parents are enrolled in a weekly parental education programme and social welfare project. They are supported to develop income-generating skills, find jobs and shelter. They make job referrals and sponsor parents to take advantage of skills training opportunities. Food packages, bedding and clothing for needy, unemployed parents are provided. A community outreach programme has been developed in three locations in poor areas with high prevalence of malnutrition. The programme includes psychosocial stimulation of children up to age 3, and a mobile toy-library.

Evaluations of interventions revealed a number of important findings. Interventions that included nutritional rehabilitation alone were shown to be insufficient to reduce malnourished children’s developmental deficit, demonstrating that medical and nutritional care are not sufficient to reduce the long-term effects of this health inequity. When this was combined with home visits that included a play programme with the aim of promoting mother–child interaction and self-esteem, over a three-year period, malnourished children were shown to catch up to the nourished group after 24 months. While this dipped once the intervention finished, it remained substantially above the malnourished control group. Mothers in the intervention group had improved knowledge of child-rearing and reductions in depressive symptoms. A 22-year follow-up study demonstrated benefits through to adulthood in areas such as cognition, educational attainment, mental health and reduced violent behaviour [17]. The group’s research has also demonstrated that it is feasible and effective to integrate the interventions into...
primary care services with benefits to children’s development and mothers’ child-rearing knowledge and practices [18].

6. ADVOCATING

Health workers should undertake advocacy related to improving SDH and reducing inequalities in SDH in different contexts. Considering their specific skills and experiences as well as their trusted due to health provision, all health professionals can contribute in advocating for the SDH.

In the health sector advocacy should include acting for patients and their families to support their social, economic and environmental conditions and promote a greater focus on the SDH in practice and education.

In the other sectors, advocating all level of policies (local, national and international) which seek to improve social and economic conditions and reduce inequalities.

HEALTH WORKERS CAN:
• Use evidence to demonstrate the role of SDH and to promote their inclusion in policymaking
• Advocate for SDH to be more fully incorporated in medical education, in local community and in practice with individual patients
• Insist on their member organisations undertaking advocacy on SDH at national level
• Provide materials to inform advocacy, including case studies
• Advocate on behalf of individual patients and for improvements in relation to improving local and community environmental, economic and social conditions

Box 6: Case study on Medical Organisations advocating for policy change, Spain

Sociedad Española de Medicina de Familia y Comunitaria – semFYC (the Spanish Society for Family and Community Medicine) and Médicos del Mundo – MdM (Doctors of the World, Spain). On 20 April 2012 the Royal Decree-Law 16/2012 was passed in Spain, which led to the exclusion of undocumented migrants from access to healthcare; tied healthcare coverage to employment status; and increased out-of-pocket charges for medication. The only remaining point of entry for many people was through hospital accident and emergency services, which mean that, increasingly, people with diseases and those who were victims of violence were not identified and given the necessary care and treatment.
Excluding vulnerable groups from access to healthcare will increase health inequity and have an effect on the whole of the population. Some experts have already predicted that, as a result of denial of access to healthcare and medications for about 2% of the population in Spain, there will be an increase of communicable diseases such as HIV and tuberculosis in the population as a whole. Other experts warned of the probability of an increase in mental health problems, including cases of suicide. Many human rights groups, including Amnesty International, have said that the law breaks many existing international acts.

In 2012 the Derecho a Curar (Right to Care) campaign was launched by semFYC, MdM and other organisations involved in primary and specialist health services, as well as a range of social sector organisations and European networks engaged in defending migrants’ rights. Various promotional materials were made available online to provide publicity for the campaign, disseminate information and enable health professionals and the general public to support the campaign. These included posters, videos, car stickers and widgets (an application to embed third party sites onto your webpage or social media account). A number of campaign videos were made and had been viewed by over 253,000 people in a few months. When the protest campaign against the law was relaunched in the social media in summer 2013, with the video series using the hashtag #leyesquematan (laws that kill), it became a trending topic on Twitter. In 2013, the Nadie Desechado campaign revealed how the healthcare reform, announced as affecting ‘only’ migrants, also excludes all of society’s most vulnerable groups from the healthcare system, in particular people with chronic health conditions. Tens of thousands of signatures in support of the campaign were collected.

MdM has promoted the establishment of ‘observatories’ to document as accurately as possible cases encountered and barriers to accessing healthcare and so far has recorded more than 1,000 cases of violation of the right to health care. Its reports have been submitted to the Health Commission of the Congress of Deputies and to the Ombudsman. MdM and semFYC urged health workers to resist and to object to the law on grounds of conscience, and to continue to treat all people in need of healthcare, regardless of their administrative status. During the first phase of the campaign, more than 2,000 health professionals formally declared their refusal to implement the exclusions required under law. In addition, 19,000 signatures were collected in support of a letter submitted to the Minister of Health at the beginning of January 2014. A number of regions, such as Andalusia and Catalonia, kept providing healthcare to illegal immigrants.

In March 2015, just before a general election, Spain’s government overturned the law [19]. The Prime Minister Rajoy cited rationale from the campaign when explaining the change in policy: “It seems more sensible and more reasonable for primary healthcare to be carried out in health centres so that, among other things, emergency centres are not overwhelmed” [20].
CLOSING REMARKS

The illustrated areas of action are all fundamental for health workers. Each health profession can be involved in tackling health inequities in NCDs. In England, for example, the UCL Institute of Health Equity collaborated with 19 different health professions organizations in order to develop statements for action (http://www.instituteofhealthequity.org/resources-reports/working-for-health-equity-the-role-of-health-professionals) [21]. Each Statement has been written by a Royal College, equivalent professional organisation, or other subject such as Medsin for medical students. They aim to provide detailed information about social determinants for specific professions and include practical actions with the specific rationale for actions and some case studies.

There are statements for each of the following professional groups:

- Nurses
- Social workers and social care
- Clinical Commissioning Groups
- General practitioners
- Paediatricians
- Midwives
- Obstetricians and gynaecologists
- Hospital doctors
- Dentists and oral health teams
- Psychiatrists
- Medical students
- Allied health professionals
- Music therapists
- Dieticians
- Occupational therapists
- Physiotherapists
- Speech and language therapists
- Paramedics
- Radiographers

These Statements demonstrate that is possible to make the difference in tackling health inequities through action across a broad range of health workers. Each health profession should play its role in reducing inequalities affecting NCDs.
REFERENCES


