Dear Dr. Moscrop,

Manuscript ID BMJ-2019-053004.R1 entitled "If social determinants of health are so important, shouldn’t we ask patients about them?"

Thank you for sending us your revised manuscript, which we discussed at our editorial meeting. I am sincerely sorry for how long it has taken us to formalize a decision on your manuscript, but I am pleased to make a provisional offer of publication if you are able to revise it to address the points made by the editors, which are as follows:

* Everybody agreed that the article was much improved. Thank you for all the hard work you’ve put into this. SES disparities have come out in a prominent way with COVID-19, so there may be increased attention on this issue which would be very welcome.

  Thanks. Appreciated. I have made reference to the unequal covid-19 mortality statistics in the opening paragraph.

* The article is strongest on the argument for collecting the data than how and what to collect, and then what to do in response to the findings. It would still be good to see more flesh on the bones re your suggestion of what data to collect, and how to respond to it. As you work on this, stylistically it would be nice to keep it from sounding overly prescriptive like a how-to guide, as people may pick at the details (don’t like the wording, think there should be another question, etc.).

  Toward the end of the paper, under the section header ‘Proposals for action’, in the first paragraph that follows, I have added content to describe what data might be collected and how, partly based on experiences in Toronto. I have then added suggestions for how the information might be responded to once
practitioners have identified patients whose socioeconomic circumstances put them at risk of poor health and care outcomes.

* The tone of the piece still needs a bit of work to avoid it feeling hectoring. Inquiring about social determinants (as in the standfirst) is not straightforward, exploring them sensitively with individual and families is what’s required. And there is an implication that simply collecting data equates to a purposeful response - and that social prescribing is all that’s required. That needs a reference where it’s first mentioned. As currently practiced it’s surely very limited in scope and we doubt that will achieve much. What might achieve more is a cadre of people linked to practices who can provide the support disadvantaged people need. The authors mention the NHS long term plan re social prescribing line workers but tell us nothing about the vision/detail here. We would also like you to consider the IORA health model.

I have sought to avoid sounding hectoring. That said, as I point out in the paper, Michael Marmot proposed monitoring health and healthcare using socioeconomic position or education in a Lancet paper back in 2013 and nothing changed. There has since been a WHO report on the same subject, making the same point, with the same effect. I wonder whether an analysis and discussion in stronger terms might be warranted.

I have added a line to stress that socioeconomic enquiries need to be made sensitively and with respect, just as doctors routinely enquire about other potentially sensitive issues such as sexuality, past trauma, drug and alcohol use, or mental health.

As described above, I have added suggestions for how socioeconomic information might be responded to in the hope that this will make clear that social prescribing is not all that is required. Unfortunately, I did not feel that there was sufficient space to expand on the vision/ detail of social prescribing beyond what I have already stated in the paper (‘Characterised as embracing everything from debt counselling for the insolvent to dance classes for the
lonely, social prescribing is intended to link patients with suitable non-medical resources from the voluntary or community sector. The aim is to address social needs, while reducing pressures on primary care services. However, I have included a reference to a more detailed BMJ paper on the subject which links out to other resources. It is an evolving field.

Many thanks for recommending the Iora model. I was certainly interested in its ethos of not just delivering health care but empowering patients to take control of their own health. However, I felt that this might be experienced by readers as a little detached from immediate possibilities within the NHS. Key to the Iora model of care is each patient having a ‘Health coach’ - a nice idea, but I can’t see this as an imminent prospect in the UK and the aim of our paper was to highlight changes in practice that were overdue, unambitious, and could occur now at little or no added expense. Moreover, I think it worth acknowledging that the health coaches appear intended to influence individual health behaviours and health decisions (a write-up I found describes them taking diabetics food shopping, running smoking cessation clinics, and acting as ‘confidants and cheerleaders’). Whilst potentially valuable, this does not demonstrate the response to social determinants of health that we propose. The Iora model does not obviously seek to define or challenge patients’ social needs or to adjust care delivery more widely. The model may be patient-centred, but it seems to leave patients individually responsible for their health outcomes (albeit with some coaching). Our proposals have a different underlying principle and aim.

* If you have not already seen it, please see the initiative about leaving nobody outside which we flagged recently in BMJ Opinion where the authors refer to a useful checklist for health providers. It’s a reminder that being people centred/ aware of health inequities /and being committed to reduce them requires more than GPs grilling people about their socio economic status. [https://blogs.bmj.com/bmj/2019/11/25/leaving-nobody-outside-our-healthcare-systems-in-europe-or-elsewhere/](https://blogs.bmj.com/bmj/2019/11/25/leaving-nobody-outside-our-healthcare-systems-in-europe-or-elsewhere/)
Again thanks for this suggestion. I reviewed the Nobody Left Outside initiative and its healthcare Checklist with interest. The authors make it clear that the checklist is intended to facilitate the design and delivery of better care for underserved and vulnerable groups, “namely: homeless people, LGBTI people, people who use drugs, prisoners, sex workers and undocumented migrants”. Whilst I wholly endorse this and consider it a valuable means of moving toward more equitable healthcare, I believe it a little off-message from the content of our paper.

We are focussing on the acknowledgement of individuals’ socioeconomic contexts or social health determinants - we mention housing as well as education, occupation, and income, but we do not allude to sexuality, drug use, detention, sex work or undocumented migrants, and I think that these elements of patients’ backgrounds would generally not be regarded as social health determinants.

Moreover, the authors of the Checklist do not concern themselves with enquiring about or documenting individual patients’ experiences or contexts. Instead they are concerned with ensuring that healthcare provision is improved in a general way and on general principles for patient groups who may be vulnerable and otherwise underserved. To be clear, I think this is great, but it is not our message.

Nonetheless, reading the BMJ Opinion piece referred to as well as some of the sources that it cites led me to the WHO / World Bank report on Universal Health Coverage. This report emphasises the need for tracking equitable coverage using wealth and education data in high-income countries. I have briefly referred to it in the paper.

* On the writing/style side, several editors felt it was a bit longwinded in places, with redundancy in parts. Can you review with an eye to improving this? In particular, can the beginning be made a bit more succinct?

I have tried to say more with less.
* We suggest removing Box 3 & 4 (four boxes is a bit too much for this format). If you feel strongly that they should be retained, they can be online only.

I would be grateful if Box 3 could be retained, at least online. It includes a patient perspective that was suggested for an earlier revision, and our patient representative was kind enough to deliver.