Social accountability at the macro level

Framing the big picture

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This is the final of 4 articles on social accountability in family medicine and the role of family doctors in advocating for health equity. Previously, we described the scope of social accountability,[1] actions that can be taken at the micro level to address the needs of individual patients or families,[2] and work that can be done at the meso level to advocate for better health at the level of a specific practice population or geographic community.[3]

These articles described how taking the social determinants of health into account can lead to actions at micro and meso levels that make a difference in the lives of our patients. However, many of the circumstances that have the biggest influence on health outcomes—income, education, employment, housing, food security, and the wider environment—are themselves influenced by policies set at the provincial, federal, or international levels. Consequently, if our primary goal is the best health for our patients, we need to think about the health of society and use the power of the physician voice to create positive political and systemic change.

The physician role in achieving greater health equity has been the subject of much discussion in recent years. In 2012, the Canadian Medical Association (CMA) interviewed doctors across Canada and released the report *Physicians and Health Equity: Opportunities for Practice,*[4] describing some of the factors that serve as barriers and facilitators to physician involvement in advocacy on the social determinants of health. The CMA also held town hall meetings that led to the 2013 report *Health Care in Canada: What Makes Us Sick?* that includes various recommendations relating to the social determinants of health, such as income, housing, food security, aboriginal health, and early childhood development.[5] In 2013, following the presidency of Sir Michael Marmot, the British Medical Association produced the report *Social Determinants of Health—What Doctors Can Do*[6] to give guidance on how physicians could respond to health inequities in the United Kingdom. The 2015 *Best Advice Guide: Social Determinants of Health* by the College of Family Physicians of Canada (CFPC)[7] sought to translate these higher-level concepts into a practical approach for family doctors to take action for health equity.

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These efforts might, at first glance, seem a difficult fit with the traditional role of physicians. Our primary responsibility is to serve individuals and families and to identify and address their immediate health needs. However, if our real goal is optimal health for our patients, our duty of care extends to advocacy for the social well-being that determines their health concerns.

What can physicians do to have an effect at a higher level? How can we take what we witness in clinic and use it to advocate for social change?

Taking action

Our position as family physicians affords us a number of advantages in advocacy. We are trained to understand evidence, giving us a background to recognize and develop cogent arguments for effective policy. More important, we are connected with people. We are exposed to the struggles of patients who experience the downstream effects of unhealthy public policy, and we can bear witness to their stories. Our professional role, and the privileged status that accompanies it, provides us with a voice that will be heard. Physicians' collective voice is consistently one of those most trusted by the Canadian public,[8] and more so when that voice is used to advocate on behalf of patients rather than for our own interests. The following is a menu of actions that family doctors can take to have more influence on health policy, as described in the CFPC Best Advice guide.[7]

Join or create an organization to advocate both with and on behalf of communities. There are many recent examples of successful macro-level advocacy by physician organizations. Canadian Doctors for Refugee Care[9] is a striking example, as its varied efforts, from street activism to court challenges, led to the reversal of cuts to the Interim Federal Health Program, which provides health care coverage for refugees and refugee claimants in Canada. Canadian Doctors for Medicare has established itself as a leading voice in championing a high-quality universal health care system and has been instrumental in bringing the idea of pharmacare to a national stage.[10]

The voice of physicians can also be influential on issues less obviously related to health care; for example, the Canadian Association of Physicians for the Environment lent credible expertise on health effects to the successful effort to see coal phased out of power production in Ontario and Alberta.[11]

For individual physicians, supporting organizations such as these is an excellent way to contribute to, as well as to learn skills from those experienced in, macro-level advocacy.

Engage with medical, health care, and social service organizations to provide organizational advocacy for improved social determinants of health. Our professional organizations are influential among policy makers and among physicians. Subgroups like the Poverty and Health Committee of the Ontario College of Family Physicians or the Social Accountability Working Group (of which the authors for this series are members) of the CFPC can help to organize these representative bodies to put greater emphasis on the role of the profession in macro advocacy.[12] The aforementioned campaign on refugee health was aided considerably by the support of professional organizations, including the CMA, the Royal College of Physicians and Surgeons of Canada, and the CFPC. Individual members can also make their concerns known to the leadership of such organizations, which exist to represent our concerns.

Advocate for remuneration arrangements and funding that incentivizes addressing social determinants of health care. There is some danger in this recommendation, as it brings the issue back to what could appear to be a self-serving advocacy role. However, recognizing that certain models of payment and practice allow for more time and support for advocacy is essential to creating that space. Such advocacy must be tied to the desire to design remuneration in ways that incentivize the best practice for patients. In that context, it can be an important place for physicians to speak up for a better system as a means to facilitate care for underserved populations and patients with complex needs.

Collaborate with other organizations to establish broad intersectoral support for healthy public policies that address upstream determinants of health. The voice of physicians can also support the work of partner campaigns and organizations. One example is Upstream, a national organization dedicated to reframing political discourse around the social determinants of health (**www.thinkupstream.net**).[13] While not an organization of physicians, it uses the voice of health care providers and the stories of patients to make the case for policy changes that will improve health outcomes, and the voice and experience of physicians is key to that message.

The voice of physicians has been influential in support of campaigns on specific issues such as paid sick days[14] or raising the minimum wage.[15] One example is the recent decision by the Ontario government to pilot a guaranteed basic income; this has largely been led by the Basic Income Canada Network[16] but has been greatly assisted by support from the CMA[6] and by concerted outreach from Ontario doctors to the Minister of Health and Long-Term Care, Eric Hoskins.[17] Physicians can also lend their voices to support community groups fighting for justice, such as Black Lives Matter or Idle No More, recognizing that discrimination is a considerable determinant of health.

Advocate for increased focus on and exposure to social determinants of health in undergraduate and postgraduate medical education. The movement for social accountability in medical education has brought a greater understanding of the need for medical learners to be exposed to the social determinants of health. This is reflected in the Future of Medical Education in Canada projects (undergraduate and postgraduate) led by the Association of Faculties of Medicine of Canada, in which social accountability plays a prominent role.[18] Advocacy has also been included as a CanMEDS[19] and CanMEDS–Family Medicine[20] competency for medical learners. However, the concepts surrounding health advocacy remain challenging to teach and are often labeled as the "soft stuff," both in curricula and in the minds of students and residents. Increasing classroom content and, more important, giving greater opportunities for service learning that incorporates a meaningful understanding of and actions on the determinants of health is necessary. An example of this approach can be found in the Making the Links Certificate in Global Health at the University of Saskatchewan in Saskatoon and other global health concentration programs that offer advanced learning opportunities for students interested in global health and advocacy.[21]

Rudolf Virchow famously said that politics is medicine on a large scale.[22] Advocacy at the macro level is an opportunity for physicians to use their knowledge and influence to make that true—to create a politics actually in service of the health of the public. When macro efforts are seen as complementary to efforts at the meso and micro levels, we see that the inverse of Virchow's dictum is true: medicine is politics on a smaller scale.[23] Our practice and its outcomes are bound up in the political realities that manifest in the social determinants of health. Using our skills and voices to make change at the macro level is a natural extension of the call to service of the profession.

> *Our 40-year-old patient, Diana, who has multiple medical conditions and was recently diagnosed with cervical cancer, has been connected with local resources and has inspired you to engage in making healthy changes in your community.[1-3] Building on these successes, you wonder how you can help patients like Diana on a broader scale.*

Helping Diana

Physicians can advocate as individuals or in groups, with everything from letter-writing campaigns to public activism, from single-issue efforts to the development of lasting organizations. Here are some examples of where to direct that activity in the case of Diana and patients like her.

- Diana frequently skips diabetes and blood pressure medications. A national pharmacare program would eliminate the competition between the cost medications and other necessities.
- Increased wages or the existence of a basic income guarantee would ensure that Diana is able to afford the nutritious food and stable housing necessary for a healthy life, especially when living with a chronic illness.
- Perhaps if more primary care services were available in her neighbourhood, Diana's cancer would have been caught earlier via an ongoing clinical relationship. More equitable distribution of full-service primary care, with Patient's Medical Home models of care located in underserved areas, would result in greater opportunities for screening and early treatment of cancer and other conditions.
- Social media and other public education campaigns that are informed by a health equity approach, and designed in a way that Diana and others like her will access and understand, can help connect people with care and supports.

Conclusion

As family physicians we are uniquely positioned to influence various factors at the micro, meso, and macro levels that can profoundly improve the health of our patients. This allows us to not only help individual patients like Diana, but also to influence health far beyond the clinic. We hope that the reflections on the Best Advice guide on the social determinants of health[7] in this series of articles[1-3] will help point to the actions and collaborations that will help family physicians raise our collective voice in service of our individual patients, our communities, and our health care system more broadly to ensure optimal health for all Canadians.

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Competing interests
None declared

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